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

May 5, 2015

Darrin Radeke, Administrator
Mini-Cassia Care Center
1729 Miller Avenue, PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **April 10, 2015**, a survey was conducted at Mini-Cassia Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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 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 **May 18, 2015**. Failure to submit an acceptable PoC by **May 18, 2015**, may result in the imposition of civil monetary penalties by **June 8, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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

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

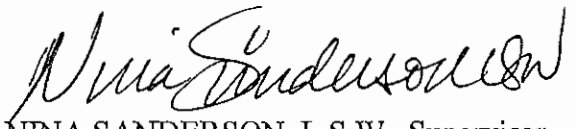
- BFS Letters (06/30/11)

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

This request must be received by **May 18, 2015**. If your request for informal dispute resolution is received after **May 18, 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: 05/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135081		C 04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINI-CASSIA CARE CENTER	1729 MILLER AVENUE BURLEY, ID 83318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification survey and complaint investigation of your facility. The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Sherri Case, LSW, QMRP Amy Barkley, RN, BSN Becca Watkins, RN The survey team entered the facility on April 6, 2015 and exited on April 10, 2015. 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 DA = Dietary Aide DDS = Director of Dietary Services DON = Director of Nursing 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 TAR = Treatment Administration Record WC = Wheelchair	F 000	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
F 151	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS	F 151	F151 The facility will promote resident rights to be free of interference, coercion, and reprisal from the facility in the exercise of his or rights as it relates to the secured/ locked unit. 1. A. The citation will be corrected for: Resident #1- Resident has signed the consent form to be on the secured unit. The resident has been assessed by the IDT for appropriateness of the secured unit. The resident meets facility criteria for the secured unit. From observation and behavioral assessment done, the	6/10/15

FACILITY STANDARDS
RECEIVED
JUN - 4 2015

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

ADMINISTRATOR 6/2/15

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

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F 151 SS=E	Continued From page 1 - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on observation, staff and physician interview, facility policy review, and record review, it was determined the facility failed to ensure residents were given the right or opportunity to make an informed choice, or give consent prior to, being placed on a locked unit. This was true for 4 of 10 (#s 1, 4, 8, & 11) sampled residents and had the potential to effect the remaining 33 resident's residing on the locked unit. The deficient practice had the potential for psychosocial harm when residents were prohibited from freely coming and going from their place of residence without assessment as to the reason their civil liberties had been infringed. Findings include: The Bureau of Facility Standards Informational Letter #2011-01, dated 3/30/11, documented: A. The resident and/or the resident representative must be informed the unit is locked prior to admission from outside facility, be given the opportunity for informed choice/consent, and the final decision should be based on meeting the resident's needs in the least restrictive way possible. B. The care of each resident must be based on the IDT assessment for each resident on the	F 151	facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. The resident meets facility criteria for the secured unit. Resident # 4 – Resident's guardian has signed the consent form to be on the secured unit. The resident has been assessed by the IDT for appropriateness of the secured unit. The resident meets facility criteria for the secured unit. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. Resident #8- Resident signed the consent forms to be on the secured unit. The resident has been assessed by the IDT for appropriateness of the secured unit. The resident meets facility criteria for the secured unit. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. Resident #11- Resident's guardian has signed the consent form to be on the secured unit. The resident has been assessed by the IDT for appropriateness	

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F 151	Continued From page 2 locked unit to include, the resident's specific behavior symptoms which make a locked unit necessary for the resident and how the locked unit is in the best interest of the resident; documetation that less restrictive means and measures were attempted and proven to be unsuccesful; and that the IDT evaluated each resident quarterly to determine the resident's continued need for the locked unit. The facility's Behavioral Care Unit Policies and Procedures, Required Components for the Secured Unit documented, "For resident safety, individuals may be admitted to the secured unit...Residents may or may not have behavioral issues to be admitted to the secured unit. Residents with high risk for elopement or have serious aggressive behaviors should be admitted or transferred to the secured unit of the Behavioral Care Unit (BCU). For those not on the secured unit with serious behavioral issues or are at high risk for elopement, a 1:1 staff member should attend [the] resident during active periods. Appropriated placement of the residents is determined by the interdisciplinary team or administrative team." 1. Resident #4 was most recently admitted to the facility on 3/5/14 with multiple diagnoses to include epilepsy, anxiety, history (hx) of trans eschemic attack (TIA), protein calorie malnutrition, and failure to thrive. The Annual MDS, dated 3/2/15, coded the resident had no hallucinations and/or delusions; no behaviors interfering with the resident's care and/or participation in activity; and no physical and/or verbal behaviors impacting or placing other residents at risk.	F 151	of the secured unit. The resident meets facility criteria for the secured unit. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. B. Information will be provided prior to admission and upon admission to the facility that the facility has a locked unit and the resident may be admitted to the secured unit. C. The IDT will assess each resident, and consider specific behavior symptoms, every quarter and PRN for appropriateness of placement on the secured unit and documented on the IDT review form. 2. Other residents will be identified during the admission process and during quarterly IDT. Residents and responsible parties will sign that they are accepting of placement on the secured unit. 3. The system will be corrected with the use of the addition on the preadmission consent form and the enhanced IDT Meeting Assessment. 4. The citation will be prevented and the plan will be monitored as these	

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F 151	Continued From page 3 2. Resident #8 was most recently admitted to the facility on 9/30/13 with multiple diagnoses to include schizoeffective disorder, anxiety, and mild intelectual disabilities. The Quarterly MDS, dated 3/19/15, coded the resident had the ability to understand others and was understood by others; was cognitively intact with a BIMS of 12; did not have inattention, disorganized thinking, altered level of consciousness, or psychomotor retardation; no hallucinations or delusions; no physical and/or behavioral symptoms directed towards others; did not reject cares; and did not wander. 3. Resident #11 was most recently admitted to the facility on 5/1/14 with multiple diagnoses to include schizoeffective disorder, delusional disorder, and the resident is deaf/mute. The Quarterly MDS, dated 3/19/15, coded the resident's hearing was highly impaired; did not speak; sometimes he had the ability to understand others sometimes he was understood by others. The resident was coded as severely cognitively impaired with a BIMS of 4; did not have inattention, disorganized thinking, altered level of consciousness, and/or psychomotor retardation; no hallucinations or delusions; no physical and/or behavioral symptoms directed towards others; did not reject cares; and did not wander. However, it could not be determined how the facility was able to accurately assess Resident #11's cognitive abilities related to the resident having the diagnoses of being deaf/mute and having only limited ability to read and write, and had not engaged a sign language interpreter. Please see F 154 for details.	F 151	interventions are put into place. May 11th, the quality assurance committee will commence to ensure that 100% of all residents on the secured unit have a Secured unit form complete, 2-quarterly IDT assessment for the secured unit. Resident Services Coordinator will head the subcommittee to monitor this action. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3. 5. The Administrator will be responsible to ensure that the plan of correction is followed properly.	

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F 151	Continued From page 4 On 4/6/15, at 8:50 AM, when asked what the process was to admit a resident on the locked unit, the Administrator said the facility receives a packet of information on the resident from the transfering facility, the packet is reviewed by the IDT and the IDT determines if placement on the secured unit is appropriate. The Administrator said once placement was determined the resident/resident representative was told the resident would not have the ability to leave the unit on his/her own. On 4/10/15, at 4:15 PM, the Medical Director stated his role in development, implementation, and revision of the policy and procedure for placement on the locked unit was not as much as he would like. He said the IDT determined placement and the facility admitted residents who, "had difficulty being placed anywhere related to their behaviors." No further information was provide to resolve the concern.	F 151	F154 The facility will ensure that residents are fully informed in a language they can understand of their total health status and informed in advance about care and treatment that my affect their well being. 1.A. The citation will be corrected for: Resident #1- Resident has been provided a communication board and does not desire to use communication board. Care plan has been updated to reflect that resident prefers to use non verbal signs to communicate at this time. If staff has difficult understanding resident they are encouraged to seek resident service specialist to clarify communications. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. Resident #11 – Resident has been provided a light weight communication board which he prefers not to carry around with him. He is provided with a note pad and pen that he sometimes carries. Resident's care plan has been updated to reflect that he prefers not to carry communication board most of the	6/8/15
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by:	F 154		

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F 154	Continued From page 5 Based on observations, staff and resident interview, and record review, it was determined the facility failed to accommodate residents' communication limitations, which led to frustration and the potential for psychosocial harm when activity, emotional, daily living, and medical needs were not addressed by facility staff. This was true for 2 of 6 (#s 1 and 11) residents reviewed for communication. Findings included: 1. Resident #1 was readmitted to the facility 12/23/14 with multiple diagnoses, which included right sided hemiplegia, expressive language disorder (difficulties with written and spoken language), aphasia (language disorder affecting the ability to communicate) due to cerebrovascular disease, and depressive disorder. The most recent quarterly MDS assessment, dated 3/13/15, documented Resident #1 had impairment on one side of the body, unclear speech, sometimes able to make self understood, usually able to understand others, and did not exhibit behaviors, psychosis, or delirium. On 4/10/15 at 3:55 PM, the DNS stated the resident was given a BIMS of 1 because his speaking language was not understood. The DNS stated awareness that the BIMS scale was for assessment of mental status and not a communication assessment. The DNS stated she was able to understand the resident's non-verbal communication. Care plan, dated 6/26/14, 9/18/14, and 9/23/14, documented Resident #1 liked to go outdoors, needed assistance to go to activities, required	F 154	time and will use pad and pen on occasion. Documentation shows resident actively participates in most activities. Closed captioning has been activated on all communal televisions. There is a communication board in resident's room that is constantly available to resident and a communication board in the lobby area. There is a poster to teach sign language to staff and others who desire to learn sign language. There is a class available for those that wish to learn signing scheduled for May 27th 2015, and a mandatory refresher class on June 10th, 2015 for simple communication education. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. 2. Other residents that have the potential to be affected by the cited tag will be identified by the MDS Matrix on Language and Communication. Corrective action will be addressed by ensuring all appropriate modes of communication are explored and documented on resident care plans, and providing items and training	

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F 154	Continued From page 6 encouragement to go on outings, liked to read books, propelled self in wheelchair with the left leg, was able to find room, recognized staff, needed engagement in guided conversations, answered yes/no to questions, used motions to support communication, caregivers were to face resident and make eye contact, needed assistance with decision making, requireed approaches that maximized involvement in daily decision making and activity, became frustrated when not understood and when not able to say wanted words, required encouragement to use gestures to assist with communication, communicated by making gestures - nodding, shaking head, body language, some verbal sounds, and required adequate time to respond. Occupational Therapy evaluation forms for 3/6/15-3/13/15, documented Resident #1 was unable to be understood with nonsensical verbalizations and visually expressed himself through acting out desires and physically pointing out his wants or needs. The social services report, dated 3/20/15, documented, "BIMS score 1, he is alert and orientated but does have communication problems." A Progress Note, dated 3/21/15, documented, "Staff understand him only by his facial expression." An Activity Progress Note, dated 1/3/15, documented, "Make sure and listen to (Resident #1) closely because he has had a stroke [CVA] and has a slur in his speech." The following was observed on 4/6/2015	F 154	conducive to enhanced communication, ie. Communication boards. 3. All residents triggered on the MDS for communication issues are to be evaluated by the Speech Pathologist and each communication care plan will be individually updated to reflect the recommendations of the Speech Pathologist. 4. The corrective action will be monitored through the QAPI program. May 15th the quality assurance committee will commence to ensure that 100% of all triggered residents have the interventions in place. Resident Services Coordinator will head the subcommittee to monitor this action. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the communication care planning monitor form. 5. The Administrator will be responsible to ensure that the plan of correction is followed properly.	

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F 154	Continued From page 7 *3:55 PM - Resident #1 gave a thumbs up to the black arm sling he was wearing, picked his blue hand splint up off the table and threw it back down in the same spot, and then scrunched up his face at it. The following was observed on 4/7/15: *10:00 AM - Resident #1 pointed to the right side of his head and said "F**k, F**k," when asked if that area was painful. *10:15 AM - The resident said "F**k, F**k," and flung his hand downward when asked if he participated in activities. The resident flipped off the air with his extended middle finger and said, "F**k," when he showed the indention in his temple from wearing his glasses. The resident pointed at the door, then pointed to the space in front of himself, and shook his finger in the air in a scolding manner after he was asked if he was allowed to go outside. The resident pointed to his hand splint, flipped his middle finger at it, then pointed his index finger in the air and shook it up	F 154		
	and down in a scolding manner, appearing to re-enact an interaction he had with staff. The resident communicated by making gestures, nodding, shaking his head, body language, some verbal sounds, and pantomiming. The resident required adequate time to respond; his manner of expression was intense and emotional; and at times it was difficult to determine if the resident was becoming distressed by re-telling the story. The resident calmed his mannerisms when the surveyor confirmed understanding. *4:10 PM - The resident was observed sitting at the end of his hallway, looking out the back glass door. The resident responded to yes/no questions; pointed at his heart then pointed outside, then pushed on the locked door handle when asked if he liked to go outside. The resident			

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F 154	Continued From page 8 kicked the corner of the door and pushed on the handle again 3-4 times when asked if he was allowed to go outside. The resident pointed at his heart when asked if he was a hunter. The resident gave two tumbs up when asked if he would like someone to take him out. *4:45 PM - RN #15, standing at the opposite end of the hallway from where Resident #1 was sitting, stated, "That's (Resident #1), he is just looking to see what the weather is like." RN #15 did not approach the resident. *4:47 PM - RN #15 observed the resident pushing on the door handle and scanning the length of the door from top to bottom. Staff stood on the right affected side of the resident and asked "You all right buddy?" The resident pushed on the door handle then shrugged his shoulder and RN #15 responded, "All right," then walked away.	F 154		
	2. Resident #11 was most recently admitted to the facility on 5/1/14 with multiple diagnoses to include schizoaffective disorder, delusional disorder, and deaf/non-speaking. The Quarterly MDS, dated 3/19/15, coded the resident's hearing was highly impaired, he did not speak, sometimes he had the ability to understand others and was sometimes understood by others. The current care plan documented, the resident was unable to hear and had limited vocabulary and understanding. Interventions included, knows some sign language and has some writing skills; communicate via pen/paper and/or communication board; and allow time to			

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F 154	Continued From page 9 write/express needs. The staff were observed each day from 4/7/15 through 4/9/15 and did not implement the following interventions as directed by the care plan: communicate with the resident via communication board, and allow the resident time to write down or express his needs. On 4/8/15 at 10:30 AM, CNA #14 said the resident had a communication board when he was first admitted, but it had disappeared and she had no idea what happened to it. The following was observed on 4/7/15: * 1:00 PM - 1:50 PM, the resident sat isolated from other residents in the lobby and watched as staff interacted with other residents watching the game show Lets Make a Deal. The Closed Captioning was not on. Additionally, staff present in the lobby were observed to speak, interact, and offer fluid to other residents, but did not interact or offer fluid to Resident #11. * 1:50 PM - 2:00 PM, the resident walked to the nurses medication cart and attempted to communicate, via sign language with RN #11. The RN pointed to her watch, shook her head back and forth, told the resident it was not time for his medication and then ended the interaction with the resident. * 2:05 PM, the resident remained at the medication cart and again attempted to communicate via sign language with the RN. The RN looked at the resident, looked at the clock , and wrote on a piece of paper, "I will go get coffee in a minute." The surveyor asked the RN about the observation and the RN told the surveyor, "I thought I could understand him, but I guess I don't understand him as well as I	F 154		

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F 154	Continued From page 10 thought." * 2:15 PM, the surveyor, with pen and paper asked the resident the following questions: - Was he able read and write? The resident furrowed his brow and lifted his hand rotating it side to side. The surveyor wrote so-so on the paper and the resident shook his head up and down. - Are you thirsty? The resident shook his head up and down and placed his right fisted hand on top of his left fisted hand and made a twisting motion. The surveyor wrote the word coffee and the resident shook his head up and down. - The surveyor asked the resident if he understood sign language and would be willing to have a conversation if a sign language interpreter was provided. The resident shook his head up and down. * 2:30 - 3:30 PM, surveyors attended the resident council meeting with the resident. The Activity Assistant sat next to Resident #11 and wrote questions down on a piece of paper for the	F 154		
	resident. The Activity Director periodically looked at the Activity Assistant and asked, "Has [Resident #11] written anything down yet," to which the Assistant replied, "We are working on it." Resident #11 was not provided the opportunity process the question being asked and/or provide input, before the Activity Director asked the next question. The hand written document provided to the survey team by the Activity Assistant included random incomplete sentences for the resident to answer and written next to several of the questions was "didn't understand" or "needs follow-up." * 4:25 PM, the resident was sitting in the lobby, placed his right fisted hand on top of his left fisted hand and made a twisting motion towards CNA #13. CNA #13 said she was not sure, but thought			

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F 154	Continued From page 11 the resident was asking for coffee. CNA #13 identified there was no more coffee on the unit and said she did not know how to tell the resident that. On 4/9/15 at 1:30 PM, the surveyors met with the resident with the assistance of a sign language interpreter. When the interpreter asked the resident how the food was, the resident signed the food was so-so; fish was okay if you scraped the topping off; and the food was not seasoned. The resident signed he was provided with a list items for each meal and he points to what he wants to eat. He signed, "Today at lunch they got it [what he wanted to eat] wrong, but I ate it anyway." When asked the resident if he was able to read and write, the resident signed, "I don't read or write well and I have been deaf my whole life." When asked if he understood staff and if the staff understood him, the resident signed, "No." On 4/10/15 at 3:35 PM, the DNS was informed of the above observations and interview. The DNS stated she did not have a problem communicating with the resident and the staff used pen and paper to communicate with him. On 4/10/15 at 7:30 PM, the Administrator was notified of the identified concern. Additional information provided to the Bureau of Facility Standards, by the facility, on 4/13/15 did not resolve the concern.	F 154		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES 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	F 166	F166 The facility will ensure prompt resolution of grievances the resident may have including those with respect to the behavior of others.	6/8/15

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F 166	Continued From page 12 of other residents. This REQUIREMENT is not met as evidenced by: Based on policy and procedures review, resident and staff interview, grievances reports and record review, it was determined the facility failed to operationalize its policy and procedure related to grievances, and did not act promptly to solve grievances or notify residents of the resolution progress. This was true for 1 of 25 residents (#24) sampled for grievances and could have affected any resident in the facility. The deficient practice had the potential for harm if residents had concerns which were not addressed by the facility. Findings included: Review of the facilities policy and procedure for complaint/grievances documented the following: * The Administrator or Director of Nursing, or their designee, were to conduct a formal investigation of all grievances, which included verifying that pertinent communication to the resident is conveyed accurately and in a timely manner. *The investigation and report should have included the date and time the incident took place, the circumstances surrounding the incident, the location of the incident, the names and any witnesses and their account of the issue, the resident's account of the issue, the employee's account of the issue. *An investigation file was to be retained in a secured location in the Amninistrator's office *A grievance log for tracking and trending data was to be maintained. On 4/8/15 the facility's grievance file was reviewed from September 2014 to April 2015. The	F 166	1. The citation will be corrected for: Resident #24- Resident has been reimbursed his alleged missing moneys as of 4/18/15. This has been corrected to resident's satisfaction. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. Resident #15 – Resident has been discharged from facility. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. c. Resident #8- Resident has stated in writing that he is satisfied with our current laundry situation and service. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. 2. Other residents that have the potential to be affected by the cited tag will be identified by resident council minute concerns and formal grievances located in the grievance binder. Resident Council minutes from 5/5/15 stated that previous concerns were	

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F 166	Continued From page 13 file consisted of various complaints identified during the monthly Resident Council meetings, along with a brief description of the facility's resolutions. The file did not document: * Individual resident grievances which had been identified to the surveyor team during resident interviews and record review. * Individuals were individually interviewed by the facility related to the reported concerns during Resident Council. * A thorough investigation of the concern(s) was completed to include: the date grievance(s) were investigated and/or resolved, and whether or not the resident(s) were satisfied with the facility's resolution. On 4/8/15 at 1:25 PM, Resident #24 stated that over 1 week ago his grey sweat pants with his wallet and money in the pocket went missing. The resident reported he noticed the items missing 7 minutes after an unidentified staff member came in and took his dirty laundry. He stated he reported it to staff immediately, however his items were already sent down the laundry chute. The resident reported staff were unable to locate the missing items. The resident reported that a few days after the incident, the Administrator searched his room looking for the items. The resident reported to the surveyor he had concerns because no one had talked to him further about the matter. On 4/8/15 at 2:30PM, the DNS confirmed all incident-related documents had been provided to the surveyors. On 4/8/15, facility grievances on file had no such report on Resident #24's grievance nor did it contain grievances filed for concerns addressed	F 166	addressed and not a concern at this time. 3. Resident council minute form will be re formatted to ensure that all prior concerns are reviewed, with the resident council president signing off that they were or were not dealt with appropriately. Each specific grievance will be written, addressed and signed by resident who voiced grievance. Residents have stated that laundry issues are much better after numerous interventions put in place. Verbal grievances will be handled as written grievances. 4. The corrective action will be monitored through the QAPI program. June 2nd the quality assurance committee will commence to ensure that 100% of grievances are dealt with timely. The Activity Director will head the subcommittee to monitor this action. This will be monitored weekly X 4, then q 2 weeks X 2, then monthly X 3 on the communication care planning monitor form. 5. The Administrator will be responsible to ensure that the plan of correction is followed properly.	

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F 166	Continued From page 14 at Resident Council meetings. On 4/9/15 at 1:15 PM, the DNS was asked to supply all incident reports specifically for Resident #24. The DNS stated, "There are none at this time, but there was something about his complaint of things missing and the Resident Service Coordinator would have that report if there was one." On 4/9/15 at 1:17 PM, the Resident Service Coordinator stated, "There are no current reports but I know he talked to the administrator but I do not have anything on it." On 4/9/15, Activities Assistant #8 reported having had a conversation with Resident #24 the day the grey sweat pants, wallet, and money went missing and stated it happened "about a week ago," and reported, "I talked to (Resident #24) at 3 or 4 PM that day and the staff took his things in the morning." Activities Assistant #8 confirmed he did not document the resident's verbal report. 4/10/15 at 2:50 PM, the Administrator stated, "I met with (Resident #24) two days ago and it happened Friday," The Administrator stated, "No," when asked if he documented the report. The Administrator stated the resident's missing money would be replaced. When asked if there were any incidents of missing laundry, money or wallets prior to Resident #24's grievance, the administrator stated, "No." Review of the Resident Councel meeting minutes, dated 9/2/14, documented, "Laundry and CNAs not checking Res[ident]. pockets. Wallets and belongings are going through washer." Resident Councel meeting minutes,	F 166		

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F 166	Continued From page 15 dated 10/7/2014, documented "Residents request CNAs and laundry check the pockets in the clothes before washing clothing. Personal items, money, change, wallets wet, damaged." 4/10/15 at 6:00 PM, Resident #24 stated, his grey pants were returned, however the wallet and money remained missing, and said, "I was just told my money will be replaced but I do not know when and would appreciate it if someone told me." The reviewed grievnaces provided to surveyors by the facility did not address all the concerns presented in the Resident Councel meeting minutes, and included repeated issues consistently not addressed. Examples included: 6/3/14 - "Residents state they have never been invited to care plan meeting and want to know why they haven't been invited." 7/1/14 - "Clothes are mixed up and other residents are wearing their clothes."	F 166		
	8/5/14 - "Clothing going to wrong person, other residents wearing their clothes." 8/5/14 - "Resident requested staff visit with residents and assist with meals rather than talking about personal things the CNAs did over the weekend." 10/7/14 - "Resident states they are still not getting care plan meeting invitations and want to know why." 1/6/15 - "Laundry takes your clothes and does not return them or they come back and they are ruined." On 4/9/15, Activities Assistant #8 confirmed the mixed and missing laundry has continued to be an issue.			

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F 166	Continued From page 16 On 4/10/15 at 5:55 PM, RN# 12 stated, "We do not have many grievances here." 2. Resident #15 was admitted to the facility on 4/9/14 with multiple diagnoses to include spinal cord injury, chronic pain, muscle spasms, and quadriplegia. Findings included: On 4/8/15, the facility's grievance file was reviewed from September 2014 to April 2015. The file consisted of various complaints identified during the monthly Resident Council meetings, along with a brief description of the facility's resolutions. The file did not include individual resident grievances which had been identified by the survey team during resident interviews record review, and a complaint investigation. The Resident Council meeting minutes dated 9/2/14 documented, Six residents were present	F 166		
	for the meeting and expressed the following, "Concerns were not dealt with to Res[ident] satisfaction. Residents would like to have concerns addressed in writing with feedback from outcome of Res. concerns read at next council meeting for them to review." There was no follow up documentation to determine if participants in the group were interviewed individually to identify specific areas of concern; how the identified concerns were addressed; or what the resolutions to the concerns were. Nurses Notes were reviewed from 8/7/14 through 2/6/15 and documented the following: *8/12/14 - "Staff are in room 40-45 minutes at a time for cares. She requests to have pillows at each side and pulled up in bed. The staff ask is			

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F 166	Continued From page 17 there anything else they can do and at times she becomes upset at them and says they want to get tout [sic] in a hurry. They try to assure her they have met all needs before they leave because they have other things to do and it may be awhile." *8/20/14 - "She continues to have various complaints about staff that is not present and critical of staff that is present." *9/18/14 - "She has been upset and stating there is a problem with the turning schedule on day and eve[ning] shift." * 9/20/14 - "Res[ident] in a mood. Res. has told one of the aids to 'get out of my room.' I did remind res that she is a 2 person assist and that she needed 2 people to provide cares. She states, ' I just can't stand it when they don't know what they are doing.' [The nurse informed the resident] this aid is a very good and seasoned aid." *9/20/14 at 10:28 PM, Resident #15, "reported this evening a desire to speak with the	F 166		
	administrator about frustration with some staff members." NOTE: There was nothing documented in the resident's record from 9/20/14 to 2/6/15 to indicate the resident had been offered the opportunity to fill out a formal grievance related to her concerns. Additionally, it could not be determined whether the Administrator had been notified or if he had followed up with the resident. On 4/10/15 at 2:50 PM, the Administrator said a written grievance is not always completed when a resident verbalizes a grievance if the grievance can be resolved promptly. The Administrator said if a grievance is reported to him he speaks with the resident about it and then investigates it. He			

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F 166	Continued From page 18 was asked how the facility ensured and documented the grievances were thoroughly investigated and resolved to the resident's satisfaction. He stated he follows up with the residents, but does not write anything in their charts. On 4/10/15 at 5:55 PM, the Social Service Director stated, "We do not have many grievances here," and directed the surveyor to review the facility's Policy and Procedure for the Complaint/Grievance Process. On 4/10/15 at 7:30 PM, the Administrator was notified of the identified concern. Additional information provided to the Bureau of Facility Standards by the facility on 4/13/15 did not resolve the concern.	F 166		
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 determined the facility failed to provide reasonable accommodations of an individual's needs. This was true for 1 of 13 sample residents (#5). Resident #5 did not have a call light accessible when assistance could be needed or	F 246	F246 The facility will ensure that there is a reasonable accommodation of individual needs and preferences, except with the health or safety of the individual or other residents would be endangered. 1. The citation will be corrected for: a. Resident #5- Call light has been taped to the transfer pole in resident's room where resident can always access it. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag.	6/8/15

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F 246	Continued From page 19 wanted. This deficient practice had the potential for physical and/or mental harm to the resident whose needs were not met. Findings included: 1. Resident #5 was admitted to the facility on 11/20/14 with multiple diagnoses including Schizophrenia, Dementia, abnormal involuntary movements, muscle weakness, and undersocialized conduct with aggressive behaviors. The resident's most recent quarterly MDS assessment, dated 2/16/15, coded severely impaired cognition, extensive to total assistance needed for bed mobility, transfers, and toileting, frequently incontinent of bladder and always incontinent of bowel, and 3 falls since prior assessment. On 4/7/15 at 4:58 PM, Resident #5 was observed lying in the bed. The resident's bed was pushed against the wall on the left side and there was a fall mat on the floor, by the bed on the right side. The resident's call light was clipped on the privacy curtain, about 5 feet from the floor. CNA #1 was present and stated the resident was turned at 3:00 PM, when they had also changed his brief. CNA #1 stated the call light, "Needs to be in reach. He needs it." The CNA acknowledged, the call light would not have been accessible for the resident being clipped in its current location on the privacy curtain. On 4/9/15 at 5:45 PM, the Administrator and DNS were informed of the concern. No additional information was provided by the facility to alleviate the issue.	F 246	2. Other residents that have the potential to be affected by the cited tag are all other residents in the facility. Staff is to make continuous patrolling rounds of the residents and will ensure that call lights are within reach during rounds and document that call lights are in reach. 3. The continuous patrolling rounds will be documented on the rounding form to ensure call lights are continuously accessible. 4. The corrective action will be monitored through the QAPI program. May 11th the quality assurance committee will commence to ensure that 100% of all triggered residents have the interventions in place. Resident Services Coordinator will head the subcommittee to monitor this action. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the communication care planning monitor form. 5. The Administrator will be responsible to ensure that the plan of correction is followed properly.	
F 248	483.15(f)(1) ACTIVITIES MEET	F 248		

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F 248 SS=E	Continued From page 20 INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview, record review, and resident council meeting minutes, it was determined the facility failed provide an ongoing program of activities designed to meet the physical, mental and psycho-social well-being of each resident. This was true for 6 of 6 residents in the Resident Group, 1 random resident (#26) and 1 sampled resident (#11). The deficient practice had the potential to cause more than minimal harm if residents experienced boredom and/or mood changes related to a lack of meaningful stimulation. Findings included: 1. The activity calendars reviewed for January, February, March, and April 2015 did not provide activites after 2:00 PM on all days of the week except in March and the first two weeks of April, when the Lawrence Welk television program was offered on Saturdays at 7:00 PM. On Sundays Newspaper reading was inconsistently offered as an activity at 8:30 AM and LDS church service was always offered at 10:00 AM. Activities during the week from 8:30 AM to 2:15 PM were random/inconsistent and included: exercise, book club, bingo, outside walk, resident council, and hand/nail care.	F 248	F248 The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident. 1. The citation will be corrected for: Random Resident #26 – The facility will educate the direct care staff on interacting with residents more and on a higher level. Education will also include activity options available for residents and for staff to use with residents to keep them engaged to the extent the resident desires. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. Resident #11– Televisions in common areas on the unit where resident resides have been adjusted to include closed captioning. There is a communication board in resident's room that is constantly available to resident and a communication board in the lobby area. There is a poster to teach sign language to staff and others who desire to learn sign language.	6/8/15

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	135081		C 04/10/2015

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F 248	Continued From page 21 Resident Council Meeting minutes reviewed and documented the following related to the Activity Program: - September 2014 through October 2014 Residents identified they would like to go on more outings; work on model cars; have a Pinewood Derby; go on fishing trips; and take trips to the Rupert Senior Center. - December 2014, residents identified, "activities have not met needs or interests" and they wanted to go on more outings. - January 2015, residents identified they wanted to go on more outings, go to the Senior Center, go to the park and have more physical activity. - February 2015, residents identified, "no real exercise" and "bus rides need to go to a destination with an activity, not just to any old location and right back." - March 2015, residents identified they wanted to go on more bus rides. - April 2015, residents identified the activities are, "boring as heck" and one resident stated she had no comment. The residents identified they wanted to go out more; go to non-LDS church service; and knit. The meeting minutes did not document the identified concerns had been addressed by the facility and/or attempts had been made to meet the residents requests related to the facility's activity program. 2. The following observations were made on the locked unit for 4/6/15 and 4/7/15: * 4/6/15 at 10:25 AM, twelve residents were observed in the lobby during the excercise group activity. Two residents were observed sleeping in their wheelchairs, two residents were observed having conversations with staff, three residents were watching the television, and five residents,	F 248	There is a class available for those that wish to learn signing scheduled for May 27th 2015, and a mandatory refresher class on June 10th, 2015 for simple communication education. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. 2. Other residents that have the potential to be affected by the cited tag will be addressed in resident council with an emphasis to ensure that resident's activity needs are met. Residents are also given a calendar for the next month and encouraged to add desired activities and return the calendars before the 15th to be included in the next activity plan. Extend an invitation to other church denominations to visit the facility regularly. Multiple activities are scheduled after 2:00pm on the activity calendar. Activity Director makes list of items that are purchased beyond her budget and is reimbursed for all moneys. Activity Director was instructed to adjust hours of the director and the activity assistant to accommodate evening and weekend	

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F 248	Continued From page 22 with limited assistance from staff, were attempting to participate in the excercises. * 4/6/15 at 10:55 AM, seven residents were observed in the lobby during the book club (story reading). Three residents were sleeping in their wheel chairs, a hearing impaired resident was sitting away from the group by himself, a resident in a gerry chair was in front of the television (which had been turned off), two residents walked back and forth from the lobby to hall. * 4/7/15 at 11:00 AM, RR #26 was sitting with a 1:1 attendant in the lobby. CNA #14 brought the resident a puzzle. RR #26's attendant dumped the puzzle pieces on a bed side table, in front of the resident, but there was no room on the table to put the puzzle together. RR #26's CNA was observed to work on the puzzle while talking to CNA #14. RR #26 did not appear to be interested in the puzzle, she was nodding off sitting in the chair. * 4/7/15 from 1:00 PM to 2:00 PM, the only activity available for the residents was to watch "Let's Make a Deal." There were no other activities schedule after 2:15 PM. On 4/10/15 at 3:00 PM, the Activity Director (A.D.) was interviewed and confirmed the Activity Program did not include enough activities during the day and or in the evenings to meet residents needs. She stated she had asked for evening activity assistant and was told the facility did not get reimbursed for activities and it was her responsibility to make the activities program work with the staff she had. The AD stated the Activity Department has limited monthly budget and most months she donates money of her own. 2. Resident #11 was most recently admitted to the facility on 5/1/14 with multiple diagnoses to	F 248	activities. 3. Resident Council minutes will emphasize addressing whether or not the activity program is meeting the needs of the residents and the calendar will be reviewed. Residents will be involved with the QAPI committee starting 4/2/15. 4. The corrective action will be monitored through the QAPI program. Resident council minutes will be brought to the QAPI meetings. The Administrator and a volunteer group of residents will monitor this action. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the resident activity satisfaction form. 5. The Administrator will be responsible to ensure that the plan of correction is followed properly.	

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F 248	Continued From page 23 include schizoaffective disorder, delusional disorder, and deaf/non-speaking. The Quarterly MDS, dated 3/19/15, coded the resident's hearing was highly impaired, he did not speak, sometimes he had the ability to understand others and was sometimes understood by others. The current communication care plan documented, the resident was unable to hear and had limited vocabulary and understanding. Interventions included, knows some sign language and has some writing skills; communicate via pen/paper and/or communication board; and allow time to write/express needs. The current activity care plan documented the resident enjoyed smoking, social interaction, shopping trips, bus rides, supervised walks, Bingo, crafts, wood work, outings to the Senior Center, and Catholic church services.	F 248		
	During the survey from 4/6/15 through 4/10/15 the following activities were available to the resident: current events, book club, Let's Make a Deal Game show, Lawerence Welk Show, Communion, movie day, excercise, bingo, bus ride, a walk outside, and bus ride. On 4/7/15 from 1:00 PM to 2:15 PM, Resident #11 was observed to sit apart from the other residents in the lobby. "Let's Make a Deal," the scheduled activity was playing on the television, but did not have the closed captioning enabled for the resident. The resident was observed to sign words and symbols in the air and then giggle to himself. CNAs #14, #17, and #18 were observed to verbally interact with the other residents in the			

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F 248	Continued From page 24 lobby, however they did not attempt to interact with Resident #11. On 4/7/15 at 2:00 PM, CNA #14 was asked how staff communicate with Resident #11. The CNA said the resident had a communication board in his room that staff used when he was first admitted, but it disappeared a "long time ago." She said sometimes staff will try to use a pen and paper to communicate with him, but she said she did not think he could read or write very well. On 4/7/15 at 2:05 PM, RN #11 was assigned to care for Resident #11. She was asked if the Activity Program and Calendar met Resident #11's needs and interests. The RN said she did not know what activities the resident liked or participated in and stated,"all of the activities here are geared towards residents that are able to hear." On 4/10/15 at 3:00 PM, the Activity Director confirmed the Activity Program was geared more towards the residents that could hear and the facility was not meeting the resident's communication needs. She said the resident did participate in Bingo, some crafts, and the mens social. On 4/10/15 at 7:30 PM, the Administrator was notified of the identified concern. Additional information provided to the Bureau of Facility Standards by the facility on 4/13/15 did not resolve the concern.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

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F 253	Continued From page 25 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to perform maintenance services necessary to maintain in good repair residents' rooms as evidenced by holes in the bathroom walls, a bathroom with loose formica, and a section of unsecured baseboard. This had the potential to affect residents and decrease the quality of life for 8 residents who resided in rooms #21, #22, #25, #26 and #34. Findings included: During the initial tour on 4/6/15 at 10:35 AM, residents in rooms #21 and #22 had a shared bathroom. The bathroom wall had 4 open screw holes, where it appeared a grab bar had been placed. The residents in rooms #25 and #26 had a shared bathroom and there were 9 open holes in the wall and 5 of the holes had metal hardware in them. The resident in room #34 had to the right side of the sink, a section of unsecured baseboard that was curled outwards into the room and the wall was discolored. On 4/8/15 at 3:12 PM, a tour of the facility was performed with the Maintenance Supervisor (MS). The MS was asked about the holes in the bathrooms for the Residents in room #s 21, 22, 25, and 26. The MS stated he was aware of the holes, but had been "unsure of how to fix them" and "I could take some silicone to try to fix them." The 4 holes in the bathroom for rooms #21 and #22 had been the result of when the MS had removed the grab bar and turned it sideways, to	F 253	F253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. The citation will be corrected for: Resident in Rooms #21and #22, and Rooms #25 and #26- The small holes where the bars had been removed were filled. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on residents from the cited tag. Resident Room #34 – the 4 inch rubber base board piece was secured. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. 2. Other residents that have the potential to be affected by the cited tag will be identified by the new maintenance manager that has been certified in housing for the elderly as part of his ongoing physical plant rounds. 3. Ongoing physical plant rounds will be documented on the maintenance rounds sheet and though the	6/8/15

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F 253	Continued From page 26 help with access to the light switch. The MS acknowledged the formica on the same wall was not secured to the wall, at the top left hand corner and needed to be repaired. The 9 holes in the bathroom for rooms #25 and #26, according to the MS were the remains of another handbar that had been removed for access for a resident and her wheelchair. The MS did not think the resident had used the bathroom though and had used a bathroom in the day room for easier accessiblity. The MS was asked about the unsecured rubber baseboard in resident's room #34, that curled outwards into the room's walkway. The MS said he had noticed it before and he had not fixed it yet, "On my list. I need to get the glue." On 4/8/15 at 8:35 PM, the Administrator and DNS were informed of the concerns. There was no additional information provided by the facility.	F 253	maintenance binders located at each nursing station. 4. The corrective action will be monitored through the QAPI program. May 18th the quality assurance committee will commence to ensure that 100% of all outstanding repairs are completed and rounding documentation will be brought to the QAPI meetings. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the communication care planning monitor form. 5. The Administrator will be responsible to ensure that the plan of correction is followed properly.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F280 The facility will ensure resident 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. Resident #2- Care plan update: Resident to be open to air while in bed to promote healing and healthy skin integrity. No psychosocial issues noted. Completed 5/ 6/15. Resident #13- IDT reviewed and	6/10/15
	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			

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F 280	Continued From page 27 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, it was determined the facility failed to review and revise care plans for 2 of 9 sampled residents (#s 2 and 13). Resident #2's care plan had not been updated or revised to only use adult briefs while the resident was in his wheelchair. Resident #13's fall care plan had not been revised to include a low bed. These failures had the potential for harm should residents receive inappropriate care due to lack of direction in their care plans. Findings included: 1. Resident #2 was admitted to the facility on 8/2/13 with diagnoses which included neurogenic bladder and diabetes. The resident's 2/2/15 quarterly MDS assessment documented the resident was moderately cognitively impaired. The resident's care plan for irregular bowel pattern, revised on 11/12/14, included an interventions the resident used an incontinent brief. During an observation on 4/8/15 at 12:15 p.m., Resident #2 was asked if he wore an adult brief and stated no, as it caused him to "sweat" which resulted in a rash. CNA #4 and CNA #5 then came into the room and assisted the resident to reposition himself in his bed. At that time CNA #5	F 280	updated care plan. Bed height remarked. Resident's bed height at knee height due to a history of self transfer. This height allows resident to plant feet on floor for stability. Non-skid strips have been put in place at bedside. No psychosocial issues noted. Completed May 6, 2015. 2. Review of both care plans and resident current use of incontinent needs by MDS and Delta-Supplies Coordinator by June 8, 2015. All bed heights marked as appropriate with tape to wall to match resident care plan by June 8, 2015 by MDS/RNA Coordinator. 3. IDT team re-educated on Care planning process, Stand-up, I & A, and Daily Clinical meeting including attendance, process and responsibilities by DNS on May 12, 2015 and May 18, 2015. Employee's re-educated during Monthly Staffing Meeting regarding Care planning including use of CNA / LN communication books to assist additions to resident desires and a Person-centered care plan; bed heights, repositioning, and incontinent care needs.	

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F 280	Continued From page 28 was asked if the resident had an adult brief on and stated no. On 4/10/15 at 1:40 p.m., the DON stated the Care Plan needed to be revised as the resident only wore an adult brief when he was in his wheelchair. 2. Resident #13 was admitted to the facility on 12/18/12 with diagnoses which included hypoxemia, urinary obstruction and epilepsy. The resident's fall care plan, revised on 2/4/15, interventions were as follows: * Anti-tip bars * Anticipate needs * Call light within reach * Appropriate foot wear * Determine root cause of falls An Incident/Accident IDT Review form for 1/9/15 documented the resident had fell when attempting to transfer himself from bed. The Facility's Plan and intervention to prevent reoccurrence was for the bed to be in the lowest position while the resident was in bed. On 4/8/15 at 12:50 p.m., CNA #7 was observed as he raised the resident's bed from the low position to prepare the resident to transfer to his wheelchair. On 4/10/15 at 2:15 p.m., the DON stated the low bed was not included in the interventions for fall prevention and "it should be." On 4/10/15 at 8:00 p.m. the Administrator and the DON were informed of the concerns The facility	F 280	Licensed Nurses re-educated regarding Care Planning process and 24hr communication book by DNS on May 12, 2015 and May 19, 2015. 4. MDS to attend Stand-up, I & A to update care plans and ADLS as needed-ongoing. DNS will be responsible if MDS is not present. Stand-up, I & A and Daily Clinical meetings will be preformed, including review of C.N.A communication, 24 hour report/LN communication and PCC Order Listing report for care planning update. This process will be competed by DNS/UM/ &-or Medical records daily unless weekend or holiday then it will be completed following day. LN will be responsible to initiate care plan changes then stated process will be a double check. This process will be ongoing to ensure resident rights and continuous comprehensive care plan. Medication / Treatment Checklist will be used with new order by Licensed Nursing staff to ensure communication with resident, family, Doctor, and staff to ensure awareness of changes to residents needs and a continues updated Person-centered comprehensive care plan. This will be	

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F 280	Continued From page 29 provided no further information.	F 280	an ongoing process starting May 13, 2015.	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure residents received appropriate care for diabetic management, bowel care, and splint management. This was true for 6 of 26 sampled residents. The deficient practice had the potential to cause harm if residents did not receive appropriate treatment for hypo- or hyperglycemic episodes, experienced constipation due to lack of bowel care, or developed skin impairment when a splint was used without proper assessment. Findings included: 1. Resident #17 was admitted to the facility on 7/13/13 with multiple diagnoses including diabetes type II, chronic kidney disease stage II, and long-term use of insulin. The resident's April 2015 recapitulation Physician's orders, dated 3/30/15, documented: "...Glucagon Emergency Kit 1 MG...Inject 1 application subcutaneously as needed for Hypoglycemic Blood sugars [BS] less than 70,	F 309	DNS / MDS will audit daily completion of above process daily x 4 weeks, then weekly x 4 weeks, then every 2 weeks x 4 weeks then monthly for QA/PI ongoing until 100% compliance with process. DNS will audit 5-10 care plans weekly x 5 weeks, then every 2 weeks x 4 weeks, then monthly ongoing for a triple check for compliance of a person-centered comprehensive care plan. If DNS out of facility MDS to complete 5-10 care plan audits. Monthly Administrator will report to QA/PI compliance of care plan reviews. F309 The facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive care plan. 1.a. Resident #17. Orders obtained to follow Hypo-Hyperglycemic Policy and Procedure. Glucagon emergency Kit DC. Order for Sliding Scale insulin clarified for BS to be obtained before giving. Resident has had no adverse affects	6/10/15

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F 309	Continued From page 30 resident unable to swallow or unconscious...start date 2/28/14..." "...Lantus Solution...Inject 12 units subcutaneously [SQ] one time a day for IDDM each morning...Start date 7/24/14...D/C [discontinued] 3/30/15..." "...Novolog Solution...Inject as per sliding scale [SS]: if 79-99=0 Hold scheduled Novolog AC; 100-199=0; 200-249=1; 250-299=2; 300-349=3; 350+=4, subcutaneously before meals...Start date 2/28/14...3/30/15 DC..." "...Blood glucose check at HS [at bedtime] one time a day...Start date 9/5/13..." "...3/30/15 Novolog 70/30 SQ BID [twice a day] 6 units...", this order was D/C on 4/6/15. "...3/30/15 Report BS < [less than] 80 to MD/PA..." Note: There were no documented Physician's orders for checking the resident's BS prior to administration of the sliding scale Novolog Insulin from 2/28/14 to 3/30/15. The resident's BS had been obtained prior to the administration of the SS insulin though. Resident #17's Physician's orders, dated 4/6/15, documented: "Change 70/30 insulin to 8u [units] sc [subcutaneously] QAM [every AM]...Check QID [four times a day] fingerstick on Wed and Thurs of this week & then D/C fingersticks..." The Novolog insulin Physician's order documented to administer 8 units of insulin one time a day and the MAR documented the time as 7:00 AM, with the BS only to be taken at HS, after Wednesday and Thursday. The resident's MAR and Nursing Progress Notes (NPN) documented: *1/8/15 - 9:00 PM-MAR: Blank in the BS space	F 309	noted prior to changes. Blank in MAR's was noted to be made by Licensed Nurse that was terminated and therefore corrected itself. Completed May 13, 2015. Residents- 11, 19, 20, & 22. Orders obtained to follow Hypo-Hyperglycemic Policy and Procedure. Completed May 13, 2015. None of the above residents had any adverse BS affects noted. Resident #1. Bowel Protocol updated to meet residents needs and likes vs. dislikes by Dietary Manager and Medical Records. Completed May 14, 2015. Resident met with MDS/ RNA Coordinator on 4/25/15 and discontinued use of splint. Residents care plan updated by UM. Completed May 14, 2015. Resident #1. OT orders obtain and completed. New Velcro placed to meet resident's expectations April 10, 2015. Care plan and RNA program updated May 14, 2015 to including hours to be worn and to monitor before and after removal of splint by RNA Coordinator on May 14, 2015. RN #11 Reoriented regarding I & A process and reporting by DNS on May 12, 2015. No adverse psychosocial concerns noted related to splint.	

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F 309	Continued From page 31 and no LN's initials. There were no NPN that addressed having an undocumented BS. *2/13/15 - 4:00 PM -MAR: Blank for the amount of units of Novolog SS given, BS blank and no LN's initials. There were no NPN that addressed having an undocumented BS and no SS insulin administered. *2/18/15 - 7:00 AM, 11:00 AM, & 4:00 PM -MAR: BS were marked with Xs, units of Novolog SS given were marked with X, and with the LN's initials a chart code of 5 on the 11:00 AM time and a chart code of 9 on the 7:00 AM and 4:00 PM. The 5 code represented: "5=Hold/See Nurse Notes" and the 9 represented: "9=Other/See Nurse Notes." There were no NPN that addressed having undocumented BS and no SS Novolog insulin administered for the 7 AM, 11 AM, and 4 PM medication administration times. *3/6/15 - 7:00 AM -MAR: The resident's BS was documented as 67. There was no documented NPN of the Physician being notified of a BS < 70, a X was charted by LN for units of SS insulin given, and no action was documented as taken. Note: The facility's Policy & Procedure for BS < 70 was to notify the Physician and implement interventions. The Physician's order for the administration of the Glucagon Emergency Kit was unclear, if the Glucagon should have been administered for a BS less than 70, since the resident was able to swallow and not unconscious. The Physician's order was documented: "Hypoglycemic Blood sugars [BS] less than 70, resident unable to swallow or unconscious." On 4/10/15 at 11:20 AM, the DNS stated, "[They]	F 309	2.All resident with Diagnosis of Diabetic evaluated by MD and recommendations to follow Hypo/Hyperglycemia Policy and Procedure implemented as appropriate by UM/Medical Records on May 22, 2015. Updated Bowel Policy and Procedure implement for every resident with comprehensive care planning by IDT team by June 8, 2015. All facility residents interviewed for likes and dislikes prunes, prune juice and BAP (banana, apple sauce and prune) and care planned by Dietary and Management Nursing team by June 8, 2015. All RNA programs reviewed and updated regarding splint use and nursing notification related potential skin issues by MDS/RNA Coordinator by June 8, 2015. 3. Education and implementation Hypo-hyperglycemic Policy and Procedure and auditing process with Licensed Nurses on May 12, 2015 and May 19, 2015 during Licensed Nurses Meeting by DNS. Education to new Bowel Policy and Procedure and resident desires plus audit of Bowel movement at shift	

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F 309	Continued From page 32 should have followed the Physician's orders," but later, added the wording of the Glucagon order was "off by a word." *3/13/15 - 11:00 AM - MAR: The resident's BS was documented as 426. There was no documented NPN of the Physician being notified of a BS > 400. The resident had received 4 units of Novolog insulin. Note: The facility's Policy & Procedure for BS > 400 was to notify the Physician. *3/15/15 - 9:00 PM - MAR: The resident's BS was documented as 401. There was no documented NPN of the Physician being notified of a BS > (greater than) 400 nor any action taken. Note: The SS Novolog order was not for the nighttime BS. *4/3/15 - 4:00 PM - MAR: The resident's BS was documented as 425. There was no documented NPN of the Physician being notified nor any action taken.	F 309	change for compliance with Bowel Policy to ensure resident rights and safety by DNS. Start May 20, 2015. RNA program training /retraining including importance reporting skin issues by the corporate MDS Trainer by June 8, 2015. MDS/RNA Coordinator educated regarding regulations, implementation, and monitoring of RNA programs by the corporate MDS trainer by June 8, 2015. 4. The corrective action will be monitored in Daily Clinical meeting for splints, bowel programs, and blood sugar issues. This will be an ongoing process starting May 13, 2015. DNS / MDS will audit daily completion of above process daily x 4 weeks, then weekly x 4 weeks, then every 2 weeks x 4 weeks then monthly for QA/PI ongoing until 100% compliance with process. DNS will audit 5-10 care plans weekly x 5 weeks, then every 2 weeks x 4 weeks, then monthly. If DNS out of facility Unit Manager to complete audits. Monthly DNS will report to QA/PI compliance of programs.	
	On 4/10/2015 at 8:50 AM, LN #3 was observed during medication pass to draw up 8 units of Novolog insulin and at 8:55 AM, administer the insulin to Resident #17. At 1:30 PM, LN #3 confirmed the resident's insulin was scheduled to be given at 7:00 AM before breakfast and was instead given at 8:55 AM after breakfast. The Physician's order dated 4/6/15 and 3/30/15, for the Novolog insulin had not been clarified to document the insulin needed to be given prior to meals. On 4/10/15 at 2:30 PM, the DNS was interviewed regarding Resident #17's diabetic care. The DNS stated in regards to the BS, "The doctor was not notified of the highs. No documentation of the doctor being notified of the 67 low or of any			

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F 309	Continued From page 33 interventions. No recheck noted." 2. Resident #18 was admitted to the facility on 2/13/09 with multiple diagnoses including diabetes type II and dysphagia due to cerebrovascular disease. The resident's April 2015 recapitulation Physician's orders documented: "...Only check finger stick glucose PRN for symptoms of Hypoglycemia or change of condition as needed for hypoglycemia or change in condition...Start date 12/8/14...End date 3/26/15..." "...Blood Sugar Checks QAM one time a day for Hypoglycemia...Start date 3/11/15..." "...Two cal one time a day for hypoglycemia bolus 120 mls...Start date 3/9/15..." Note: The resident's Physician's orders did not document the Enteral Feed Order. The Enteral Feed Order was documented on the April 2015 MAR as follows: "...Enteral Feed Order five times a day for NPO due to dysphagia Jevity 1.5 237mls (1 can), manual bolus via peg tube per gravity...Order date 12/8/14..." The times documented for the bolus Jevity were 7:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, and 9:00 PM. The resident did not have any documented emergency orders such as a Glucagon Emergency Kit for hypoglycemic episodes. The resident's MAR and Nursing Progress Notes (NPN) documented: *2/1 through 4/9/15 7:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, & 9:00 PM- The MAR documented the Jevity 1.5 (237 ml) administered manually by bolus via peg tube. *2/24/15 - 5:19 AM: The resident's BS was documented as being 56.	F 309		

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F 309	Continued From page 34 The NPN documented, "Only check finger stick glucose PRN for symptoms of Hypoglycemia...BS 56 s/s [signs and symptoms] pale, shakiness, anxiety..." *2/24/15 - 5:22 AM: The NPN documented, "...PRN Administration was: Effective. Sugar water administered. Blood sugar up to 65 in 10 minutes..." There was no documentation the facility had notified the Physician of the BS of 56 and 65, no Physician's order for sugar water, no documentation the route of administration of the sugar water, no documentation of concentration or amount of sugar water administered, and no documentation of a recheck of the BS of 65 and further interventions. *3/9/15 - 10:00 PM: The Two Cal bolus for hypoglycemia was documented as being administered from 3/9/15 throughout the survey period at 10:00 at night. *3/15/15 - 6:00 AM: The resident's BS was documented as 62.	F 309		
	There were no documented NPN of the Physician being notified nor any actions taken. *3/17/15 - 6:00 AM: The resident's BS was documented as 64. There were no documented NPN of the Physician being notified nor any actions taken. *3/21/15 - 6:00 AM: The resident's BS was documented as 67. There were no documented NPN of the Physician being notified nor any actions taken. *3/22/15 - 6:00 AM: The resident's BS was documented as 68. There were no documented NPN of the Physician being notified nor any actions taken. On 4/10/15 at 2:35 PM, the DNS was interviewed regarding the diabetic care for Resident #18. The			

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F 309	Continued From page 35 DNS stated the sugar water was administered because they "felt it was the same as juice", had been told juice was not the best thing through a peg tube and, "Two cal had not been ordered yet." The DNS acknowledged the facility's Hypoglycemia and Hyperglycemia Policy & Procedures were not being followed. The DNS said the Physician had not been notified, interventions were not being implemented, and BS were not being rechecked. There were 4 other identified diabetic residents (#s 11, 19, 20, & 22) who were reviewed on survey, whom had similar findings. These residents could experience hypo- or hyperglycemia had their care compromised, when the facility failed to provide adequate diabetic management as evidenced by the Physician's orders for hypo- and hyperglycemia or include parameters, or target ranges, for hypoglycemia and hyperglycemia; the lack of consistent and appropriate interventions for hypo- and	F 309		
	hyperglycemia events; the lack of consistent follow-up monitoring for hypoglycemia; the failure to notify physicians of hypo- and/or hyperglycemic episodes; the failure to monitor BS as the Physician ordered; and, the failure to follow their own Hypo- and Hyperglycemia Policy and Procedures. 3a. Resident #1 was re-admitted to the facility on 12/23/14 with multiple diagnoses which included a history of digestive disease, abdominal pain, intestinal obstruction, and constipation. The most recent quarterly MDS assessment, dated 3/13/2015, documented Resident #1 did not have constipation present. However, record review and staff interview confirmed the resident experienced constipation for six days from 3/9/15			

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F 309	Continued From page 36 through3/14/15. On 4/10/15 at 3:55 PM, the DNS stated Resident #1 "has a huge issue with his abdominals and bowels." The current care plan documented the resident had concerns related to constipation. The goal indentified for Resident #1 was to have a normal bowel movement every 2-4 days. The following interventions documented: *Give bowel medications as ordered and utilize bowel protocol. *Report to MD for ineffective or inadequate bowel treatments. *Report unresolved or worsening signs and symptoms of constipation, gas/bloating, to MD. Physician orders, dated 12/23/14, documented the following: *Bowel movement (BM): document L=Large, M=Medium, S=Small, 0=None. Document	F 309		
	1=Incontinent, C=Continent every shift. *"On day 2 (not 48 hours) if no BM, give prune juice before or after breakfast meal. every 24 hours as needed. *Day 3, if no BM give 30cc (cubic centimeters) MOM (milk of magnesium), place on alert charting until resolved. *On NOC (night) shift of day 3, if no BM, give 10MG (milligram) ducolax suppository (PR) [Per Rectal] every 24 hours as needed. *If no BM in the morning of the 4th day, give fleets enema (PR) every 24 hours as needed. *If no BM within 3 hours of giving the fleets enema, call the physician immediately, every 24 hours as needed." From 2/1/15 through 2/28/15, Resident #1's			

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F 309	Continued From page 37 medical record documented he did not have a bowel movement for 2 days on 2 occassions and ordered interventions were not attempted. On another occasion, Resident #1 went 3 days without a bowel movement and only one intervention was implemented, which took place on the second day of the three day period. From 3/9/14 through 3/14/2015, when the resident did not experience a bowel movement, ordered interventions were not attempted other than prune juice, which was offered and refused on the second day of the six day period. The resident's medical record did not include documentation that the intervention was re-attempted or that education regarding the resident's refusal was provided. This was confirmed by the DNS on 4/10/15 at 10:10 AM. A 3/16/15 telephone order confirmed the physician was contacted on the eighth day that the resident had still not had a bowel movement. The physician telephone order stated, "Send to ER (Emergency Room) to eval (evaluate) and txt (treat) related to no bowel movement." NOTE: On 4/10/15 at 10:10 AM, the DNS stated the physician should have been notified on the fourth day the resident did not have a bowel movment. A local hospital ER report, dated 3/16/15, documented diagnostic studies indicated Resident #1 had constipation. From 4/2/14 through 4/4/15, medical records documented Resident #1 did not experience a bowel movment and that ordered interventions were not attempted.	F 309		

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F 309	Continued From page 38 On 4/10/15 3:55 PM, the DNS was asked to provide any additional related information related to the resident's lack of bowel movements for extended periods of time and the facility's response to those time periods. The DNS provided a blank copy of a "Bowel Report" form, which she stated should have been, but was not completed for Resident #1. 3b. Resident #1 was re-admitted to the facility on 12/23/14 with multiple diagnosis which included right sided hemiplegia and muscle spasm. The most recent quarterly MDS assessment, dated 3/13/15, documented Resident #1 had impairment on one side of his body, and was at risk for pressure ulcers. The MDS Restorative Nursing Program section did not identify a splint was in use. The current care plan documented the resident was to have skin audits weekly with showers and PRN (as needed) and that the nurse was to be notified of any bruises, scrapes, skin tears, redness, excoriation, or other concerns. The care plan included a handwritten entry, dated 4/3/15, that documented, "RNA (restorative nurses aid) program to apply splint to right hand in AM and off in PM, and to monitor for skin impairment with use of splint." The care plan did not identify the time the splint was to be on or off, nor when or how often the skin under the splint should have been monitored. A 4/3/15 RA (restorative assistant) referral form documented, "Placement of resting hand splint to R (right) hand 3 hours daily or to pt's (patient's) tolerance, " and was marked "yes," in the section	F 309		

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F 309	Continued From page 39 stating completion of nurse rehab training was performed. On 4/6/2015 at 3:55 PM, A black arm sling was observed around Resident #1's right arm. Resident gave a thumbs up to the black arm sling then picked up the blue hand splint sitting on the TV table and threw it back down in the same spot and scrunched up his face at it. On 4/7/2015 at 10:15 AM, a blue hand splint was observed on Resdient #1's right hand. A reddened area on the right wrist, thumb side, was visible under the hand splint. Resident #1 pointed to the hand splint and shook his head "yes" when asked if he was told he had to wear it. The resident then shook his pointer finger in the air, re-enacted a scene of someone yelling or scolding him, then pointed to his right hand splint and flipped it off. Resident #1 appeared to be frustrated with right hand splint. When asked why he had to wear the hand splint, Resident #1 stuck	F 309		
	his middle finger in the air and showed the surveyor how it spread out his fingers. On 4/8/15 at 5:50 PM, RN #12 was alerted to Resident #1's reddened area on his right wrist. RN #12, when asked whether the reddened area was caused by the hand splint, stated it was from scratching and she had not seen it before. On 4/9/15 at 10:49 AM, Resident #1 was observed at the nurses nurses station, where she placed the blue hand splint on the counter. The resident pointed to the velcro on the splint and then his hand, and then showed the nurse the velcro and tape on the splint and pointed to the reddened area on his right wrist. RN #11 asked the resident if he wanted the splint back on. The			

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F 309	Continued From page 40 resident shrugged his shoulders up and RN #11 stated, "Okay, I'll get someone to help you place the splint back on." RN #11 did not address the reddened area. On 4/9/15 at 6:00 pm, the DNS was asked for and supplied "all forms related to all skin issue for Resident #1." None of the forms documented identification, assessment, concerns, and/or interventions related to the reddened area on the resident's right wrist. On 4/10/2015 at 3:35 PM, the DNS stated she was "pretty sure" a skin sheet and incident and accident report for the reddened area on the right wrist was completed. The DNS was again asked to provide any related additional information. The DNS explained the following process for identifying skin concerns: 1. The skin concern is reported to the nurse. 2. The nurse fills out an incident/accident report and distributes/collects witness statements.	F 309		
F 314 SS=G	3. If the skin concern is related to a device, Occupational Therapy is asked to evaluate. On 4/10/2015 at 3:55 PM, the DNS reported a reddened area on Resident #1's right wrist had just been identified, the nurse was working on it "now," and Occupational Therapy would evaluate the splint. No further information or documents were provided. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314	F314 The facility will ensure that residents who enter the facility without a pressure sore does not develop a pressure sore unless the individual's condition demonstrates that they were unavoidable; and a resident having a pressure sore receives necessary treatment to promote healing, prevent infection and prevent new sores from developing.	6/10/15

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F 314	Continued From page 41 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure residents with pressure ulcers received thorough wound assessments and interventions and failed to develop and implement systems for prevention of pressure ulcers. This was true for 3 of 15 sample residents (#s 2, 5, & 15) reviewed for pressure ulcers. Resident #5 was harmed when he developed multiple pressure ulcers and Resident #15 was harmed when her single pressure ulcer deteriorated from a Stage I to a Stage IV wound. These failures also created the potential for harm for Resident #2, who was not provided pressure relief interventions according to care plan. Findings included: The facility's Pressure Ulcer Risk Assessment and Pressure Ulcers/Skin Breakdown Policy and Procedures, dated February 2014, documented: *"...Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated...the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers..." *"...the nurse shall describe and document/report the following: ...Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue..."	F 314	1.The citation will be corrected for: Resident #5 Care plan updated. Skin currently intact with fragile skin. Resident #2 Care plan updated. IAD continues, on April 29, 2015. Therefore assisting with moisture. Resident #15 Discharged from facility on February 11, 2015. 2. To identify other residents having a potential to be affected, all residents care plans will be reviewed. 3. Systematic changes to prevent recurrence of practice are: daily auditing will be completed for positioning by Licensed Nurses x 4 weeks. DNS / MDS will audit daily completion of above process daily x 4 weeks, then weekly x 4 weeks, then every 2 weeks x 4 weeks then monthly for QA/PI ongoing until 100% compliance with process. 4. Monitoring will be done as DNS will audit 5-10 care plans weekly x 5 weeks, then every 2 weeks x 4 weeks, then monthly. If DNS out of facility Unit Manager to complete audits. Monthly DNS will report to QA/PI compliance of programs. Monthly staffing meeting addressed reporting, positioning, and prevention May 8, 2015. Then Licensed nurses	

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F 314	Continued From page 42 1. Resident #5 was admitted to the facility on 11/20/14 with multiple diagnoses including Schizophrenia with acute exacerbation, undersocialized conduct with aggressive behavior, abnormal involuntary movements, muscle weakness, chronic pain, and edema. The resident's quarterly MDS assessment, dated 2/16/15, documented: *BIMS score of 1, severely impaired; *Bed mobility, transfers, toilet use, personal hygiene, bathing, total dependent with 2 person assist; *Walk in room, walk in corridor, locomotion off unit, did not occur; *Frequently incontinent of bladder; *Always incontinent of bowel; *Risk of pressure ulcer, yes; and, *Had no unhealed pressure ulcers, no. Resident #5's current Skin Care Plan identified the focus: "I have high risk for impairment to skin integrity r/t [related to] fragile skin, medication use, decreased mobility/need for assist with ADLs, dementia/schizophrenia, and incontinence," with goals documented as, "I will have no complications r/t skin breakdown or injury through the review date," and "Pressure related breakdown to coccyx will be resolved by review date," dated 12/3/14. Documented interventions included: "Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short," dated 12/3/14. "Dressings/treatments to open areas as ordered," dated 12/3/14. "Follow facility protocols for treatment of injury,"	F 314	reeducated regarding Skin Program, forms & A reporting skin issues, treatment and prevention, measurements (including depth and undermining), drainage, odor, location, wound type, onset date and fully completed form. DNS will weekly review MDS for accuracy related to skin/wounds. Weekly skin checks and shower days residents skin will be assessed and interventions placed as needed. Licensed nursing will assess resident skin, compare TAR with skin measurement sheets make copy and give to DNS in which DNS will review and ensure completeness and appropriate interventions for prevention. DNS/UM during Daily Clinical will review daily completion of TAR/MARSs to ensure no blanks in TARs/MARs. Weekly the Wound Nurse will measure all wounds. Staff inservicing, orientation and supervision on the entire program, forms, weekly skin checks, weekly documentation on wounds, notifications, incident reports, appropriate treatment, positioning, etc will be done on hire and annually.	

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F 314	Continued From page 43 dated 12/3/14. "I need pressure relieving/reducing cushion to protect the skin while up in chair [and] while in bed," dated 12/3/14. "Incontinent products/skin protectant with incontinence," dated 12/4/14. "Keep skin clean and dry. Use lotion on dry skin. Do not apply on coccyx," dated 12/3/14. "Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx [signs & symptoms] of infection, maceration etc. to MD," dated 12/3/14. "Encourage me to lay down first after meals and up last before meals," dated 2/25/15. The resident's MD progress notes documented: 11/18/14 - (2 days prior to admit, resident's current MD but assessed at another facility) "...Lesion on his coccyx is healed. They are still using Allevyn for skin protection. He is more ambulatory now and because of this is less likely to develop pressure sore..."	F 314		
	12/1/14 - "...Coccyx lesion is healed, but still protected with Alevyn...observe coccyx closely and make sure remains healed..." Resident #5's Physician orders and MARs/TARs documented: * Apply Allevyn dressing to coccyx, change every 72 hrs for protection (hx of skin breakdown). Apply skin prep with each change. Order date: 11/20/14 and D/C (discontinued) date 12/30/14. 12/5/14 to 12/29/14 on the MAR/TAR - Marked with an H to signify "on Hold by physician." * Weekly Skin Assessments - Order date: 11/20/14. 1/8/15 and 1/22/15 on the MAR/TAR - Blank signified the weekly skin assessments were not done.			

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F 314	Continued From page 44 * Monitor approx 1 cm irregular triangle - reopened old area over coccyx. Monitor daily for improvement, apply Calmoseptine as ordered with incontinence changes. Order date: 12/29/14 and D/C date 1/15/15 1/8/15 on the MAR/TAR - Blank signified it was not done. *Zinc/Calmoseptine to bilateral buttocks and coccyx until resolved. Encourage resident to lay down between meals and position on side, three times a day for open areas to bilat ischium and coccyx. Order date- 12/4/14. 12/15, 12/19, & 12/25/15 at 2:00 PM; 1/6/15 at 2:00 PM; 1/8/15 at 7:00 AM & 2:00 PM; 1/20/15 at 7:00 AM & 2:00 PM; 2/12/15 at 2:00 PM; 2/14/15 at 2:00 PM; 3/9/15 at 2:00 PM; 3/10/15 at 2:00 PM; and 3/19/15 at 2:00 PM on the MAR/TAR - Blank signified it was not done. * Monitor reddened area to coccyx, right, and left buttocks one time a day for approx 1 cm reopened old area over coccyx. Monitor daily for improvement, apply Calmoseptine as ordered	F 314		
	with incontinence changes. Order date: 1/15/15 and D/C date: 1/31/15. 1/20/15 on the MAR/TAR - Blank signified it was not done. * Monitor coccyx/gluteal crevice wound daily, ensure that dressing is staying in place and amount of drainage if any until healed, one time a day. Order date: 2/19/15. * Cleanse wound on coccyx/gluteal crevice with NS [normal saline], and apply dressing of choice appropriate for wound based on wound characteristics and stage of healing, change every 3 days and PRN. Order date: 2/20/15. The resident's Nursing Progress Notes (NPN) documented: 11/20/14 - "Resident arrived at 11:30 by facility			

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F 314	Continued From page 45 van...Res able to stand with assistance during transfers and cares...Dressing over coccyx changed, some non-blanching discoloration noted at indentation over coccyx. No other skin issues noted." 12/3/14 - "Aids called me in to assess resident's buttocks. Resident Allevyn was missing and there was a 1.5cm diameter open area to coccyx and 3X2cm open areas to bilat ischium. Allevyn re-applied to cover all 3 areas." 12/29/14 - "Old skin issue reappeared - 1 cm triangle reopened on coccyx, , 0.1 cm deep. Discussed w/ [with] wound care nurse, cont w/ calmoseptine to coccyx, discussed finding ways of moving resident from WC more often..." 1/17/15 - "Coccyx area nearly healed, calmoseptine liberally applied..." 2/19/15 - "...while doing skin check and Tx [treatment] completely cleaned off old calmoseptine and spread buttocks and discovered in upper inner crevice/coccyx area a wound, that was deep tissue in nature,	F 314		
	complicated by friction/shear/pressure and incontinence, wound is irregularly shaped and partially covered with hard non-viable tissue, parts of the wound had small openings, but non-viable skin was adhering to wound bed...approximated measurements at 3cmX4cm, cleaned area and applied allevyn dressing, doctor notified by fax..." 2/20/15 - "...unstageable pressure sore in upper crevice of buttocks/coccyx. Resident is totally dependent with mobility, is incontinent of bowel & bladder..." 2/21/15 - "...last one up and is [first] one down...repositioned every to [two] hours side to side, dressing is still in place and calmoseptine continues to be applied to rest of buttocks..." 2/23/15 - "...Calmoseptine cream applied to			

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F 314	Continued From page 46 wound on coccyx with Allevyn dressing not staying adhered to skin..." 2/24/15 "...wound on resident's coccyx is starting to slough some of the old non-viable tissue, about 90% of wound red and open, no drainage or foul odor noted, no s/s of infection, peri wound that was denuded is starting to resolve..." 2/27/15 - "...Coccyx healing well. Open area decreasing in size. Dark purple areas noted to be resolving..." 2/28/15 - "...coccyx area pink and blanchable, closed with no open areas..." 3/1/15 - "Wound to coccyx healing well...Open area to right buttock decreasing in size. No bleeding or discharge noted..." 3/4/15 - "Wound to coccyx area has opened larger. Continue with calmoseptine at this time. Wound cleansed..." 3/11/15 - "...open area to bottom that appears to be healing well, new dressing was applied...no drainage, foul odor..." 3/14/15 - "...Remains slightly red with no open areas." 3/21/15 - "...Changed dressing to coccyx area...reddish pink...clean site with NS [normal saline] and applied tegaderm dressing..." 3/28/15 - "...Coccyx closed with no open areas. No discharge or drainage..." 3/30/15 - "Resident repositioned every 2 hours continues with redness to buttock although not open healing well." No NPN regarding skin/pressure issues from 3/31/15 to 4/9/15. The resident's weekly Skin Conditions/Reports documented six open sites with start dates ranging from 11/20/14 through 1/4/15 and all 6 of these sites with resolutions dated 1/31/15.	F 314		

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F 314	Continued From page 47 a. Site- Identified as "tailbone" with no date of onset, not marked on admit, described as open, pressure, and the diagram had 5 circles on the buttocks area: 11/20/14 - No measurements for length/width or depth, listed as red and nonblanchable, no odor, no tunneling, Stage I, and no pain. 1/31/15 - Line through the measurements, color/drainage, odor, tunneling, stage, and pain. The word "resolved" and the LN's initials. Note: There was no weekly documentation of assessments on the Skin Condition/Reports from 11/20/14 through 1/31/15, when the open pressure wound had resolved. b. Site- Identified as left gluteal fold with no date of onset, not marked on admit, described as open, pressure, and the diagram had 5 circles on the buttocks area: 12/3/14 - No other information documented except the LN's initials. 1/31/15 - Line through the measurements,	F 314		
	color/drainage, odor, tunneling, stage, and pain. The word "Resolved" and the LN's initials. Note: There was no weekly documentation of assessments on the Skin Condition/Reports from 12/3/14 through 1/31/15, when the open pressure had resolved. c. Site- Identified as right gluteal fold with no date of onset, not marked on admit, described as open, pressure, and the diagram had 5 circles on the buttocks area: 1/4/15 - No other information documented except LN's initials. 1/31/15 - Line through the measurements, color/drainage, odor, tunneling, stage, and pain. The word "Resolved" and the LN's initials. Note: There was no weekly documentation of			

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F 314	Continued From page 48 assessments on the Skin Condition/Reports from 1/4/15 through 1/31/15, when the open pressure had resolved. d. Site - Identified as left ischium with no date of onset, not marked on admit, described as open, pressure, and the diagram had 5 circles on the buttocks area: 12/3/14 - No other information documented except LN's initials. 1/31/15 - Line through the measurements, color/drainage, odor, tunneling, stage, and pain. The word "Resolved" and the LN's initials. The DNS added a late entry, dated 4/8/15, with the measurements for this pressure ulcer documented as 3 X 3 cm and identified as a Stage II wound on 12/3/14. Note: There was no weekly documentation of assessments on the Skin Condition/Reports from 12/3/14 through 1/31/15, when the open pressure had resolved.	F 314		
	e. Site - Location was blank, but identified as a second area on the left ischium by the DNS on 4/8/15, with no date of onset, not marked on admit, described as open, pressure, and the diagram had 5 circles on the buttocks area: 11/29/14 - Measurements 3 X 1 cm, no depth, wound color as purple and scattered, no odor, no tunneling, N/A written for staging, No for pain, and open to air with LN's initials. 1/1/15 - All information the same as above. 1/9/15 - All information the same as above except measurements of 3 X 1.5 cm. 1/31/15 - Line through the measurements, color/drainage, odor, tunneling, stage, and pain. The word "Resolved" and the LN's initials. Note: There were no weekly documentation of assessments on the Skin Condition/Reports after			

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F 314	Continued From page 49 11/29/14 until 1/1/15 and then again, from 1/9/15 to 1/31/15 when the open pressure had resolved. f. Site - Identified as right ischium with no date of onset, not marked on admit, described as open, pressure, and the diagram had 5 circles on the buttocks area: 12/3/14 - No other information documented except LN's initials. 1/31/15 - Line through the measurements, color/drainage, odor, tunneling, stage, and pain. The word "Resolved" and the LN's initials. Note: There was no weekly documentation of assessments on the Skin Condition/Reports from 12/3/14 through 1/31/15 when the open pressure had resolved. 2. There was 1 identified pressure ulcer as of 2/19/15: a. Site- Identified as coccyx with date of onset as 2/19/15, described as pressure ulcer, and the diagram had 1 large circle on the buttocks area:	F 314		
	2/19/15 - Length/Width 3.0 X 4.0 CM; Depth 0.25; drainage color as Serosanguineous; Amount as Scant; color as red; odor as 0; Stage III; pain-Yes; "Monitor daily until resolved, treat [tx] as ordered"; and LN's initials. 2/23/15 - Length/Width 1.5 X 0.7 & 0.5 X 0.5 Depth <0.1; 0 drainage; color as Pink; odor as 0; Stage N/A; pain-No; "Monitor daily until resolved, treat as ordered; and LN's initials. 3/14/15 - No information marked on this line except the date. 3/22/15 - "Coccyx area sl [slightly] reddened, Tegaderm drsg [dressing] intact;" "Monitor daily, tx as ordered; and LN's initials. 4/1/15 - "Closed"; 0 drainage; color as red; "Reddened, barrier cream (Zinc)" and no additional information except the LN's initials.			

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F 314	Continued From page 50 4/7/15 - "Closed"; color as red; "Reddened, barrier cream (Zinc)" and no additional information except the LN's initials. On 4/8/15 at 1:35 PM, the Wound Care Nurse (WCN) was observed while a weekly skin assessment of the buttocks was completed on Resident #5. The resident had no open pressure sores on the coccyx. The area from the sacrum down through the gluteal cleft was red, blanchable, no open areas, no drainage, no odor. The WCN did not clean the area and there was white ointment present, throughout the time the buttocks area was being assessed. The WCN said she forgot to take measurements while in the room and would need to return and measure. On 4/10/15 at 2:55 PM, the DNS was interviewed regarding the facility's policy and procedures for residents with skin integrity concerns. The DNS stated, "The policies and procedures are evaluation, assessing for risks, implementing interventions, completion of I & As, documentation on the resident, and notification to the resident, family, and MD." The DNS said the skin checks and documentation need to be done weekly at least and more often as needed. The wound or pressure sore documentation needed to include measurements, drainage, and staging. When the DNS was asked if the staff were following policy and procedure for pressure sores, she stated, "No." 2. Resident #15 was admitted to the facility on 4/9/14 with multiple diagnoses to include spinal cord injury, chronic pain, muscle spasms, and quadraplegia.	F 314		

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F 314	Continued From page 51 Resident #15's MDS Assessments coded the following: - Admisson MDS, dated 4/16/14, one unstageable deep tissue injury; - Quarterly MDS, dated 7/17/14, one Stage 2 pressure ulcer, which developed on 7/10/14; - Quarterly MDS, dated 10/15/14, documented one Stage 2 pressure ulcer, worsened since prior assessment; and - Quarterly MDS, dated 1/14/15, one Stage 3 pressure ulcer, which measured 0.8 cm (length) x 0.4 cm (width) x 4.7 cm (depth). For the above identified assessments the resident was coded as extensive assist to total assist for bed mobility, transfers, toileting; limited range on motion in bilateral upper/lower extremities, and did not ambulate. Resident #15's Skin care plan documented the resident was at risk for pressure ulcer development related to immobility and quadraplegia.	F 314		
	* Interventions implemented on 4/22/14 included, assess skin weekly and prn (as needed), halo bar and trapeze bar to assist with positioning in bed, and, air mattress for fragile skin. * Interventions implemented on 7/30/14 included, only up for meals and to work with therapies, reposition every 2 hours, and wound nurse consult as needed. * Intervention implemented on 8/15/14 was wound clinic consult. The following information was obtained from Physician's Orders (PO), Care Plan (CP), Progress Notes (PN), Wound Clinic Notes (WC), Skin Impairment Sheet (SIS), Dietary Note (DN), and Treatment Administration Record (TAR): 1. Right Ischium Wound:			

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F 314	Continued From page 52 * 6/27/14 (SIS) - Unstageable right ischium wound identified and measured 4 cm x 3 cm. * 7/10/14 (WN) - "Pt [patient] has an unstageable wound to the Rt [right] ischum [sic]. She is on an air bed and as of yesterday was on a firm w/c [wheelchair] cushion but is on a Roho cushion now. The wound is 4.5 cm approx[imately] with approx[imately] 2.5 cm center is white with slough. This appears to be a sitting wound. Turn every 2 hours, 24 hours a day, side, back, side. Air flo chucks on bed; do not leave chucks or lift sheet under the resident while in bed; Incontinent brief on only when up, monitor Roho cushion for air, last up and first down for meals, and only up for meals and therapies. * 7/9/14 - through 7/31/14 - There was nothing documented on the SIS related to the wound on the right ischium. * 8/1/14 through 8/18/14 (SIS) - Right ischium wound measured 4.5 cm x 2.5 cm. * 8/15/14 (PN) - Resident taken to Physician's office for evaluation of wound.	F 314		
	* 8/17/14 (PN) - "Resident is currntly on antibiotics for MRSA...Right ischeal wound has pink peri wound white 1.5 [cm] x 1.5 cm area debreaded [sic] by wound doctor...awaiting progress notes, no odor present serosangneous [sic] drainage small amount." * 8/18/14 to 8/22/14 (SIS) - Unstageable right ischium wound measured from 4.5 cm x 2.5 cm to 4.5 cm x 1.5 cm x 0.1 cm. * 8/22/14 (PN) - "Resident returned from the wound DR [doctor] order to use iodasorb and cover with dressing 3 x a week and f/u 2 weeks." * 8/25/14 (PN) - "Moderate amount of serosanguineous drainage present, no odor, peri-wound measured 3.5 cm beefy red tissue 1 cm depth in the center of the wound." It could not be determined if the length of the wound was			

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F 314	Continued From page 53 measured as it was not documented. * 8/26/14 (SIS) - "Unstageable" Right ischeal wound measured 4.5 cm x 0 cm x 0.1 cm. It could not be determined if the length of the wound was measured as it was not documented. Additionally, it was unclear how a wound with depth was documented as "unstageable." * 9/5/14 (SIS) - Right ischeal Stage 3 pressure ulcer measured 3 cm x 1.5 cm x 1 cm. * 9/7/14 (PN) - "Resident returned from wound clinic with orders for wound vac to right ischiem [sic] [change] every 2 days and prn. Wound vac placed on resident as ordered, resident educated on the importance of repositioning and order for bed rest for 2 weeks." * 9/9/14 (PN) - ... some odor detected with removal of old dressing. Skin pink, serosangneous [sic] drainage. Area cleansed and new dressing applied. * 9/13/14 (PN) - Wound vac in place and continues to drain serosanguineous fluid. When resident rests on the right side tubing can be	F 314		
	compressed and the wound vac stops working. * 9/14/14 throught 9/17/14 (PN) wound vac intact and functioning properly. * 9/18/14 (PN) - "She [resident] has been upset stating there is a problem with the turning schedule on day and evening shifts." The resident's record did not document what the problem was or that the facility had addressed and resolved the resident's concern. * 9/27/14 (PN) - Right ischeal wound area smaller and measured 0.8 cm x 0.8 cm x 0.5 cm. 2. Right Trochanter Wound: * 7/10/14 (TAR) - Monitor 4.5 cm x 2.5 cm open area on right trochanter everyday for dressing placement. * 7/11/14 (CP) - Right trochanter wound			

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F 314	Continued From page 54 measured 4.5 cm x 2.5 cm. * 8/1/14 (PN) - Wet to dry dressing change three times a day for three days and then return to regular dressing change. Call Wound Consultant on monday [8/4/14] and report. NOTE: The resident's record documented the Wound Consultant was not called until 8/13/14. * 8/3/14 (PN) - "...Noted open area with red drainage out of wound, and very strong odor is noted when changing this dressing." * 8/5/14 (PO) - "...HOB (head of bed) at or less than 30 degrees at all times, up in chair 1 hour with breakfast and dinner only, do press ups every 15 minutes while up in chair, turn q 2 hrs while in bed, order KCI [wound]vac ASAP (as soon as possible)..." * 8/10/14 (PN) - "Wound to right trochanter measures 1x cm [sic] and beefy red periwound with white slouth [sic] in the center, serosangneous [sic] drainage." * 8/13/14 (PN) - "Called Wound Consultant to clarify dressing order. Apply wet guaze pack into wound. Gauze over the top. Cover with clear tegaderm. Don't use Allevyn. Physician notified." * 8/14/14 Lab results - Wound culture grew 2+ Staphylococcus aureus, 2+ Enterococcus faecalis, and 1+ Escherichia coli. Physician order received to start Augmentin 875 mg twice daily for ten days related to the diagnosis of "cellulitis." * 8/15/14 (PN) - Resident transported to doctor appointment to assess wound. Resident stated the doctor's office would fax orders. "Have not seen any new orders thus far." * 8/16/14 (PN) - "TX [treatment] nurse called provider concerning culture results. N.O. [new order] to DC [discontinue] Bactrim start Doxycycline and Rocephin." The resident was started on Augmentin for cellulitis based on the identified organisms being susceptible to that	F 314		

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F 314	Continued From page 55 antibiotic. The resident was not taking Bactrim for this wound, therefore it could not be determined why the nurse requested the Bactrim to be discontinued. * 9/1/14 (PN) - Resident has been in bed most of the day per her preference and has been repositioned q [every] 2 hours and prn [as needed]. Replace [sic] dressing on the right trochanter. Noted minimal yellow drainage. Note wound bed to be pink, and noted wound to be yellow and red in appearance. Applied telfa island dressing to wound." * 9/2/14 (PN) - Resident continues to be repositioned every 2 hours and head of bed is at 30 degrees. 3. Left Outer Buttock Wound: * 6/27/14 (CP) - Left outer buttock abrasion identified and measured 4 cm x 3 cm. * 7/8/14 (PN) - Left buttock wound, measured 5 cm x 4 cm with 2 cm of eschar in the middle of the wound. Due to the lack of documentation	F 314		
	provided by the facility to the survey team, it could not be determined if the facility had assessed this wound from 6/27/14 to 7/8/14, at which time the left buttock wound had deteriorated from an "abrasion" to a stage 2 pressure ulcer. * 7/9/14 (PN) - A Wound consult and wound culture ordered for the left buttock wound. Registered Dietician (RD) recommended 1 ounce of extra protein three times a day with meals to aid in wound healing. NOTE: The postioning schedule for the resident was not added to the resident's care plan until 7/30/14. * 7/11/14 - Lab results idenitified the resident had 3+ Staphylococcus in the left buttock wound. The resident was started on Bactrim DS twice a day for 10 days.			

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F 314	Continued From page 56 * 8/11/14 (PN) - "...dressing changed to lt [left] buttocks as ordored [sic]; small amt [amount] grey/green drainage noted on old dressing slight odor." Wound nurse consulted order received for minesota solution wet to wet dressing three times a day for seven days; obtain a wound culture; and consult with specialty clinic wound doctor. * 8/13/14 (PN) - "Refuses [to get] out of bed today due to wound on buttocks. Resident stated she didn't know what caused the wound and asked about w/c [wheelchair]. Patient educated on causes and effects." 4. Right Buttock Wound: * 7/28/14 (PN) - "Resident #15 has developed a wound to her right buttocks. It is assessed...as a stage 2, involving Epidermal and some dermal tissue there are 2 small areas of wound which have sloughing or eschar tissue and these areas are unstageable, however most of the wound is a stage 2." * 8/8/14 (PN) - ...right buttock wound	F 314		
	non-stageable. * 8/10/14 (PN) - Resident is compliant with staying off of her bottom for wound healing. * 8/29/14 (PN) - "...Dressing was satureated with pink-brown drainage on gauze..." * 9/6/14 (PN) - "Resident has been turned q 2 hours. Wound on R[ight] buttock cleaned and silvadene [sic] applied. Covered with bordered [sic] dressing. Resident requested picture of wound be taken..." On 4/10/15 at 5:30 PM, the Administrator and DNS were informed of the concerns with the development of worsening of pressure ulcers in the facility. On 4/13/15 the facility faxed additional information to the Bureau of Facility Standards, however this information did not resolve the			

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F 314	Continued From page 57 concerns.	F 314		
	3. Resident #2 was admitted to the facility on 8/2/13 with diagnoses which included neurogenic bladder and diabetes. The resident's 2/2/15 quarterly MDS assessment documented the resident was moderately cognitively impaired and required extensive assistance of 2 staff for bed mobility. The resident's 8/8/14 annual MDS assessment documented the resident was cognitively intact and required extensive assistance of 2 staff for bed mobility. The resident's April 2015 Medication Review Report (recapitulation orders) included to encourage the resident to stay off of his buttocks. The resident's 11/12/14 Skin at Risk Care Plan included an intervention to encourage the resident to lay down and to turn every 2 hours. During an observation on 4/7/15 at 8:20 a.m., the resident was observed in bed with a pillow to his right side. At 10:45 a.m. the resident was observed with the same pillow to his right side.			

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F 314	Continued From page 58 The resident stated he did not get turned every 2 hours. At 11:45 a.m., the resident was observed in the same position with the same pillow to his right side. At 1:01 p.m. the resident remained in the same position with the same pillow observed to the right side. At 2:28 p.m. the resident was observed in the same position but informed the surveyor he had requested to be repositioned. At 4:35 p.m., the resident had been repositioned and the pillow was now to his left side. The resident stated staff had repositioned him at 3:29 p.m. On 4/8/15 at 9:38 a.m., the resident was observed in bed with a pillow to his right side. At 11:29 a.m., the resident was observed in bed with the same pillow to his right side. At 12:07 p.m., the resident informed CNA #4 he would like to be turned after he received a pain pill. After receiving his pain pills at 12:10 p.m., CNA #4 and CNA #5 repositioned the resident by moving the pillow to his left side.	F 314		
F 323 SS=D	On 4/9/15 at 5:45 p.m., the Administrator and the DON were informed of the above concern. The facility provided no further information. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced	F 323	F323 The facility will ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. The citation will be corrected for: Resident #1- IDT met to review resident's safety on 4/18/15 to review	6/8/15

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F 323	Continued From page 59 by: Based on observation, record review, staff interviews, and policy review, it was determined the facility failed to identify, implement, monitor, review and revise interventions to prevent both injury and non-injury falls. This was true for 1 of 10 (#1) sampled residents. This failed practice placed the resident at risk for head injuries and fractures. Resident #1 was most recently admitted to the facility on 12/23/14 with multiple diagnoses which included right-sided hemiplegia, muscle spasm, and paralysis agitans (trembling of hands, arms, legs, jaw and face, stiffness of the arms legs and trunk, slowness of movement and poor balance and coordination). The most recent quarterly MDS assessment, dated 3/13/15, documented Resident #1 had impairment on one side of the body, required one person assist for bed mobility, transfers, dressing, and toilet use, and had a history of non-injury and injury falls in the previous six months. The resident's care plan, dated 6/13/14 and 12/30/14, identified the need for extensive assist of one for bed mobility and dressing, often transferred self to the toilet but may have required limited assist of one for transfers, use of the transfer pole to transfer from the bed to the wheelchair independently, falls due to independence/refusals to call for assistance and staff was to anticipate the resident's needs and encourage help. Additionally, the same care plan, dated 6/26/14, identified impaired cognitive function, thought processes and communication, did not use words but could answer yes/no questions, and used motions to communicate. On	F 323	and identify the root cause of falls including hemiplegia, vision impairment, muscle spasms and paralysis agitans and assure that all interventions from all incident and accident reports have been implemented. New MDS coordinator continues to have weekly or semi weekly training from corporate MDS trainer to ensure consistency in charting and evaluations. Resident is cognitively aware . MDS evaluation will utilize visual assistance in completing the BIMS. All conflicting notes, care plans, assessments and MDS will be reviewed, verified and updated 5/14/15. New interventions were put into place on the care plan on 9/23/14, as well as all other falls. Resident has received the therapy evaluations related to the fall on 2/20/15, Friday, with an order dated 2/23/15, Monday. Non skid strips had been place at bed side on 12/14/14. Resident Room #34 – Bed cord has been replaced on 4/9/15. 2. Other residents that have the potential to be affected by the cited tag will be identified by having a quarterly and annual assessment for fall risk as well as a fall risk assessment for fall	

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F 323	Continued From page 60 9/23/14, the care plan identified the resident was at high risk for falls related to unsteady walking, poor balance and right-sided weakness with poor communication and comprehension. Care plan interventions for falls, dated 9/13/14, documented staff were to anticipate and meet needs, ensure call light was within reach and encourage use for assistance as needed, ensure appropriate footwear was worn when transferring and mobilizing in wheelchair, follow facility protocol, evaluation and treatment by physical therapy as ordered PRN (as needed), review information related to previous falls, attempt to determine cause of falls, record possible root causes, alter or remove any potential causes if possible, and educate resident/family/caregivers/IDT (interdisciplinary team) as to causes. Current care plan interventions for falls, dated 3/17/15, documented Physical Therapy was working to increase the resident's strength, had provided brake extenders to the left wheel brake and ensured it was functioning properly, provided anti-roll back brakes to wheelchair and ensured proper function. Additionally, the care plan documented Resident #1 would loosen bolts on the back-up brakes so lock tite bolts were also added to prevent the resident from loosening those bolts. Fall risk assessments completed for 4 of 6 falls documented on 12/14/14, 2/20/15, 2/24/15 and 4/4/15 several areas of conflicting information related to Resident #1. Six examples were as follows: 1. The resident was able to see in adequate light; the resident had impaired vision in adequate light.	F 323	related incidents, and ongoing maintenance rounds. 3. The Fall Risk Assessments will be reviewed each standard work day by the IDT to ensure that proper interventions are implemented to prevent fall issues. An ongoing physical plant rounds will be documented on the maintenance rounds sheet and through the maintenance binders located at each nursing station. 4. The corrective action will be monitored through the QAPI program. April 12th the quality assurance committee will commence to ensure that 100% of all Fall Risk Assessments are completed and interventions are implemented. This information will be compiled by the DNS and brought to QAPI meeting for review. Maintenance rounding documentation will be brought to the QAPI meetings. May 18th the quality assurance committee will commence to ensure that 100% of all outstanding repairs are completed. Maintenance rounding documentation will be brought to the QAPI meetings. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the communication care planning monitor	

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F 323	Continued From page 61 2. The resident exhibited loss of balance; the resident did not exhibit loss of balance. 3. The resident required hands-on assistance; the resident does not require hands-on assistance. 4. The resident had decreased muscle function; the resident did not have decreased muscle function. 5. The resident exhibited jerking and instability when making turns; the resident did not exhibit jerking and instability when making turns, 6. The resident used assistive devices; the resident did not use assistive devices. The Facilities incidents and accidents reporting policy and procedure documented all incident/accident reports were to be reviewed by the IDT to ensure appropriate corrective interventions were care planned. On 12/14/14, an incident/accident report documented the IDT identified the root cause for Resident #1's fall as, "The resident desires independence." The planned interventions were to monitor injuries, use non skid strip, and encourage resident to use call light. NOTE: Encouraging the resident to use the call light was already on the care plan as of 9/23/14. No new interventions were put in place related to THE resident not using call light. On 4/10/15, The DNS stated a non skid strip was placed in the bathroom. However, three identified causes for the fall were not provided with accompanying interventions, including the wheelchair brakes were not locked, no protective devices were in place, including anti-roll back bars, and the resident not using his call light. On 1/25/15, the incident/accident report documented the IDT identified the root cause for	F 323	form. 5. The Administrator will be responsible to ensure that the plan of correction is followed properly.	

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F 323	Continued From page 62 Resident #1's fall as, "Self transferring and wheelchair brakes were not locked." Planned interventions included repair to the anti-roll back bars. However, three identified causes for this fall did not include accompanying interventions, including wheelchair brakes not locked, no protective devices in place including anti-roll back bars and the resident not using his call light. On 2/20/15, the fall incident/accident report documented the IDT identified the root cause for Resident #1's fall as, "Self transferred bed to chair and foot slipped." Planned interventions included monitoring of injuries and Physical Therapy evaluation. On 4/10/15 at 10:10 AM, the DNS was asked to supply all related information. Therapy notes were not supplied for this fall. The issue of the resident slipping during transfer was identified after the 12/14/14 fall and an anti slip matt was placed in the residents bathroom. In this case, the resident fell transferring from the bed to wheelchair. Interventions were not put into place for three identified causes - the resident slipped, no protective devices were in place at the time of the fall, including anti roll back bars, and thw resident did not use his call light. A 3/3/15 fall incident/accident report documented the IDT identified the root cause for Resident #1's fall as, "Resident disengages anti-rollback bar." Planned interventions included locking tight screws and skin monitors. Two identified causes for this fall, which went without interventions, included the wheelchair brakes were not locked and the resident again did not use his call light. On 3/17/15, four days after the fall, the care plan directed staff to ensure the wheelchair roll-back	F 323		

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F 323	Continued From page 63 bar and brake extenders were working properly. The 4/3/15 fall incident/accident report documented the IDT identified the root cause for Resident #1's fall as, "Self transferring, wheelchair brakes not locked on resident's affected side." The planned interventions included, lock tight screws and monitor skin. Identified causes for this fall that went without interventions included the wheelchair brakes were not being locked on the resident's affected side, and the resident did not use the call light. On 4/10/15 at 10:10 AM, the DNS was notified of the above concerns. When asked how the interventions were appropriate for the root causes identified, the DNS said anti-lock brakes were put on the resident's wheelchair, a non-skid strip was placed in the bathroom and the resident was re-educated to use the call light. The DNS stated the resident was cognitively aware and able to use the call light, but chose not to. The DNS said after the 4/13/15 fall, it was identified the resident had tools in his room and removed the anti-roll back bars. It was identified in four previous falls that the anti-roll back bars were not in place, however no interventions were put in place after these previous falls. The DNS confirmed Resident #1 had poor safety awareness and staff did frequent checks when walking by the resident's room. However, the facility did not provide documentation that 15 minute checks were implemented. 2. On 4/6/15 at 10:35 AM, during the initial tour, the bed in room #21-A was observed with a headboard being crooked and appeared unattached from the frame on the left side of the	F 323		

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MINI-CASSIA CARE CENTER	1729 MILLER AVENUE BURLEY, ID 83318

(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 323	Continued From page 64 bed and a bed control lying at the foot of the bed with the insulation integrity of the electrical wiring being compromised. An environmental facility tour took place on 4/8/15 at 3:12 PM with the Maintenance Supervisor (MS). The MS was shown the headboard and bed control in room #21. The MS stated in regards to the headboard, "It's attached to the top instead of the bottom slot. The resident likes to grab things." The MS pulled the headboard out of the bed frame and placed both sides in the appropriate slots to secure the headboard in place. The bed control had numerous areas in which there were cuts in the cord, which exposed electrical wiring and comprised the insulation integrity, and left ragged edges on the outer protective jacket. The MS stated the resident "doesn't use" the bed control and it appeared the expandable cord had been pinched in the bed frame numerous times. The MS unplugged the bed control and attempted to remove it from the frame of the bed without success. On 4/8/15 at 8:35 PM, the Administrator and DNS were informed of the concerns. The MS did notify the surveyors the bed control had been removed from room #21 and had been replaced with one in good repair.	F 323		
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 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329	F329 The facility will ensure that each resident's drug regime will be free of unnecessary drugs.	6/8/15

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F 329	Continued From page 65 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined the facility failed to ensure each resident's drug regimen had adequate indications for medication use. This was true for 3 of 9 (#s 1, 2, and 7) residents sampled for psychoactive medications. Additionally the facility failed to ensure 4 of 9 sampled residents (#s 1,4,8, and 11) had justification for duplicate therapy or gradual dose reductions. This failed practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included: 1. Resident #2 was admitted to the facility on 8/2/13 with diagnoses which included neurogenic	F 329	1. The citation will be corrected for: Resident #1- Resident was noted exhibit signs of psychotic behavior prior to admission and after appropriate evaluation period with no behaviors a gradual dose reduction was made and the medication was discontinued under physician review. BIMS assessment will utilize visual assistance for completion. Resident #2 – Resident strengths and specific coping skills were addressed an resident care plan. Resident is also able to speak freely to the resident services coordinator. Specific non-pharmacological interventions for each behavior have identified and placed on care plan. Staff will be educated on care plan changes as they occur. Hours of sleep are tracked on behavior tracking sheets. Resident #7- Resident is care planned to be assessed for pain and to be able to express her concerns. All behavior issues are delineated in the care plan with specific non-pharmacological interventions for each. Resident #4- Will be assessed by new psychiatrist, Dr. Abilash Desai for appropriate of medications on 5/17/15. e. Resident #8- Will be assessed by new	

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F 329	Continued From page 66 bladder,anxiety, chronic pain, depressive disorder, and diabetes. The resident's April 2015 Medication Review Report (recapitulation orders) included an order for Citalopram (antidepressant) 20 mg every day for depression with a start date of 2/14/15. Resident #2's 2/2/15 Care Plan for "mood problem r/t (related to) diagnosis of depression, feelings of being a failure and having trouble sleeping." The interventions included: *Assist me to identify strengths and positive coping skills and reinforce these. *Encouragement/assistance/support to maintain as much independence and control as possible. *Monitor mood to determine if problems seem to be related to external causes.... *Need time to talk freely. Encourage me to express feelings. The interventions did not include what strengths or positive coping skills were to be reinforced, how to support the resident to maintain independence, what to talk "freely" about or what external causes triggered the depression. Note: The care plan did not include non-pharmalogical interventions to address the resident's having trouble sleeping. Additionally the care plan did not include criteria to determine how many hours of sleep the resident was to have each day. Without criteria it would not be possible to determine if the resident's continued need for medication for sleep. The resident's Behavior Management Plan (undated) included an area for "Signs and Symptoms of depression: these can include	F 329	psychiatrist, Dr. Abilash Desai for appropriate of medications on 5/17/15. Resident #11- Will be assessed by new psychiatrist, Dr. Abilash Desai for appropriate of medications on 5/17/15. 2. Other residents that have the potential to be affected by the cited tag will be identified by having all residents on psychotropic medications by new specialized psychiatrist, Dr. Abilash Desai for appropriateness. 3. All residents will have ongoing monitoring and consideration by the team including, psychiatrist, Dr. Abilash Desai for appropriateness. 4. The corrective action will be monitored through the QAPI program. May 17th the quality assurance committee will commence to ensure that 100% of all triggered residents have the interventions in place. Resident Services Coordinator will head the subcommittee to monitor this action. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the communication care planning monitor form. 5. The Administrator will be responsible to ensure that the plan of correction is followed properly.	

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F 329	Continued From page 67 insomnia, weight loss, crying." The interventions were to talk to the resident, to get the resident involved in the facility and to assist the resident to call a family member. The Behavioral Monthly Review included areas to document hours of sleep and depression. The form did not include weight loss, how the depression was displayed, statements of being a failure or crying. Additionally the monitor form did not document when or what intervention were implemented to address each behavior. Without monitoring effectiveness of the interventions it would not be possible to identify if the interventions needed to be continued or different interventions implemented to reduce the behavior. The Resident Service Director (RSD) stated the resident's strengths were he was well traveled and was proud of building his own house and needed to be included in the care plan for staff to implement. The RSD stated the care plan should include it was hard for the resident to not be away from his family and a possible trigger for depression was if the resident talked with a family member. The RSD stated a strength of the resident was he was able to go in the community without supervision, but it was not identified in the care plan for staff. The RSD stated the intervention to talk freely was to be able to talk with the RSD regarding sexual issues without being judged. Note: The care plan identified nursing staff as the staff identified to be able to talk freely to. 2. Resident #7 was admitted to the facility on 10/22/11 with diagnoses which included	F 329		

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F 329	Continued From page 68 depression and dementia. The resident's April 2015 Medication Review Report included an order for Seroquel (antipsychotic) 100 mg twice each day for manic psychosis (start date 2/14/15) . The resident's 2/11/14 behavior care plan identified false accusations, loud vocals, noncompliance, verbal assault and signs and symptoms of depression. The Behavior Management Plan identified: *Loud vocals as extreme yelling, using profanity in public areas. Interventions were to speak in a soft tone, involve in an activity and to ask her to return to her room. *Non-compliance was defined as refusing ADLs or diet 2 times. Interventions were to explain before starting ADLs, to involve the resident in an activity, to encourage her to choose a time for staff to come back to complete the task and to change to a different care giver. *Depression was defined as defined as negative verbalizations, sad expression and crying. Interventions were to listen to the resident, talk about things the resident liked to do, invite to activities, and to give medication. *Demanding was defined as one episode is wanting to see the nurse constantly for the same reason, refusing to do anything for themselves. The care plan identified the diagnoses of Bipolar as a trigger for the behavior. The Behavior Care plan interventions included to ask what was wrong, but did not include to assess the resident for pain or, how the resident typically communicated physical needs such as pain or emotional and psychological needs such	F 329		

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F 329	Continued From page 69 as frustration or boredom. Additionally, the care plan identified the diagnosis of Bipolar as a trigger rather then antecedent events which initiated the behavior (loud noises, refusing medications etc.). On 4/9/15 at 2:15 p.m., the RSD stated the care plan interventions were not specific and therefore staff may not have consistently documented the correct behaviors. The RSD was informed without accurate monitoring of the behaviors or documentation of which intervention was implemented and its effectiveness, it would not be possible to determine if the interventions needed to be revised or the medication reduced. On 4/10/15 at 7:30 p.m., the Administrator and the DON were informed of the above concern. The facility provided no further information to alleviate the concern. 3. Resident #1 was admitted to the facility on 6/13/14, and re-admitted to the facility on 12/23/14, with multiple diagnoses which included: -aphasia (damage to the brain that controls language); -expressive language disorder (difficulties with written and spoken language); -hemiplegia on dominant side (right) of the body due to cerebral vascular accident; -unspecified psychosis, onset date 6/3/14; -depressive disorder, onset date 6/3/14; -other specified disturbance of conduct, onset date 6/3/14; -constipation; and -other convulsions, onset date 6/3/14. NOTE: A physician progress note, dated 12/30/14, documented the resident had a current	F 329		

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F 329	Continued From page 70 medical condition and a history of seizures and depression, however there was no documentation that the resident currently experienced or had a history of conduct disturbance and/or unspecified psychosis. It could not be determined why there were discrepencies between the facility's admission diagnosis information and the physician's progress note. The 3/13/15, MDS documented the resident: -had unclear speech -sometimes made self understood -usually was able to understand others -had impaired vision -was severely impaired with a BIMS score of 1 -did not exhibit behaviors, psychosis, or delirium toward self or others -had no acute mental changes -experienced minimal depression -did not reject cares -did not display wandering -identified reading materials, music, animals, outside and religion as very important -required limited supervision and assistance for locomotion off the unit -had impairment on one side of the body affecting the upper and lower extremities NOTE: On 4/10/15 at 3:55 PM, the DNS stated the resident was assessed as severely impaired with a BIMS score of 1 because his speaking language was not understood by staff. The DNS confirmed she was aware that the BIMS scale was a mental status assessment, not communication assessment. The DNS stated she was able to understand the resident's non-verbal communication. The resident's admission Physician Orders	F 329		

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F 329	Continued From page 71 documented the following medications: -Ordered 12/3/2015 - Amitriptyline HCl Tablet 25 mg (milligrams) Give 2 tablet by mouth at bedtime for chronic pain related to abdominal pain ... personal history of digestive disease r/t (related to) irritable bowel syndrome. -Ordered 12/23/15 - SEROquel Tablet 50MG (QUEtiapine Fumarate) Give 1 tablet by mouth two times a day related to unspecified psychosis. -Ordered 12/29/14 - TraMADol HCl Tablet 50 MG Give 1 tablet by mouth as needed for moderate Pain related to generalized pain, give 1 tab up to 4 times a day prn pain. -Ordered 12/23/14 - Dilantin Capsule (Phenytoin Sodium Extended) Give 200 mg by mouth one time a day related to other convulsions. According to the Nursing 2015 Drug Handbook, adverse reactions for Amitriptyline, Seroquel and Tramadol prescribed to the resident include risk of cardiovascular accident, convulsions, and constipation. Additionally, contraindications and cautions for Seroquel warned it was to be used cautiously in pateints with cerebrovascular disease and a history of seizures (convusions). The resident's care plan and behavioral management plan, dated 6/26/14, 9/18/14, 9/23/14, and 3/15/15 identified the following: -behavior problems related to loud vocalizations, verbal assault, rejection of cares, physical assault and wandering -used psychotropic medications (Seroquel) for unspecified psychosis -impaired cognitive function and thought processes secondary to cerebrovascular accident and communication problems -at risk for injury related to seizure disorder -communication problems related to aphasia	F 329		

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F 329	Continued From page 72 secondary to cerebrovascular accident -right-sided hemiplegia/hemipharesis related to stroke The resident's behavior management plan, dated 3/15/15, defined the following behaviors: -Verbal assault - defined as "name calling," -"Non-compliance/rejection of cares" - defined as not complying with instructions after they have been explained; refusing cares, i.e.bathing, ADLs, and diet. If refused twice it was defined as an "episode." -Intense yelling to peers and staff: One episode defined as voice volume higher than normal or "unkind words that offend others." -Elopement - defined as actual or attempt to leave hall/facility unattended. -Wandering - defined as going aimessly from place to place, with no purpose. -"Trespassing" - defined as going into others' rooms uninvited, going into roommate's space/belongings, not honoring others' personal boundaries. -Throwing things - defined as picking items up and throwing those things with no regard for others' safety. The same current care plan as above documented the following interventions: -discuss with medical doctor, family and resident the ongoing need for use of psychotropics medication -monitor/record occurance for target behavior symptoms, loud vocals, rejection of cares, wandering, verbal assault, and physical assault, and document per facility protocol -monitor behavior episodes, determine underlying cause, document behavior and potential causes -provide a progrma of activities of interest and	F 329		

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F 329	Continued From page 73 accomodate currents status, needs and desires -liked to go outdoors -needed assistance to go to activities -needed encouragement to go on outings -liked to read books -propelled self in wheelchair with left leg, able to find room, recognized staff -needed engagement in guided conversations -answered yes/no to questions -useed motions to support communication -caregivers to identify self, face resident, and make eye contact when speaking -needed assistance with all decision making -requireed approaches that maximized involvement in daily decision making and activity -became frustrated and agitated when not understood and when not saying the wanted words -requireed encouragement to pantomine and showing what he was trying to communicate -communicateed by making gestures, nodding, shaking head, body language, some verbal sounds -use communication techniques that enhances interaction, allow time to respond -repeat/reinforce message as necessary -use statements for clarification don't just nod in agreement -use communication book/board, writing pad, gestures, signs, and pictures -served in the Marines, had a problem with loud noises and became frightened during fire drills The behavioral / psychotropic medication BMP monthly reviews summarized Resident #1 continued to display minimal behaviors and was usually easily redirected. The monthly reviews also documented the following: 8/2014 - no behaviors	F 329		

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F 329	Continued From page 74 9/2014 -2 episodes of loud vocals 10/2014 -3 episodes of rejection of cares 11/2014 - no behaviors 12/2014 - blank - no documentation 1/2015 - no behaviors 2/2015 - no behaviors 3/2015 - no behaviors The psychotropic drug review documented the following related to the above identified behaviors: 10/2014 - no behaviors 12/2014 - no behaviors Occupational Therapy evaluations for 3/6/15 through 3/13/15, documented Resident #1 was unable to be understood with nonsensical verbalizations and visually expressed himself through pantomiming desires and physically pointing out his wants or needs. A Social Services report, dated 3/20/15, documented, "BIMS score 1, he is alert and orientated but does have communication problems." An Activity Progress Note, dated 1/3/15, documented, "Make sure and listen to (Resident #1) closely because he has had a stroke [CVA] and has a slur in his speech." Progress notes documented the following: -12/23/14 - "Res[ident] has salad words when he speaks, speech was affected by the CVA. Res is very had to understand at times." -1/8/15 - "Res does shake his head no." -1/6/15 - "Resident back from appointment, made face when asked about appt (appointment) & made disparaging sounds."	F 329		

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F 329	Continued From page 75 -1/1/15 - "...he shakes head no. Res has speech that is not understandable..." -2/23/15 - "Res has not voiced c/o (complaints of) pain ... I tired to talk with res but I couldn't understand most of his conversation." -2/22/15 - "Res points to lower abdomen ... Res is able to express all needs to staff." -3/21/15 - "Responds non-verbally and nodding his head. He does has very garbled speech and staff understand him only by his gestures and facial expression, no appearant visual and hearing problems." -4/7/15 - "I like to go outside and just sit on the walkway so I may have some sunlight when it is warm." Observatons from 4/7/15 through 4/10/15 identified incidences when Resident #1 presented as frustrated when attempting to communictae and be understood, which reflected behaviors identified in the care plan above. The resident used his middle finger to express dislike at a hand splint, said the word "F**k" when asked if he was frustrated and on two occassions threw his hand splint on a counter top, flipping it off while re enacting a scene of someone pointing a finger at him and scolding him. Resident was able to answer all yes/no question and was able to point to items when questioned about them, including pointing outside when asked if he ever goes out. Please refer to F154 for a more detalied description of the resident's behavioral communication related to staff interactions and to F309 for identification of why the resident refused to wear a hand splint. On 4/10/15, the DNS confirmed the resident did not exhibit behaviors, however daily documentation of frequency and duration of his	F 329		

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F 329	Continued From page 76 behaviors was not completed by staff. The PDR's (psychotropis drug review) documented the following: The PDR dated 10/2/14, documented: -Seroquel 50 mg twice a day for psychotic agitation. -Celexa 20 mg qd (every day) for depression. The reason documented for not tapering the medication was "Can't communicate d/t (due to) CVA was at CVA." It cannot be determind what "...was at CVA" means. Guidance at F329; documented the facility is required in the first year in which a resident was admitted on a psychopharmacological medication (other than an antipsychotic or sedative/hypnotic), or after the facility has initiated such medication, to attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. The facility's rationale for not attempting a gradual dose reduction for the resident's psychopharmacological medications could not be determined from the resident's medical record. Similar findings for Resident #11.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F332 The facility will ensure that the medication error rate is below 5%. 1. The citation will be corrected for: Res #17 Insulin has been given as order. No adverse reaction to late administration noted. Potassium	6/8/15

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F 332	Continued From page 77 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure a medication error rate of less than 5 percent. This was true for 3 of 20 medications, or 15% of the medications passed, affecting Resident #17. Insulin 70/30 was administered late and not per manufacturer's specifications, and Potassium Chloride Extended Release (ER) tablet, as well as a Keppra Tablet, were crushed against manufacturers specifications and administered to the resident. The physician's written order, dated 7/13/2013, documented, "K-Tabs Tablet Extended Release 10 MEQ [Potassium Chloride ER] Give 1 tablet by mouth one time a day related to unspecified essential hypertension." The physician's written order dated 7/24/2014, documented, "Keppra tablet 500 MG [milligrams] Give 1 tablet by mouth two times a day for seizures." A physician's telephone order, dated 4/6/15, documented, "Change 70/30 insulin to 8 u [units] sc [subcutaneous] Q [every] AM + 4 u sc QPM [every night]." Wolters, Kluwer, Nursing 2015 Drug handbook documented: *"Give NovoLog Mix 70/30 up to 15 minutes before start of a meal." (p. 748) * Related to administration of Potassium Chloride Extended Release (ER) tablet - "Do not crush controlled-release or extended-release forms." (p1157) *Related to administration of Keppra, "Tablets	F 332	changed to liquid and all other medications reviewed for crushability on April 17, 2015.Keppra tab noted that crushing is not optimum related to *bitter taste.* Therefore due to this medication and its effectiveness for this resident's seizures and no concerns with her not taking her medications no change for this drug at this time on April 17, 2015. 2. Others will be identified who may be affected by the deficient practice by using the Common Oral Dosage Forms That Should Not Be Crushed was added to Narc. Count Book for easy access. Licensed Nurses tested on Release Characteristics of medications that should not be crushed. Pharmacy is to place Do Not Crush stickers on bubble packs to also alert Licensed Nurses. Licenses Nursing Meeting review basic medication administration, Insulin administration, Hypo-hyperglycemic Policy and Procedure, & crushed medication on May 12, 2015 with follow-up inservice on May 19, 2015 and June 3, 2015 presented by DNS. Insulin administration demonstration will be preformed by all Licensed Nursing staff with review of Non-	

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F 332	Continued From page 78 should be swallowed whole and shouldn't be chewed, broken, or crushed." (p832) On 4/10/15 at 8:50 AM, LN #3 was observed during medication pass to crush a Potassium Chloride Extended Release (ER) tablet and draw up 8 units of NovoLOG insulin into a syringe. LN#3 verbalized she crushed the potassium and then administered it to the resident with CNA#2 present. On 4/10/15 at 12:10 PM, CNA #2 stated the medications were given after the resident ate breakfast. On 4/10/15 at 1:30 PM, LN #3 confirmed insulin was scheduled to be given at 7:00 AM before breakfast and was instead given at 8:55 AM, after breakfast. LN#3 also confirmed she crushed the Potassium Chloride Extended Release (ER) tablet. On 4/10/15 at 4:50 PM, the Director of Nursing Services (DNS) was informed of the observations. The DNS confirmed these observations were deficient practice. No additional information on the issue was provided.	F 332	crushable medications by June 8, 2015 by UM or DNS. Weekly cart audit to check Do not crush stickers present x 4 weeks, then monthly there after x 3 months to insure pharmacy follow through. All residents that require crushed medications reviewed by Pharmacy and recommendations to MD and follow through with changes as need by May 19, 2015. 3. The systematic change to ensure deficient practice does not recur is the use of Common Oral Dosage Forms That Should Not Be Crushed was added to Narc. Count Book for easy access. Licensed Nurses tested on Release Characteristics of medications that	
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 490	should not be crushed. Pharmacy is to place Do Not Crush stickers on bubble packs to also alert Licensed Nurses. Licenses Nursing Meeting review basic medication administration, Insulin administration, Hypo-hyperglycemic Policy and Procedure, & crushed medication on May 12, 2015 with follow-up inservice on May 19, 2015 and June 3, 2015 presented by DNS. Insulin administration demonstration will be preformed by all Licensed	

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			Nursing staff with review of Non-crushable medications by June 8, 2015 by UM or DNS. 4.Weekly cart audit to check Do not crush stickers present x 4 weeks, then monthly there after x 3 months to insure pharmacy follow through. All residents that require crushed medications reviewed by Pharmacy and recommendations to MD and follow through with changes as need by May 19, 2015. Weekly Licensed Nursing medication pass audits will be performed x 4 weeks then x 1 month for 3 months or until result medication errors reduced to less than 5 % by MDS or UM. QA/PI will audit medication errors, including results of cart audits and Insulin administration performance on June 29, 2015 and monthly thereafter to ensure less than 5% medication error rate by DNS.	

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F 490	Continued From page 79 by: Based on a staff interviews, resident interview, group interview, review of grievances, record review, review of the facility's policies and procedures for pressure ulcers, the locked unit, accidents, diabetic management and review of the admission packet, it was determined the Administrator, DNS, and management team failed to administer resources effectively and efficiently to prevent systematic problems for 6 of 15 sampled residents (#s 1, 2, 5, 11, 13, & 16) and 9 random residents (#s 17-23 & 2 unidentified residents at group), with the potential to affect all residents in the facility. This failure resulted in the Administrator, DNS, and management team providing insufficient direction and control, necessary to ensure residents' Quality of Life and Quality of Care needs were being met. The facility failed to provide sufficient implementation, monitoring, evaluation and continued oversight to maintain regulatory compliance in the following areas: A. Refer to F151 - facility failed to ensure residents were given the right or opportunity to make an informed choice, or give consent prior to, being placed on a locked unit which had the potential for psychosocial harm when residents were prohibited from freely coming and going from their place of residence without assessment as to the reason their civil liberties had been infringed upon. B. Refer to F154 - facility failed to accommodate residents' communication limitations, which had the potential to lead to frustration and psychosocial harm when activity, emotional, daily	F 490	F490 The facility will administer in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental and psychosocial well-being of each resident. 1.The citation will be corrected for: F151- Resident #1- Resident has signed the consent form to be on the secured unit. The resident has been assessed by the IDT for appropriateness of the secured unit. The resident meets facility criteria for the secured unit. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. The resident meets facility criteria for the secured unit. Resident # 4 – Resident's guardian has signed the consent form to be on the secured unit. The resident has been assessed by the IDT for appropriateness of the secured unit. The resident meets facility criteria for the secured unit. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from	6/8/15

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F 490	Continued From page 80 living, and medical needs were not addressed by facility staff. C. Refer to F248 - facility failed provide an ongoing program of activities designed to meet the physical, mental and psycho-social well-being of each resident. The deficient practice had the potential to cause more than minimal harm if residents experienced boredom and/or mood changes related to a lack of meaningful stimulation. D. Refer to F309 - the facility failed to operationalize the policy and procedure for hypoglycemia and hyperglycemia which created the potential for harm should residents experience complications and/or compromised medical status related to hypoglycemia/hyperglycemia. The facility failed to ensure a resident with a history of constipation received necessary bowel care on several occasions which resulted in two visits to the Emergency Room. The facility failed to administer pain medication in a timely manner which had the potential for the resident to experience unresolved pain. E. Refer to F314 - the facility failed to ensure residents with pressure ulcers received thorough wound assessments and interventions, and failed to develop and implement systems for prevention of pressure ulcers. Two residents were harmed when they developed multiple pressure ulcers and deterioration of those pressure ulcers. The Administrator, DNS, and management team were unable to show the facility was able to provide resources effectively and efficiently to prevent systematic problems in Quality of Life	F 490	the cited tag. Resident #8- Resident signed the consent forms to be on the secured unit. The resident has been assessed by the IDT for appropriateness of the secured unit. The resident meets facility criteria for the secured unit. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. Resident #11- Resident's guardian has signed the consent form to be on the secured unit. The resident has been assessed by the IDT for appropriateness of the secured unit. The resident meets facility criteria for the secured unit. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. B. Information will be provided prior to admission and upon admission to the facility that the facility has a locked unit and the resident may be admitted to the secured unit. C. The IDT will assess each resident, and consider specific behavior symptoms, every quarter and PRN for	

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			appropriateness of placement on the secured unit and documented on the IDT review form. F154- Resident #1- Resident has been provided a communication board and does not desire to use communication board. Care plan has been updated to reflect that resident prefers to use non verbal signs to communicate at this time. If staff has difficult understanding resident they are encouraged to seek resident service specialist to clarify communications. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. Resident #11 – Resident has been provided a light weight communication board which he prefers not to carry around with him. He is provided with a note pad and pen that he sometimes carries. Resident's care plan has been updated to reflect that he prefers not to carry communication board most of the time and will use pad and pen on occasion. Documentation shows resident actively participates in most activities. Closed captioning has been activated on all communal televisions.	

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			There is a communication board in resident's room that is constantly available to resident and a communication board in the lobby area. There is a poster to teach sign language to staff and others who desire to learn sign language. There is a class available for those that wish to learn signing scheduled for May 27th 2015, and a mandatory refresher class on June 10th, 2015 for simple communication education. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. F248- Random Resident #26 – The facility will educate the direct care staff on interacting with residents more and on a higher level. Education will also include activity options available for residents and for staff to use with residents to keep them engaged to the extent the resident desires. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. Resident #11– Televisions in common areas on the unit where resident	

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			resides have been adjusted to include closed captioning. There is a communication board in resident's room that is constantly available to resident and a communication board in the lobby area. There is a poster to teach sign language to staff and others who desire to learn sign language. There is a class available for those that wish to learn signing scheduled for May 27th 2015, and a mandatory refresher class on June 10th, 2015 for simple communication education. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. F309- Resident #17. Orders obtained to follow Hypo-Hyperglycemic Policy and Procedure. Glucagon emergency Kit DC. Order for Sliding Scale insulin clarified for BS to be obtained before giving. Resident has had no adverse affects noted prior to changes. Blank in MAR's was noted to be made by Licensed Nurse that was terminated and therefore corrected itself. Completed May 13, 2015. Residents- 11, 19, 20, & 22. Orders obtained to follow Hypo-Hyperglycemic	

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			Policy and Procedure. Completed May 13, 2015. None of the above residents had any adverse BS affects noted. Resident #1. Bowel Protocol updated to meet residents needs and likes vs. dislikes by Dietary Manager and Medical Records. Completed May 14, 2015. Resident met with MDS/ RNA Coordinator on 4/25/15 and discontinued use of splint. Residents care plan updated by UM. Completed May 14, 2015. Resident #1. OT orders obtain and completed. New Velcro placed to meet resident's expectations April 10, 2015. Care plan and RNA program updated May 14, 2015 to including hours to be worn and to monitor before and after removal of splint by RNA Coordinator on May 14, 2015. RN #11 Reoriented regarding I & A process and reporting by DNS on May 12, 2015. No adverse psychosocial concerns noted related to splint. F314- Resident #5 Care plan updated. Skin currently intact with fragile skin. Resident #2 Care plan updated. IAD continues, on April 29, 2015. Therefore assisting with moisture. Resident #15 Discharged from facility	

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			on February 11, 2015. 2.Identification and treatment of other residents: F151- Other residents will be identified during the admission process and during quarterly IDT. Residents and responsible parties will sign that they are accepting of placement on the secured unit. F154- Other residents that have the potential to be affected by the cited tag will be identified by the MDS Matrix on Language and Communication. Corrective action will be addressed by ensuring all appropriate modes of communication are explored and documented on resident care plans, and providing items and training conducive to enhanced communication, ie. Communication boards. F248- Other residents that have the potential to be affected by the cited tag will be addressed in resident council with an emphasis to ensure that resident's activity needs are met. Residents are also given a calendar for the next month and encouraged to add desired activities and return the calendars before the 15th to be included in the next activity plan. Extend an invitation to other church	

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			denominations to visit the facility regularly. Multiple activities are scheduled after 2:00pm on the activity calendar. Activity Director makes list of items that are purchased beyond her budget and is reimbursed for all moneys. Activity Director was instructed to adjust hours of the director and the activity assistant to accommodate evening and weekend activities. F309- All resident with Diagnosis of Diabetic evaluated by MD and recommendations to follow Hypo/Hyperglycemia Policy and Procedure implemented as appropriate by UM/Medical Records on May 22, 2015. Updated Bowel Policy and Procedure implement for every resident with comprehensive care planning by IDT team by June 8, 2015. All facility residents interviewed for likes and dislikes prunes, prune juice and BAP (banana, apple sauce and prune) and care planned by Dietary and Management Nursing team by June 8, 2015. All RNA programs reviewed and updated regarding splint use and	

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			nursing notification related potential skin issues by MDS/RNA Coordinator by June 8, 2015. F314- To identify other residents having a potential to be affected, all residents care plans will be reviewed. 3.Systematic changes to correct deficient practices: F151-The system will be corrected with the use of the addition on the preadmission consent form and the enhanced IDT Meeting Assessment. F154- All residents triggered on the MDS for communication issues are to be evaluated by the Speech Pathologist and each communication care plan will be individually updated to reflect the recommendations of the Speech Pathologist. F248- Resident Council minutes will emphasize addressing whether or not the activity program is meeting the needs of the residents and the calendar will be reviewed. Residents will be involved with the QAPI committee starting 4/2/15. F309- Education and implementation Hypo-hyperglycemic Policy and Procedure and auditing process with Licensed Nurses on May 12, 2015 and	

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			May 19, 2015 during Licensed Nurses Meeting by DNS. Education to new Bowel Policy and Procedure and resident desires plus audit of Bowel movement at shift change for compliance with Bowel Policy to ensure resident rights and safety by DNS. Start May 20, 2015. RNA program training /retraining including importance reporting skin issues by the corporate MDS trainer by June 8, 2015. MDS/RNA Coordinator educated regarding regulations, implementation, and monitoring of RNA programs by the corporate MDS trainer by June 8, 2015. F314- Systematic changes to prevent recurrence of practice are: daily auditing will be completed for positioning by Licensed Nurses x 4 weeks. DNS / MDS will audit daily completion of above process daily x 4 weeks, then weekly x 4 weeks, then every 2 weeks x 4 weeks then monthly for QA/PI ongoing until 100% compliance with process. 4. How the facility will monitor performance: F151- The citation will be prevented and the plan will be monitored as these	

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			interventions are put into place. May 11th, the quality assurance committee will commence to ensure that 100% of all residents on the secured unit have a Secured unit form complete, 2-quarterly IDT assessment for the secured unit. Resident Services Coordinator will head the subcommittee to monitor this action. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3. F154- The corrective action will be monitored through the QAPI program. May 15th the quality assurance committee will commence to ensure that 100% of all triggered residents have the interventions in place. Resident Services Coordinator will head the subcommittee to monitor this action. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the communication care planning monitor form. F248- The corrective action will be monitored through the QAPI program. Resident council minutes will be brought to the QAPI meetings. The Administrator and a volunteer group of residents will monitor this action. This will be monitored weeklyX4, then q 2	

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			weeks X 2, then monthly X 3 on the resident activity satisfaction form. F309- The corrective action will be monitored in Daily Clinical meeting for splints, bowel programs, and blood sugar issues. This will be an ongoing process starting May 13, 2015. DNS / MDS will audit daily completion of above process daily x 4 weeks, then weekly x 4 weeks, then every 2 weeks x 4 weeks then monthly for QA/PI ongoing until 100% compliance with process. DNS will audit 5-10 care plans weekly x 5 weeks, then every 2 weeks x 4 weeks, then monthly. If DNS out of facility Unit Manager to complete audits. Monthly DNS will report to QA/PI compliance of programs. F314- Monitoring will be done as DNS will audit 5-10 care plans weekly x 5 weeks, then every 2 weeks x 4 weeks, then monthly. If DNS out of facility Unit Manager to complete audits. Monthly DNS will report to QA/PI compliance of programs. Monthly staffing meeting addressed reporting, positioning, and prevention May 8, 2015. Then Licensed nurses reeducated regarding Skin	

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			Program, forms & A reporting skin issues, treatment and prevention, measurements (including depth and undermining), drainage, odor, location, wound type, onset date and fully completed form. DNS will weekly review MDS for accuracy related to skin/wounds. Weekly skin checks and shower days residents skin will be assessed and interventions placed as needed. Licensed nursing will assess resident skin, compare TAR with skin measurement sheets make copy and give to DNS in which DNS will review and ensure completeness and appropriate interventions for prevention. DNS/UM during Daily Clinical will review daily completion of TAR/MARSs to ensure no blanks in TARs/MARs. Weekly the Wound Nurse will measure all wounds. Staff inservicing, orientation and supervision on the entire program, forms, weekly skin checks, weekly documentation on wounds, notifications, incident reports, appropriate treatment, positioning, etc will be done on hire and annually. The Corporate Operations Officer or the Corporate Compliance Officer will review documents to ensure compliance with plans of correction and suggest other areas to target.	

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

PRINTED: 05/05/2015
FORM APPROVED
OMB NO. 0938-0391

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			The Corporate Operations Officer or the Corporate Compliance Officer review the plan of correction supportive documents weekly x 5, Q 2 weeks X 2, then Monthly and track those on the POC Tracking Form and bring findings to the QAPI committee.	

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F 490	Continued From page 81 and Quality of Care areas. On 4/10/15 at 7:30 PM, the Administrator was notified of the identified concern. Additional information provided to the Bureau of Facility Standards by the facility on 4/13/15 did not resolve the concern.	F 490		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. 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	F520 The facility has maintained a quality assurance program that has identified and deficient practices in the facility and continues to work to correct them with good faith attempts and has made significant improvements as it has done so. 1.The citation will be corrected for individuals per tag: F246- The citation will be corrected for: a. Resident #5- Call light has been taped to the transfer pole in resident's room where resident can always access it. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. F248- The citation will be corrected for: Random Resident #26 – The facility will educate the direct care staff on interacting with residents more and on a higher level. Education will also	6/8/15

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F 520	Continued From page 82 Based on observation, record review, staff interview, and a review of the facility's compliance history, it was determined the facility's quality assessment and assurance (QAA) committee failed to take actions that identified and resolved systematic problems for 8 of 15 sampled residents (#s 1, 2, 4, 5, 8, 11, 13, & 16) and 9 random residents (#s 17-23 & 2 unidentified residents at group), with the potential to affect all residents in the facility. This failure resulted in the QAA committee providing insufficient direction and control, over the facility, necessary to ensure residents' quality of life, assessments, and quality of care needs were being met. Findings included: The QAA committee failed to provide sufficient monitoring and oversight and the ability to sustain regulatory compliance, as evidenced by the recitation of the following citations for the current annual recertification survey, dated 4/10/15. a. Refer to F246 as it related to the QAA committee's failure to ensure there were individualized accommodation of needs met, as evidenced by inaccessibility of residents' call lights. The facility was previously cited at F246, scope and severity D, during the annual recertification survey, dated 1/31/14. The facility was recited at F246 for the current annual recertification survey, dated 4/10/15, at a scope and severity of D. b. Refer to F248 as it related to the QAA committee's failure to ensure there were individualized activities to meet the interests and physical, mental, and psychosocial well-being of each resident. The facility was previously cited at F248, scope and severity E, during the annual recertification survey, dated 1/31/14. The facility	F 520	include activity options available for residents and for staff to use with residents to keep them engaged to the extent the resident desires. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. Resident #11– Televisions in common areas on the unit where resident resides have been adjusted to include closed captioning. There is a communication board in resident's room that is constantly available to resident and a communication board in the lobby area. There is a poster to teach sign language to staff and others who desire to learn sign language. There is a class available for those that wish to learn signing scheduled for May 27th 2015, and a mandatory refresher class on June 10th, 2015 for simple communication education. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. F253- Resident in Rooms #21and #22, and Rooms #25 and #26- The small holes where the bars had been	

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F 520	Continued From page 83 was recited at F248 for the current annual recertification survey, dated 4/10/15, at a scope and severity of E. c. Refer to F253 as it related to the QAA committee's failure to ensure housekeeping and maintenance services were provided to maintain a sanitary and comfortable environment. The facility was previously cited at F253, scope and severity E, during the annual recertification survey, dated 1/31/14. The facility was recited at F253 for the current annual recertification survey, dated 4/10/15, also at a scope and severity of E. d. Refer to F280 as it related to the QAA committee's failure to ensure care plans were revised and reflected the care needs of the residents. The facility was previously cited at F280, scope and severity E, during the annual recertification survey, dated 1/31/14. The facility was recited at F280 for the current annual recertification survey, dated 4/10/15, at a scope and severity of E. e. Refer to F309 as it related to the QAA committee's failure to ensure the facility provided the necessary care and services to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. The facility was previously cited at F309, scope and severity D, during the annual recertification survey, dated 1/31/14. The facility was recited at F309 for the current annual recertification survey, dated 4/10/15, at a scope and severity of G. f. Refer to F323 as it related to the QAA committee's failure to ensure residents environment remained as free of accident	F 520	removed were filled. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on residents from the cited tag. Resident Room #34 – the 4 inch rubber base board piece was secured. From observation and behavioral assessment done, the facility feels that there were no negative physical or psychosocial effects on resident from the cited tag. F280- Resident #2- Care plan update: Resident to be open to air while in bed to promote healing and healthy skin integrity. No psychosocial issues noted. Completed 5/ 6/15. Resident #13- IDT reviewed and updated care plan. Bed height remarked. Resident's bed height at knee height due to a history of self transfer. This height allows resident to plant feet on floor for stability. Non-skid strips have been put in place at bedside. No psychosocial issues noted. Completed May 6, 2015. F309- Resident #17. Orders obtained to follow Hypo-Hyperglycemic Policy and Procedure. Glucagon emergency Kit DC. Order for Sliding Scale insulin clarified for BS to be obtained before giving.	

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F 520	Continued From page 84 hazards as is possible and ensure residents receive supervision to prevent accidents. This was evidenced by three residents harmed with major injuries and increased pain after their falls and one resident at risk for harm with unsupervised wandering. The facility was previously cited at F323, scope and severity G, during the annual recertification survey, dated 1/31/14. The facility was recited at F323 for the current annual recertification survey, dated 4/10/15, at a scope and severity of D. g. Refer to F333 as it related to the QAA committee's failure to ensure residents were free of significant medication errors, as evidenced by a resident whom had not received the prescribed amount of anticonvulsant medication. The facility was previously cited at F333, scope and severity D, during the annual recertification survey, dated 1/31/14. The facility was recited at F333 for the current annual recertification survey, dated 4/10/15, at a scope and severity of D. On 4/10/15 at 3:37 PM, the Administrator was interviewed regarding the facility's QAA process and the concerns with the Activities Program observed during the survey. The Administrator stated the Activities Program had been addressed after the previous year's survey. There were changes made for the lack of activities on the weekends, various programs for the residents' different levels of functioning, and the individualization of care plans. The Administrator stated, the QAA committee looked closely at the "higher functioning residents" and added "more robust" exercise programs and ability for "going out on more outings." The Administrator also stated, the QAA committee audited a sample of care plans to ensure activities were	F 520	Resident has had no adverse affects noted prior to changes. Blank in MAR's was noted to be made by Licensed Nurse that was terminated and therefore corrected itself. Completed May 13, 2015. Residents- 11, 19, 20, & 22. Orders obtained to follow Hypo-Hyperglycemic Policy and Procedure. Completed May 13, 2015. None of the above residents had any adverse BS affects noted. Resident #1. Bowel Protocol updated to meet residents needs and likes vs. dislikes by Dietary Manager and Medical Records. Completed May 14, 2015. Resident met with MDS/ RNA Coordinator on 4/25/15 and discontinued use of splint. Residents care plan updated by UM. Completed May 14, 2015. Resident #1. OT orders obtain and completed. New Velcro placed to meet resident's expectations April 10, 2015. Care plan and RNA program updated May 14, 2015 to including hours to be worn and to monitor before and after removal of splint by RNA Coordinator on May 14, 2015. RN #11 Reoriented regarding I & A process and reporting by DNS on May 12, 2015. No adverse	

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F 520	Continued From page 85 individualized. When asked if this was still taking place, the Administrator stated, "No, we are done with the monitoring piece, but still involve the whole team in helping develop interventions that are attainable and enjoyable," and "We look at the complete process constantly." The facility was unable to show the QAA process to be effective at sustaining compliance as evidenced by the repeated deficiencies in 7 areas of quality of life, resident assessment, and quality of care categories.	F 520	psychosocial concerns noted related to splint. F323- Resident #1- IDT met to review resident's safety on 4/18/15 to review and identify the root cause of falls including hemiplegia, vision impairment, muscle spasms and paralysis agitans and assure that all interventions from all incident and accident reports have been implemented. New MDS coordinator continues to have weekly or semi weekly training from corporate MDS trainer to ensure consistency in charting and evaluations. Resident is cognitively aware . MDS evaluation will utilize visual assistance in completing the BIMS. All conflicting notes, care plans, assessments and MDS will be reviewed, verified and updated 5/14/15. New interventions were put into place on the care plan on 9/23/14, as well as all other falls. Resident has received the therapy evaluations related to the fall on 2/20/15, Friday, with an order dated 2/23/15, Monday. Non skid strips had been place at bed side on 12/14/14. Resident Room #34 – Bed cord has been replaced on 4/9/15. 2. The citations will identify residents	

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			who have the potential to be affected by the cited issues as follows per tag number: F246- Refer to the plan of correction. Other residents that have the potential to be affected by the cited tag are all other residents in the facility. Staff is to make continuous patrolling rounds of the residents and will ensure that call lights are within reach during rounds and document that call lights are in reach. F248- Other residents that have the potential to be affected by the cited tag will be addressed in resident council with an emphasis to ensure that resident's activity needs are met. Residents are also given a calendar for the next month and encouraged to add desired activities and return the calendars before the 15th to be included in the next activity plan. Extend an invitation to other church denominations to visit the facility regularly. Multiple activities are scheduled after 2:00pm on the activity calendar. Activity Director makes list of items that are purchased beyond her budget and is reimbursed for all moneys. Activity	

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			Director was instructed to adjust hours of the director and the activity assistant to accommodate evening and weekend activities. F253- Other residents that have the potential to be affected by the cited tag will be identified by the new maintenance manager that has been certified in housing for the elderly as part of his ongoing physical plant rounds. F280- Review of both care plans and resident current use of incontinent needs by MDS and Delta-Supplies Coordinator by June 8, 2015. All bed heights marked as appropriate with tape to wall to match resident care plan by June 8, 2015 by MDS/RNA Coordinator. F309- All resident with Diagnosis of Diabetic evaluated by MD and recommendations to follow Hypo/Hyperglycemia Policy and Procedure implemented as appropriate by UM/Medical Records on May 22, 2015. Updated Bowel Policy and Procedure implement for every resident with comprehensive care planning by IDT team by June 8, 2015.	

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			All facility residents interviewed for likes and dislikes prunes, prune juice and BAP (banana, apple sauce and prune) and care planned by Dietary and Management Nursing team by June 8, 2015. All RNA programs reviewed and updated regarding splint use and nursing notification related potential skin issues by MDS/RNA Coordinator by June 8, 2015. F323- Other residents that have the potential to be affected by the cited tag will be identified by having a quarterly and annual assessment for fall risk as well as a fall risk assessment for fall related incidents, and ongoing maintenance rounds. 3. Measures and systematic changes to ensure that deficient practice does not recur: F246- The continuous patrolling rounds will be documented on the rounding form to ensure call lights are continuously accessible. F248- Resident Council minutes will emphasize addressing whether or not the activity program is meeting the needs of the residents and the calendar will be reviewed. Residents will be	

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			involved with the QAPI committee starting 4/2/15. F253- Ongoing physical plant rounds will be documented on the maintenance rounds sheet and though the maintenance binders located at each nursing station. F280-. IDT team re-educated on Care planning process, Stand-up, I & A, and Daily Clinical meeting including attendance, process and responsibilities by DNS on May 12, 2015 and May 18, 2015. Employee's re-educated during Monthly Staffing Meeting regarding Care planning including use of CNA / LN communication books to assist additions to resident desires and a Person-centered care plan; bed heights, repositioning, and incontinent care needs. Licensed Nurses re-educated regarding Care Planning process and 24hr communication book by DNS on May 12, 2015 and May 19, 2015. F309- Education and implementation Hypo-hyperglycemic Policy and Procedure and auditing process with Licensed Nurses on May 12, 2015 and May 19, 2015 during Licensed Nurses	

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			Meeting by DNS. Education to new Bowel Policy and Procedure and resident desires plus audit of Bowel movement at shift change for compliance with Bowel Policy to ensure resident rights and safety by DNS. Start May 20, 2015. RNA program training /retraining including importance reporting skin issues by the corporate MDS trainer by June 8, 2015. MDS/RNA Coordinator educated regarding regulations, implementation, and monitoring of RNA programs by the corporate MDS trainer by June 8, 2015. F323- The Fall Risk Assessments will be reviewed each standard work day by the IDT to ensure that proper interventions are implemented to prevent fall issues. An ongoing physical plant rounds will be documented on the maintenance rounds sheet and through the maintenance binders located at each nursing station. 4. The corrective action monitoring to ensure cited issues do not recur for each respective area are as follows: F246- The corrective action will be monitored through the QAPI program. May 11th the quality assurance	

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			committee will commence to ensure that 100% of all triggered residents have the interventions in place. Resident Services Coordinator will head the subcommittee to monitor this action. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the communication care planning monitor form. F248- The corrective action will be monitored through the QAPI program. Resident council minutes will be brought to the QAPI meetings. The Administrator and a volunteer group of residents will monitor this action. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the resident activity satisfaction form. F253- The corrective action will be monitored through the QAPI program. May 18th the quality assurance committee will commence to ensure that 100% of all outstanding repairs are completed and rounding documentation will be brought to the QAPI meetings. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the communication care planning monitor form. F280- MDS to attend Stand-up, I & A to update care plans and ADLS as needed-	

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			ongoing. DNS will be responsible if MDS is not present. Stand-up, I & A and Daily Clinical meetings will be preformed, including review of C.N.A communication, 24 hour report/LN communication and PCC Order Listing report for care planning update. This process will be competed by DNS/UM/ &-or Medical records daily unless weekend or holiday then it will be completed following day. LN will be responsible to initiate care plan changes then stated process will be a double check. This process will be ongoing to ensure resident rights and continuous comprehensive care plan. Medication / Treatment Checklist will be used with new order by Licensed Nursing staff to ensure communication with resident, family, Doctor, and staff to ensure awareness of changes to residents needs and a continues updated Person-centered comprehensive care plan. This will be an ongoing process starting May 13, 2015. DNS / MDS will audit daily completion of above process daily x 4 weeks, then weekly x 4 weeks, then every 2 weeks x 4 weeks then monthly for QA/PI	

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			ongoing until 100% compliance with process. DNS will audit 5-10 care plans weekly x 5 weeks, then every 2 weeks x 4 weeks, then monthly ongoing for a triple check for compliance of a person-centered comprehensive care plan. If DNS out of facility MDS to complete 5-10 care plan audits. Monthly Administrator will report to QA/PI compliance of care plan reviews. F309- The corrective action will be monitored in Daily Clinical meeting for splints, bowel programs, and blood sugar issues. This will be an ongoing process starting May 13, 2015. DNS / MDS will audit daily completion of above process daily x 4 weeks, then weekly x 4 weeks, then every 2 weeks x 4 weeks then monthly for QA/PI ongoing until 100% compliance with process. DNS will audit 5-10 care plans weekly x 5 weeks, then every 2 weeks x 4 weeks, then monthly. If DNS out of facility Unit Manager to complete audits. Monthly DNS will report to QA/PI compliance of programs. F323- The corrective action will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135081		C 04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINI-CASSIA CARE CENTER	1729 MILLER AVENUE BURLEY, ID 83318

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			monitored through the QAPI program. April 12th the quality assurance committee will commence to ensure that 100% of all Fall Risk Assessments are completed and interventions are implemented. This information will be compiled by the DNS and brought to QAPI meeting for review. Maintenance rounding documentation will be brought to the QAPI meetings. May 18th the quality assurance committee will commence to ensure that 100% of all outstanding repairs are completed. Maintenance rounding documentation will be brought to the QAPI meetings. This will be monitored weeklyX4, then q 2 weeks X 2, then monthly X 3 on the communication care planning monitor form. The Corporate Operations Officer or the Corporate Compliance Officer will review documents to ensure compliance with plans of correction and suggest other areas to target. The Corporate Operations Officer or the Corporate Compliance Officer review the plan of correction supportive documents weekly x 5, Q 2 weeks X 2, then Monthly and track those on the POC Tracking Form and bring findings to the QAPI committee.	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
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FILE COPY

August 7, 2015

Darrin Radeke, Administrator
Mini-Cassia Care Center
1729 Miller Avenue, PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **April 10, 2015**, an unannounced on-site complaint survey was conducted at Mini-Cassia Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #6673

ALLEGATION #1:

The complainant stated the facility smelled like unwashed bodies.

FINDINGS #1:

The allegation was investigated in conjunction with the facility's licensing and recertification survey from April 6, 2015 through April 10, 2015. Daily observations were completed at varying times across shifts; interviews were conducted with two shower aides, individual residents, the resident group association and family members.

Resident Council minutes and resident grievances for the past three months were reviewed. Shower schedules for ten sample residents were reviewed.

During observations, throughout the five days, transient odors were present; however, the odors were for a short period and were not identified as body odor.

Four individual residents interviewed and two family members stated the facility was cleaned regularly and there was not a problem with odors in the facility.

Six residents participating in a meeting with the surveyors stated odors in the facility were not a problem. Five of the residents stated they received showers 2-3 times a week, which was sufficient. One resident stated she would like showers every day, but was not currently receiving a daily shower.

The two bath aides stated if a resident missed a shower then it would be rescheduled for the following day. Both aides stated at the current time there were no residents receiving a daily shower, but they had residents in the past who were showered on a daily basis.

Ten sample residents' shower records documented they received two to three showers a week unless the shower was refused.

Minutes from the Resident Council Meeting and grievances reviewed did not document concerns with odors in the facility.

Based on observations, residents interviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated therapy is "atrocious." No further details were provided.

FINDINGS #2:

Interviews were conducted with the Supervisor of therapy services, the Restorative Nursing Assistant and two residents receiving range of motion services.

Therapy care plans and notes were reviewed for five sample residents.

Observations for the use of adaptive equipment were completed.

The Supervisor of Therapy stated the facility had process for referring a resident to therapy. Typically, nursing assistants would express concerns regarding range of motion to the Supervisor of Therapy. The Supervisor would meet with the nurse for the identified resident and they would develop a plan for the type of therapy required for the resident. The Supervisor of Therapy stated she also got referrals from the resident's physician. If a resident were referred, the appropriate discipline would evaluate whether therapy services were necessary. If a resident experienced a decline in their physical abilities, the therapist would write an appropriate restorative nursing program to complement and enhance the resident's current therapy.

The Restorative Nursing Assistant stated for one of the sample residents he was working on range of motion for his lower extremities. The Restorative Nursing Assistant stated for another identified resident he had been working on walking, but the resident had consistently refused and the therapy was eventually discontinued. The resident's medical records confirmed the information the Restorative Nursing Assistant relayed to the surveyor.

A resident receiving range of motion for his lower extremities stated the Restorative Nursing Assistant worked with him on moving his legs. Another stated she did not receive range of motion services "anymore."

Physical Therapy notes reviewed from April 14, 2014 through July 22, 2014, documented the resident had been participatory in therapy; however, the resident was discharged from Physical Therapy on July 22, 2015, related to their medical condition.

Occupational Therapy notes reviewed from April 11, 2015 through August 23, 2014, documented the resident had been participatory in therapy; however, on August 23, 2014, the resident was discharged from Occupational Therapy related to the same medical condition.

Five residents and two family members interviewed did not verbalize concerns related to the therapy programs provided by the facility.

Six residents who participated in the group interview did not verbalize complaints and/or concerns related to the therapy programs provided by the facility.

Based on observations, residents interviewed and staff interviewed, it was determined the allegation could not be substantiated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the identified resident developed a pressure ulcer, with MRSA, on his/her buttocks.

FINDINGS #3:

During the survey, the medical records of four residents identified by the facility as high risk for pressure and/or having pressure ulcers were reviewed.

The facility's Policy and Procedures for Pressure Ulcers was reviewed.

Weekly skin assessment forms, care plans, physician orders and wound treatments were reviewed.

The Director of Nursing was interviewed.

This allegation was substantiated and cited at F314.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant reported staff had a bad attitude and were sarcastic in their tone of voice.

FINDINGS #4:

There was no quantifiable or measureable way to determine staff attitude. Additionally, there is no specific federal regulatory requirement related to customer service and/or best practice.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated there were no signs posted on resident doors to check with the nurse related to infections before going into the resident rooms.

The complainant stated staff did not wash their hands before or after residents were changed and/or before or after staff took their gloves off.

FINDINGS #5:

The Center for Disease Control (CDC) recommends that Standard Precautions and Contact Precautions be used when working with a resident who has MRSA in a wound. The CDC does not require Long Term Care facilities to place signage on a resident's door directing visitors to contact the nurse prior to entering the resident's room for a resident with a covered wound containing a MRSA infection.

The federal requirement at F441, Infection Control, requires the facility to establish an Infection Control Program that reflects the current CDC guidelines and does not require the facility to place a sign on the resident's door to check with the nurse prior to entering the resident's room.

Federal regulation F281, standards of practice, does not require the facility to place signage on a resident's door, under the reported circumstance.

During the survey process, multiple proper hand washing observations, across various shifts were made.

The facility's infection control program reviewed by the survey team did not identify concerns related to

improper hand washing.

Staff in-services on hand washing reviewed documented in-services were done at least quarterly and more often if necessary.

The Infection Control nurse stated she "spot checks" staff providing care to ensure proper hand washing is being done and provides further education and demonstration when areas of concern arises.

Based on observations, policy review, staff interview and review of regulatory and CDC requirements, it was determined the above allegations could not be substantiated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

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

NS/dmj

IDAHO DEPARTMENT OF
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FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 21, 2015

Darrin Radeke, Administrator
Mini-Cassia Care Center
1729 Miller Avenue, PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **April 10, 2015**, an unannounced on-site complaint survey was conducted at Mini-Cassia Care Center. The complaint allegations, findings and conclusions are as follows:

Review of the facility's admit pack, which included Residents Rights documented the facility would provide necessary communication services to the residents, to include a sign language interpreter.

Observations of residents with special communications needs were made over a four day period.

The records of residents with special communications needs were reviewed.

The Director of Nurses was interviewed.

Complaint #6959

ALLEGATION #1:

The complainant stated the facility failed to accommodate resident's communication needs.

FINDINGS #1:

The allegation was substantiated and cited at F154.

CONCLUSIONS:
Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the facility transferred residents to the hospital without notifying the family.

FINDINGS #2:

The complainant stated he/she filed a formal complaint with facility related to the identified concern and the Director of Nursing acknowledged the incident and implemented the necessary corrective action.

Based on the information provided by the complainant and the facility's response to the concern, it was determined the allegation could not be substantiated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated a resident had been distraught when hospitalized as translation services were not provided there.

FINDINGS #3:

The Long Term Care Survey team does not survey the care and services provided to patients and/or residents in the hospital setting; therefore, the survey team could not investigate the identified concern.

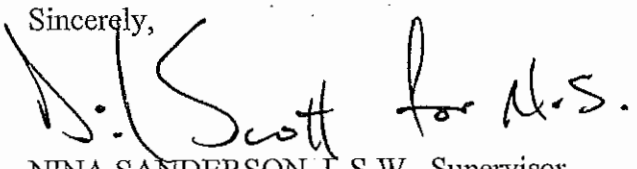
CONCLUSIONS:
Unsubstantiated. Long Term survey team does not investigate the care and services to residents in a hospital.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as

it will be addressed in the provider's Plan of Correction.

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

Sincerely,



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

NS/dmj