



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
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FILE COPY

May 15, 2015

Warren "Doug" Bodily, Administrator
River's Edge Rehabilitation & Living Center
714 North Butte Avenue
Emmett, ID 83617-2725

Provider #: 135020

Dear Mr. Bodily:

On **April 24, 2015**, a survey was conducted at River's Edge Rehabilitation & Living 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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) and on or before the "Opportunity to Correct." **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.**

Warren "Doug" Bodily, Administrator
May 15, 2015
Page 2 of 4

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 28, 2015**. Failure to submit an acceptable PoC by **May 28, 2015**, may result in the imposition of civil monetary penalties by **June 17, 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 29, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 29, 2015**. A change in the seriousness of the deficiencies on **May 29, 2015**, may result in a change

Warren "Doug" Bodily, Administrator
May 15, 2015
Page 3 of 4

in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 29, 2015** includes the following:

Denial of payment for new admissions effective **July 24, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 24, 2015**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 24, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

Warren "Doug" Bodily, Administrator
May 15, 2015
Page 4 of 4

<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 28, 2015**. If your request for informal dispute resolution is received after **May 28, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,

A handwritten signature in black ink that reads "Nina Sanderson for N.S.". The signature is written in a cursive style.

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

NS/dmj
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2015
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83817	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Linda Kelly, RN Kendra Deines, RN, BSN</p> <p>The survey team entered the facility on April 20, 2015 and exited on April 24, 2015.</p> <p>Survey Definitions: ADL = Activities of Daily Living BG = Blood Glucose BIMS = Brief Interview for Mental Status BID = Two times per day cm = Centimeters CNA = Certified Nurse Aide 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</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River's Edge Rehabilitation does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
F 164 SS=D	483.10(e), 483.75(l)(4), PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164		

RECEIVED
JUL 09 2015
FACILITY STANDARDS

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

TITLE

(X6) DATE

[Handwritten Signature]

ADMINISTRATOR

6/22/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 164	<p>Continued From page 1</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure privacy was maintained for 1 of 6 sample residents (#3). Failure to provide privacy during personal care created the potential for a negative effect on the resident's psychosocial well-being. Findings included:</p>	F 164	<p><u>F 164: PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</u></p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>Involved CNA #4 was re-educated related to privacy, closing doors, window blinds and using privacy curtains when providing personal care. Resident #3 did not exhibit any complications related to the incident observed.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>DON and SDC observed involved CNA providing personal cares to other residents on her shift. No other residents affected by deficient practice.</p>

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F 164	Continued From page 2 On 4/22/15 at 11:05 am, 2 surveyors entered Resident #3's room with permission. CNA #4, who was in the restroom with the resident, opened the restroom door and left it open while she assisted Resident #3 on the toilet. The resident's roommate was in bed facing the middle of the room. However, the roommate's door side privacy curtain was pulled only half way which allowed for a direct view into the restroom. At 11:10 am, CNA #4 wheeled Resident #3 to her bed and transferred her onto the bed using a gait belt (Refer to F 498 for details regarding CNA competency in skills and techniques). The privacy curtain between the 2 residents was in use; however, the CNA did not close the window blind before or while she provided personal care, including pericare and incontinence brief change, for Resident #3. Immediately afterward, CNA #4 was informed of the aforementioned observations. When asked about the open restroom door while the resident was on the toilet, CNA #4 stated, "Yes, I missed that step." When asked about the open window blind during the resident's personal care, the CNA stated, "Oh yes, I missed that step." 4/24/15 at 5:40 pm, the Administrator, DON and several other staff were informed of the issue. The facility did not provide any other information regarding the issue.	F 164	The DON, SDC, and LCSW will conduct in servicing of nursing staff involved with direct personal care regarding personal privacy and confidentiality starting 6/2/2015. <u>Measures that will be put into place to ensure that this deficiency does not recur:</u> DON, SDC or designee will educate on the topic of privacy related to personal cares starting on 6/2/2015. This education will continue thereafter on a quarterly basis. <u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u> The DON, SDC or designee will conduct observations of personal care, three times a week for one month on all shifts, and then once a week on all shifts for two months to ensure compliance with maintaining resident personal privacy and confidentiality. Audits will begin the week of 6/1/2015.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

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F 241	<p>Continued From page 3 enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure assistance at meals was provided in a manner to maintain or enhance each resident's dignity when a staff member stood and used a straw for soup instead of a spoon, while assisting residents to eat. This was true for 1 of 2 sampled residents (#2) observed during a meal. This deficient practice had the potential to cause psychosocial harm if residents became embarrassed about the manner in which assistance was provided. Findings included:</p> <p>On 4/22/15 at 6:15 PM, during the dinner meal observation in the Cherry Blossom dining room, four residents were seated at a square table along with four staff members. Resident #2 was at this table, being assisted by LN#1 whom stood at her side. The LN fed the resident and gave her drinks of fluid while standing for the full meal. Resident #2 did not have a spoon available at the table for her cream of potato soup, so LN#1 inserted a straw into the soup and proceeded to have the resident try to suck the soup up through the straw. The resident was able to consume some of the liquid portion of the soup with the straw, but not the vegetable pieces.</p> <p>On 4/22/15 at 6:30 PM, LN#1 stated, "I do usually sit." The LN said they had a family visitor at another table and so they did not have any more stools available. The LN said she did not like sitting in the chairs. LN #1 stated, "I don't usually</p>	F 241	<p>The DON will review and report results of audits monthly in QA Committee.</p> <p><u>Corrective action completed by:</u> 6/9/2015.</p> <p><u>F 241: DIGNITY AND RESPECTY OF INDIVIDUALITY</u></p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>The involved LN^{5.1} educated on feeding residents from a sitting position and providing appropriate eating utensils. ^{6.2} Adequate seating provided to accommodate visitors and staff.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>DON and SDC monitored LN staff during meal times, monitoring did not reveal any other residents affected by the deficient practice.</p> <p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p>	

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F 246	Continued From page 5 (HOB) but the button end of the call light was not readily visible. On 4/20/15 at 10:25 am, the resident was still awake in bed and the call light cord was still behind the HOB. Upon close inspection, the button end of the call light was observed on the floor between the HOB and the wall. Immediately afterward, CNA #3 was asked how the resident got the staff's attention if she needed help or wanted something. The CNA stated, "She uses the call light or she calls out." The CNA then accompanied 2 surveyors into the resident's room. When asked to find the call light, the CNA found it on the floor at the HOB. The CNA moved the call light within the resident's reach and clipped it to the bed linens. The CNA stated, "She throws it sometimes." The CNA showed the surveyors a camera on the resident's bedside table which was pointed directly at the resident while she was in bed. At the nurses' station, the CNA pointed out the monitor for camera. (Refer to F 460 for details regarding full visual privacy in bedrooms.) The CNA said staff "check on her frequently and go in and put the call light back." 4/24/15 at 5:40 pm, the Administrator, DON and several other staff were informed of the issue. The facility did not provide any other information regarding the issue.	F 246	Audits will begin 6/1/2015 CDM will review and report results of audits monthly QA Committee. <u>Corrective action completed by:</u> 6/9/2015 <u>F 246: REASONABLE ACCOMODATION OF NEEDS/PREFERENCES</u> <u>Corrective action for residents found to have been affected by this deficiency:</u> Nursing staff who provide care to resident #7 were educated on the requirement of call lights being accessible to residents while in there room. DON checked resident #7's room and confirmed that call light was appropriately placed. <u>Corrective action for residents that may be affected by this deficiency:</u> A review of residents with call lights was conducted by DON and ED, no further issues were discovered.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interview, it was determined the facility failed to ensure the flooring in 1 of 2 Clean Utility Rooms (Hall 2) was in good repair for the second consecutive recertification survey in a row. The failure created the potential for a negative psychological affect for 7 of 12 sample residents (#s 1, 2, 3, 5, 6, 7, and 12) and other residents who were weighed in the room. Findings included:</p> <p>On 4/20/15 at 2:35 p.m. and all other days of the survey, the floor tiles in the Hall 2 Clean Utility Room were observed in disrepair. Each floor tile was 12 inches long by 12 inches wide. Black marks covered 25% to 50% of 7 of the floor tiles in the vicinity of the wheelchair scale, 4 of the floor tiles directly under the ice machine drain spout were broken, and 10 adjoining floor tiles had a black substance 12 inches long by 1/8 to 1/2 inch wide in the gap between them. The unsightly floor tiles were in direct view of anyone in the room or on the scale.</p> <p>On 4/24/15 at 11:45 am, during an tour of the facility environment with the Maintenance Supervisor (MS), the MS was asked about the Hall 2 Clean Utility Room flooring. The MS said staff sometimes moved the wheelchair scale back and forth and that caused "scuff marks" on those floor tiles. The MS also acknowledged the broken floor tiles under the ice machine down spout and the black substance between the other floor tiles. He indicated nothing that could be done unless the floor was replaced.</p> <p>On 4/24/15 at 5:40 pm, the Administrator, DON</p>	F 253	<p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>The DON or SDC will provide in-servicing to all nursing staff on the appropriate placement and accessibility of call light to the resident starting on 6/2/2015.</p> <p>DON or designee will observe CNA change of shift rounds, and monitor that visual confirmation is taking place to ensure that call lights are appropriately placed starting 6/2/2015.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency</u></p>

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F 253 F 278 SS=D	<p>Continued From page 7 and several other staff were informed of the issue. The facility did not provide any other information regarding the issue.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and chart review, it was</p>	F 253 F 278	<p><u>has been corrected and will not recur:</u></p> <p>The ED or designee will conduct audits of patient rooms, assessing for appropriate access to call lights. DON will conduct observation audits of change of shift report to confirm that nursing staff are checking call light placement. Audits will be conducted weekly on each shift for one month and then each shift bimonthly for two months.</p> <p>Audits will begin the week of 6/1/2015.</p> <p>The DON will review and report audit results in the monthly QA Committee.</p> <p><u>Corrective action completed by:</u></p> <p>6/9/2015</p>	

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F 278	<p>Continued From page 8</p> <p>determined the facility's assessment of 1 out of 13 (Resident #3) sampled residents did not accurately reflect the resident's severe weight loss. The failure created the potential for interventions to not be implemented, placing resident's health at risk. Findings include:</p> <p>Resident #3 was admitted to the facility 10/1/13 with multiple diagnoses including depression, anxiety, muscle weakness, dementia, and contracture of hand joint.</p> <p>The resident's 2/28/15 quarterly MDS coded no known weight loss or gain in the past 6 months, weight of 133 pounds and height 60 inches.</p> <p>Guidance at F325 suggested parameters for evaluating significance of unplanned and undesired weight loss are greater than 5% in one month or greater than 7.5% in 3 months for severe weight loss.</p> <p>Review of the resident's weights revealed weight declined 12.4 pounds from 1/7/15 (145.4 lb) to 2/3/15 (133 lb). This was approximately an 8.5% weight loss in 1 month (a severe weight loss).</p> <p>On 4/24/15 at 9:00 the MDS Coordinator was interviewed. She said, "the computer catches the more than 5% in a month for drops in weight." The MDS Coordinator then calculated the percentage of weight that was lost from 1/7/15 to 2/3/15, found it significant and stated, "I didn't recognize that and neither did my computer and neither did my dietitian. The computer should have triggered it at 5% or greater."</p> <p>On 4/24/15 at 6:00 p.m., the Administrator and DON were notified of this issue. The facility did</p>	F 278	<p><u>F 253: HOUSE KEEPING AND MAINTENANCE SERVICES</u></p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>Residents #1, #2, #3, #5, #6, #7, #12 or any other residents will no longer be weighed in the Clean Utility Room, this room is no longer considered a resident space and will be utilized as a utility room only.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>All residents weighed in the clean utility room on the 200 hall are at risk.</p> <p>Going forward, all residents will be weighed in new scale room.</p> <p>Floor of clean utility has been repaired, and professionally stripped and waxed.</p>

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F 278 F 280 SS=D	<p>Continued From page 9 not provide any further information on the issue.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews with staff, and record review, it was determined the facility failed to update and/or revise the care plans for 2 out of 13 sampled residents (#2 & #3). The deficient practice had the potential to cause when care plans did not reflect the resident's current status to ensure appropriate provision of care, and/or it could not be determined when new interventions had been implemented. Findings included:</p>	F 278 F 280	<p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>Facility scale for weighing residents has been permanently moved out of the clean utility room to a different, larger room which has a newer non tile floor. Scale is also on a non-skid surface to prevent scuffing of floor.</p> <p>Housekeeping staff will clean weight room daily starting 5/29/2015. Housekeeping staff education started</p>	

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F 280	<p>Continued From page 10</p> <p>1. Resident #3 was admitted in 2013 with multiple diagnoses including muscle weakness, dementia, and contracture of the hand joint.</p> <p>a. The resident's 2/28/15 quarterly MDS and record review of weights revealed evidence of weight loss for the resident, with a severe weight loss (8.5%) from 1/7/15 to 2/3/15.</p> <p>Note: Refer to F235 details regarding weight loss for Resident #3.</p> <p>On 2/19/15 an interdisciplinary note documented "house shakes BID (two times a day)" was implemented as an intervention for the resident's weight loss.</p> <p>The care plan documented on 2/5/15 "house shakes BID" for the nutritional problem focus. The care plan also documented on 3/3/15 "house shakes BID" for the "unplanned/unexpected weight loss" focus.</p> <p>On 4/2/15 an order was started as an intervention for the weight loss, for "house shakes TID."</p> <p>Note: The care plan did not address the "house shakes TID" order change.</p> <p>On 4/23/15 at 10:25 a.m., the Staff Development Coordinator (SDC) was asked about the discrepancy, she stated, "The care plan needs to be adjusted to reflect the TID order."</p> <p>b. Revisions to Resident #3's care plan, dated 3/11/15, identified interventions to address weight loss including: *Offer assistance as needed and as resident will allow all meals.</p>	F 280	<p>5/28/2015, to clean smudge marks from the floor in the event that they occur.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>Maintenance supervisor or designee will audit newly designated weight/scale room bi-monthly for three months and then monthly thereafter to ensure a sanitary, orderly and comfortable interior.</p> <p>Audits will begin the week of 6/1/2015.</p> <p>The DON will review and report audit results in the monthly QA Committee.</p> <p><u>Corrective action completed by:</u> 6/9/2015.</p>

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F 280	<p>Continued From page 11</p> <p>*RNA dining at least 6 days a week for 15 minutes. Cut up food in small pieces. For first bite, load utensil and hand to resident. Cue to eat, assist when she is unable.</p> <p>Dining observations revealed minimal cueing for the resident to feed herself. Refer to F325 for details of these observations.</p> <p>On 4/23/15 the SDC stated, "if we try to assist her 1:1 she spits the food out...she has aggressive behavior...so we are subtle with cueing..." When asked if the aggressive behavior or subtle cueing was care planned, she confirmed it was not.</p> <p>On 4/24/15 at 6:00 p.m., the DON and Administrator were notified of these issues with the care plan. No further information was provided by the facility for this issue.</p> <p>2. Resident #2 was admitted to the facility on 5/29/14, discharged on 8/4/14, then readmitted on 9/11/14 with multiple diagnoses including chronic airway obstruction, dysphagia, Alzheimer's, dementia without behavioral disturbances, and depression.</p> <p>Both admission and a quarterly MDS assessments, dated 6/5/14, 9/18/14 and 3/17/15, documented the resident was severely cognitively impaired with a BIMS score of 3. 6/5/14 admission MDS documented the resident weighed 161 lbs and a height of 63 inches with no weight loss, and no nutritional approaches. The 9/18/14 MDS documented the resident's weight was 136 lbs and a height of 68 inches, with a mechanically altered diet with no weight loss. The 3/17/15 quarterly MDS documented the</p>	F 280	<p><u>F 278: ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</u></p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>Residents #3's 2/28/2015 MDS has been modified to reflect that significant weight change occurred during that MDS time period.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>Last three months MDS assessments, for residents who lost more than 5% in one month or greater than 7.5% in three month, have been reviewed for accuracy by the DON or SDC.</p> <p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>Starting 6/4/2015 the CDM and Registered Dietician will be educated to not remove the weight loss indicator from the electronic medical record system without first notifying the MDS coordinator.</p>	

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F 280	<p>Continued From page 12.</p> <p>resident weighed 119 lbs and a height of 68 inches, with weight loss noted.</p> <p>Resident #2's April 2015 recapitulation Physician's Orders documented, "90 mL [milliliters] of 2 cal with med pass two times a day...Order date 02/05/2015"</p> <p>The resident's current Care Plan documented: *Focus: "Nutritional concerns r/t [related to] diet restrictions. Mechanically altered texture w/ [with] nectar thick liquid. Weight loss. Date Initiated: 09/11/2014 Created on: 06/11/2014...Revision on: 03/19/2015." *Goal: "Will tolerate modified texture. Will have no significant weight loss this quarter. Date Initiated: 3/18/2015 Created on: 6/11/2014...Revision on: 03/19/2015." *Interventions: "90 cc 2 cal. TID [three times a day] w/meds. Date Initiated: 09/11/2014 Created on: 06/30/2014...Revision on: 09/11/2014."</p> <p>Resident #2's March and April 2015 MARs documented, "90 mL of 2 cal with med pass two times a day. Order date-02/05/2015"</p> <p>On 4/23/15 at 2:25 PM, the DON acknowledged Resident #2's Care Plan needed to be revised to reflect the current order for twice a day dosing for the 90 mL of 2 cal. The RD documented the resident had received the 90 mL of 2 cal three times a day during the first admit to the facility. The facility provided no further information to resolve this concern.</p>	F 280	<p>Starting 6/4/2015 weekly facility IDT nutrition meeting to review any resident weight losses, and report those losses to MDS to ensure accurate information is recorded in the MDS assessments.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>LCSW or designee will use the weekly significant weight loss list, from the weekly IDT nutrition meeting, to compare with respective MDS assessments to ensure accurate weight information is recorded. This will occur weekly for three months</p> <p>Audits will begin the week of 6/1/15.</p> <p>The DON will review and report the audits results to monthly QA meetings.</p> <p><u>Corrective action completed by:</u> 6/9/2015.</p>
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309	

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F 309	<p>Continued From page 13</p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure:</p> <p>a) The specific anticholinergic side effect (SE) of a medication was documented and reported to the physician immediately as ordered;</p> <p>b) Medications were administered as ordered;</p> <p>c) Monitors for hours of sleep, pain levels, anxiety and behaviors were consistently documented;</p> <p>d) Consistent communication with a hospice agency was maintained;</p> <p>e) Interventions for hypoglycemia were implemented and parameters were in place for insulin administration;</p> <p>f) Physicians were notified of hypoglycemic events, when insulin was held and when a resident's condition changed; and,</p> <p>g) The facility's Hypoglycemia and Hyperglycemia Policies and Procedures (P&P) met standards of care.</p> <p>These failures affected 5 of 12 (#s 2, 6, 5, 7, & 8) sampled residents. The failures created the potential for residents to experience complications, compromise to their medical condition and a negative affect on their psychosocial well-being. Findings included:</p> <p>1. Resident #8 was readmitted to the facility on 2/4/13 with multiple diagnoses including</p>	F 309	<p><u>F 280: RIGHT TO PARTICIPATE PLANNING CARE-REVISE CARE PLAN</u></p> <p>Care plans have been revised to reflect the current status of residents #2 and #3.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>A review of residents with orders for house shakes, 2 cal, and residents with a RNA dining care plan was conducted by the DON, SDC and ED, care plans for those residents were updated and or revised to reflect current status for provision of care.</p> <p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>The DON and SDC will provide in-service starting 5/26/2015 to Licensed Nurses regarding updating care plans to reflect residents current status as ordered by provider.</p>

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F 309	<p>Continued From page 14</p> <p>congestive heart failure, chronic airway obstruction, chronic pain, depression, bipolar, urinary retention, and anxiety.</p> <p>The resident's recapitulation of Physician's Orders for April 2015 and the March and April 2015 MARs included the following orders: * 7/25/11 - "Monitor for these effects and notify the MD [physician] immediately if any occur: Common anticholinergic side effects [SE] include constipation, dry mouth, dry eyes, blurred vision, urinary retention, delirium and hallucinations every shift." * 11/14/14 - "Document # hours resident sleeps...every night shift."</p> <p>The resident's MARs documentation included: * 3/5 and 3/12/15 - only a "-" [dash mark] was recorded, however, the hours of sleep was not documented. * 4/3/15 night shift - a "Y" was documented which indicated the resident did have an anticholinergic effect. Note: There was no documentation regarding what kind of anticholinergic SE the resident experienced. In addition, there was no documented evidence the physician was notified about the SE.</p> <p>A 3/14/15 Physician's Order documented, "Gentamicin Sulfate Solution 0.3% Instill 2 drops in both eyes four times a day for eye infection for 7 administrations give 1-2 drops each eye four times a day X [times] 7 days. (Note: There was no documented evidence clarification was requested regarding whether the Gentamicin was 7 administrations only or 7 days.)</p> <p>The resident's March 2015 MAR documented the</p>	F 309	<p>Facility IDT committee to update care plan as needed to reflect residents current status. Orders to be reviewed and correlated to care plan by medical records.</p> <p>SDC will hold weekly meetings starting 6/4/2015 with RNA staff. The care plan for all residents receiving RNA dining services will be evaluated</p> <p>and updated if needed to ensure plan of care is effectively meeting the needs of the resident.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>Starting 6/5/2015 the DON, SDC or designee will conduct weekly reviews for three months of all orders for house shakes and 2 cal to ensure care plan correctly reflects current status of resident orders.</p>	

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F 309	<p>Continued From page 15</p> <p>Gentamicin was administered 3/14 at 6:00 PM and 9:00 PM, 3/15 at 8:00 AM, 1:00 PM, 6:00 PM and 9:00 PM and 3/16/15 at 8:00 AM. The Gentamicin was documented as administered only 7 times rather than four times a day for 7 days (28 doses).</p> <p>On 4/22/15 at 4:15 PM, the DON was asked about Resident #8's anticholinergic SE, hours of sleep and Gentamicin. Regarding the anticholinergic SE, the DON said "Y" meant the resident had an anticholinergic SE. The DON confirmed there was "no documentation related to that [SE]" and said he would not know what SE the resident experienced. The DON confirmed the physician was not notified of the SE. Regarding documentation of the hours of sleep, the DON said "not done." Regarding the Gentamicin, the DON said the order was "entered as 7 times of administration instead of 7 days." The DON acknowledged the order should have been clarified and that 21 doses of Gentamicin were not administered to the resident.</p> <p>2. Resident #2 was admitted to the facility on 5/29/14 and discharged on 8/4/14, then readmitted to the facility on 9/11/14 with multiple diagnoses including chronic airway obstruction, dysphagia, Alzheimer's, dementia without behavioral disturbances, and depression.</p> <p>A 1/29/15 laboratory (lab) report documented the resident's Vitamin B12 level was "309" (the reference range was 211-946). An undated, handwritten, signed order on the lab report documented, "B12 borderline[,] 1 cc Cyanocobalamin IM [intramuscular] q [every] 1 mo [month] f/u [follow up] CBC in 3 mo." It was documented at "noted" on 2/3/15 at 3:30 AM.</p>	F 309	<p>Starting 6/5/2015 the SDC or designee will conduct bimonthly dining room observations, for three months, of residents receiving RNA dining services, to ensure that care plan reflects services needed.</p> <p>Audits will begin the week of 6/1/2015.</p> <p>The DON will review and report audit results in the monthly QA Committee meeting.</p> <p><u>Corrective action completed by:</u> 6/9/2015.</p>	

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F 309	<p>Continued From page 16</p> <p>The resident's March 2015 recapitulation of Physician's Orders included the following orders: * 9/11/14 - "Monitor level of pain every shift..." * 11/18/14 - "Monitor behaviors for Anxiety...every shift...Intervention..." * 3/9/15 - "Cyanocobalamin Solution 1000 mcg/ml [micrograms/milliliter] Inject 1 cc intramuscularly every month starting on the 10th and ending on the 10th related to blood in stool..."</p> <p>The resident's March 2015 MAR included the following: * 3/9/15 night shift - The space to document the monitor for anxiety was blank. * 3/9/15 night shift - The space to document pain was blank.</p> <p>The March 2015 MAR included the aforementioned 3/9/15 order for Cyanocobalamin. It also included a 2/6/15 order for the Cyanocobalamin to be administered IM "every month starting on the 6th and ending on the 6th...-Order Date- 2/3/2015..." However, the 2/6/15 Cyanocobalamin order was discontinued on 3/9/15.</p> <p>The March 2015 MAR contained evidence that the Cyanocobalamin was not administered on 3/6 or 3/10/15.</p> <p>In addition, there was no documentation in the resident's clinical record regarding why Cyanocobalamin was not administered in March and no evidence the physician was notified of the error.</p> <p>On 4/22/15 at 3:40 PM, the DON was asked about the resident's Cyanocobalamin and</p>	F 309	<p><u>F 309: PROVIDE CARES/SERVICES FOR HIGHEST WELL BEING</u></p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>Residents #8, #2, #6, #5 and #7 do not exhibit any complications or compromise to their medical condition related to provision of care/services for highest wellbeing, provider made aware. LN staff who work with resident #8 educated on need for provider notification for positive anti cholinergic side effects. LN staff that work with resident #2 educated on reordering if medication found to be unavailable in the facility. DON confirmed that resident #2 did receive the next B12 injection ordered. DON audited patient #6 MAR to ensure that current medications and monitors have appropriate documentation and have educated staff where needed. Resident #5 has been discharged from the facility. Hospice documentation has been obtained and placed in chart for Resident #7.</p>	

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F 309	<p>Continued From page 17</p> <p>behavior/pain level monitors. The DON acknowledged that Cyanocobalamin was not documented as administered in March, there was no documentation of why the medication was not administered, or of physician notification. He also confirmed that behaviors and pain levels were not consistently documented as monitored.</p> <p>3. Resident #6 was originally admitted on 12/14/12 and readmitted on 7/11/13 with multiple diagnoses including chronic airway obstruction, dysphagia, atrial fibrillation, cerebrovascular disease, and dementia with behaviors.</p> <p>The resident's Physician's Orders included the following orders: * 12/14/12 - "Levothyroxine Sodium...75 mcg by mouth every morning..." * 11/14/14 - "Document # hours resident sleeps at night every night shift..." * 4/29/14 - "Monitor level of pain every shift..." * 11/18/14 - "Monitor behaviors for Depressed, withdrawn...hallucinations/paranoia/delusions...every shift..."</p> <p>The resident's March 2015 MAR documentation included: * 3/10/15 at 5:00 AM - Space to documentation levothyroxine was blank. * 3/9/15 night shift - Space to document hours of sleep was blank. * 3/9/15 night shift - Space to document pain was blank. * 3/9/15 night shift - Space to document behavior was blank.</p> <p>On 4/22/15 at 3:35 PM, the DON said the computers were down on 3/9, 3/10, 3/23; and</p>	F 309	<p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>DON review of residents with orders to monitor anti cholinergic side effects, no other positives found without notification to the provider. LN educated related to order.</p> <p>DON reviewed all orders and documentation for residents with monitors for hours of sleep, behaviors, anxiety, depression, hallucinations,</p> <p>paranoid delusions, pain level and BG's. DON also reviewed reporting of abnormal BGs outside of parameters for every shift. LNs educated upon any instance of lack of documentation found.</p> <p>DON reviewed order in question of resident #8, LN immediately educated regarding input of orders related to 'duration' versus 'duration by administration.'</p> <p>DON reviewed policy and procedure for when electronic MAR is inoperable, LNs immediately educated regarding the same.</p>	

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

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F 309	<p>Continued From page 18</p> <p>3/24/15 and the staff used paper charting to document medications and monitoring of pain, behaviors, hours of sleep, and "anything else" that would normally be documented on the EMAR.</p> <p>On 4/24/15 at 2:15 PM, the DON was asked about Resident #6's levothyroxine. The DON acknowledged the Levothyroxine was not documented as administered on 3/10/15. He stated, "Should have been documented on the paper chart." The DON said some staff were better in their charting than others and he was not aware that charting was not complete.</p> <p>4. Note: The American Diabetes Association's (ADA) article, Hypoglycemia (Low Blood Glucose), last edited 9/16/14, defined hypoglycemia, "...a condition characterized by abnormally low blood glucose (blood sugar) levels, usually less than 70 mg/dl [milligrams/deciliter]...may also be referred to as an insulin reaction, or insulin shock...The only sure way to know...is to check your blood glucose...Severe hypoglycemia has the potential to cause accidents, injuries, coma, and death...left untreated, hypoglycemia may lead to a seizure or unconsciousness..."</p> <p>Resident #5 was readmitted to the facility on 6/7/14 with multiple diagnoses including diabetes mellitus (DM), peripheral angiopathy, below the knee lower limb amputation, and depression.</p> <p>The resident's Physician Orders included the following orders: * 11/14/14 - "Monitor Behaviors...every shift..." * 8/2/14 - "Monitor Level of pain every shift..." * 12/23/14 - "2 hour post prandial BG [blood</p>	F 309	<p>DON immediately educated LN on importance of administration of monthly ordered injection for resident #2.</p> <p>DON review of all residents with BG monitoring parameters and adjusted all incorrect 'greater than' or 'less than' symbols and immediately educated all LNs.</p> <p>DON reviewed residents with BG monitoring parameters and confirmed that provider is being notified if BGs fall outside of provider parameters. LN staff educated in regard to requirement of provider notification in the event that BG levels fall outside of parameters.</p> <p>Medical records reviewed all hospice patient charts for verification of complete documentation. Respective hospice agencies notified on any noncompliance with any documentation requirements.</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 19</p> <p>glucose] after meals...Notify physician if BG < [less than] 400 or if BG > [greater than] 60..."</p> <p>Note: The < and > symbols were backwards. The order should have read: notify if BG > (greater than) 400 or < (less than) 60. Refer to F514;</p> <p>* 12/23/14 - "Fasting BG one time a day for DM. Notify physician if BG <400 or if BG >60..."</p> <p>Note: The < and > symbols were backwards as noted above.</p> <p>* 3/13/15 - "Bydureon Pen injector 2 mg...Inject 1 dose subcutaneously [SC] one time a day every 7 day(s) for DM..."</p> <p>* 3/11/15 - "Lantus Solution 100 unit/ml...Inject 40 units [SC] at bedtime..."</p> <p>* 3/11/15 - "Metformin HCl Tablet Give 1000 mg by mouth two times a day..."</p> <p>* 9/5/14 - "Novolog FlexPen ...100 unit/ml...Inject 15 unit [SC] in the afternoon..."</p> <p>* 3/11/15 - "Novolog FlexPen ...100 unit/ml...Inject 15 unit [SC] one time a day..."</p> <p>* 9/23/14 - "Novolog FlexPen ...100 unit/ml...Inject 15 unit [SC] one time a day..."</p> <p>* 1/8/15 - "Novolog FlexPen ...100 unit/ml...Inject 20 unit [SC] as needed for DM give with each snack..."</p> <p>The resident's March and April 2015 MARs documentation included:</p> <p>* 3/9 night shift - depression not monitored</p> <p>* 3/9 day shift - pain not monitored.</p> <p>* 3/10 day shift - depression not monitored</p> <p>* 4/19 at 5:00 PM - Novolog 15 units not administered, "Hold/See Nurse Notes" was documented.</p> <p>The resident's Nursing Progress Notes (NPN), dated 3/11/15 - 4/19/15 at 5:59 PM, documentation included:</p> <p>* 4/19 at 2:14 PM - "...c/o [complaint of] 'not</p>	F 309	<p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>The DON and SDC will provide in-service starting 5/26/2015 to LN staff regarding accurate documentation per orders of the following; depression, hallucinations, paranoid delusions, hours of sleep, BG monitoring, pain, anti-cholinergic side effects, hours of sleep, and abnormal BGs outside of parameters.</p> <p>LN staff to be trained starting 5/26/2015 on latest ADA recommendations and updated policy and procedure regarding interventions for hypo and hyperglycemia.</p> <p>Starting 6/2/2015 LNs will add residents who exhibit positive anti cholinergic side effects to the 24 hour report. DON or designee will monitor 24 hour report starting 6/2/2015.</p> <p>DON or SDC will offer in-service starting 5/26/2015 to LN staff regarding 7 rights of medication administration, accurate transcription of provider orders. LNs will be educated starting 5/26/2015 to order medication promptly if medication found not in stock in the facility.</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F-309	<p>Continued From page 20 .</p> <p>feeling good' @ [at] lunchtime. Min. [minimum] food eaten...leaving dining room...pale, hanging head, slow to answer any questions...checked BG @ 1400 [2:00 PM] which was 44...taken back into dining room...8oz [ounces] orange juice...spoonful of peanut butter...completed 100%. Rechecked BG @ 1415 [2:15 PM] - 66...color back...more appropriate answers...continue to monitor."</p> <p>Note: * 4/19 at 5:59 PM - "Re-checked BG before dinner - 84. Held insulin to monitor what res. will eat for dinner."</p> <p>The BG of 44 was not reported to the Physician. When the BG rose to 66, another intervention for a BG less than 70 was not implemented and the BG was not rechecked for 45 more minutes. In addition, the LN held the scheduled 5:00 PM dose of Novolog insulin without contacting the physician and there was no documented evidence the physician was notified about the changes in the resident's condition and eating.</p> <p>The facility's Hypoglycemia P&P, dated 5/2007, documentation included, "Hypoglycemia...It is the policy of this facility to restore normal blood glucose level...Observe for the following signs and symptoms: Headaches, Shakiness, Perspiration, Sleepiness... Obtain finger stick blood sugar level...When nurse determines resident is hypoglycemic, check chart for blood sugar glucose orders If no orders, notify physician: give four ounces of fruit juice (orange or apple)...If resident rallies immediately and is able to swallow; follow up with food if it is more than thirty (30) minutes until the next meal...Supervise that resident eats food and does not fall back to sleep. ..Call physician immediately for orders..."</p>	F 309	<p>Starting 5/26/2015 meds found not available at time of administration, pharmacy will be notified and medication reordered immediately.</p> <p>The involved hospice agency has incorporated an auto-fax process. Starting 6/4/2015, once hospice caregiver has completed resident charting a summary will be auto-faxed to the facility and placed in the resident chart.</p> <p>DON or SDC will in-service staff starting 5/26/2015 on Facility Clinical System Disaster Action Plan, which includes protocol related to documentation on paper MAR record.</p> <p>Starting 5/26/2015 for patients who fall outside of BG parameters, LN will place the residents on the 24 hour report to alert oncoming shift and physician will be notified.</p> <p>On 5/26/2015 DON and SDC reviewed and updated the hypo/hyperglycemia policy based off of recommended ADA standards. LN staff educated by SDC starting 5/26/2015 on the updated hypo/hyperglycemia policy.</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 21</p> <p>The facility's Hypoglycemia/Hyperglycemia Policies and Procedures did not include any parameters for low or high blood glucose levels and directed nurses to determine hypoglycemic or hyperglycemic by signs and symptoms. The facility's Policies and Procedures did not follow the standards of care for diabetic residents.</p> <p>On 4/20/15 at 10:35 AM, 4/21/15 at 12:45 PM, and 4/22/15 at 10:42 AM, Resident #5 was observed on her bed. The resident said she was ill and had the "stomach flu." The resident said she had not felt well since the last week, she that she had stayed in her room for some meals and that she tried to eat "a little something" at each meal "because of the diabetes."</p> <p>On 4/23/15 at 1:55 PM, the DON was asked about Resident #5's diabetic care. The DON said the LN "failed to notify the Physician" when the resident's BG was 44. The DON said the resident was "considered hypo [hypoglycemic] under 60" and the order meant the physician was to be notified when the BG was "under 60." The DON said there were no physician ordered parameters to hold or give insulin and the LN should have contacted the physician for orders.</p> <p>On 4/24/15 at 5:40 PM, the Administrator, DON, and several other staff members were informed of the concerns. The facility did not provide any additional information to alleviate the issues.</p> <p>1. Resident #7 was admitted with multiple diagnoses in October 2013 and started receiving hospice services in December 2013. The resident's most recent quarterly MDS dated 2/17/15 coded the resident for receiving hospice services.</p>	F 309	<p>LN staff in serviced by DON or SDC on 5/26/2015, regarding discontinued use of symbols for BG parameters and to instead use words "greater than or less than" in BG orders.</p> <p>Starting 6/5/2015 DON, SDC or designee will review all patients with diabetes mellitus and update orders, parameters and care plan to ensure that these are in accordance with ADA recommendations.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p>

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F 309	<p>Continued From page 22</p> <p>The most recent hospice recertification period was 2/14/15 to 4/14/15, and documented a nursing visit frequency of once per week for 9 weeks. The CNA frequency was documented as 4 times per week for 8 weeks and twice per week for 1 week.</p> <p>Review of Resident #7's facility hospice binder revealed the following notes: *LPN visit 1/27/15 *LPN visit 3/4/15 *CNA visit 3/12/15 *CNA visit 4/9/15 *CNA visit 4/13/15</p> <p>Note: Five nursing visit notes and twenty eight CNA visit notes were missing from the facility's documentation.</p> <p>On 4/23/15 at 10:05 a.m., the Staff Development Coordinator (SDC) was interviewed about additional hospice nursing visit notes. When asked how nursing visits were documented and communicated to the facility, she said she was "not sure if each discipline has a routine or not [to communicate with the facility]...we would probably have to call them and ask for that documentation."</p> <p>On 4/23/15 at 3:30 p.m., the SDC stated she "called to get hospice nursing visit notes, they weren't in the facility."</p> <p>On 4/24/15 at 6:00 p.m., the administrator and DON were notified of this issue. The facility did not provide any further information about this issue.</p>	F 309	<p>DON or designee will review weekly for three months all patients with anticholinergic monitors to ensure appropriate documentation.</p> <p>DON or designee will audit all LN documentation of residents who appear on the 24 hour report due to positive effects of anticholinergic side effects or BGs outside of provider parameters, or resident condition change to ensure that provider was notified, three times a week for one month and then weekly for two months.</p> <p>Medical records will review medication administration records, will notify DON of missing medication and will confirm that medication was ordered and received by patient. This audit will be performed three times a week for one month and then weekly for two months.</p> <p>DON, LCSW, MDS, ED or designee will review monitors for hours of sleep, pain levels, anxiety and behaviors weekly for three months for consistent documentation.</p>

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F 323 F 323 SS=E	<p>Continued From page 23</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure hazardous chemicals were secured in the Hall 2 Janitor's Closet, adequate supervision was provided to prevent falls, and bed side rails were assessed to determine if they were safe for individual residents to use. These failures created the potential for skin/eye irritation/burns or poisoning for cognitively impaired, independently mobile residents in the vicinity of the Hall 2 Janitor's Closet, injury from falls for 1 of 2 sample residents (#3) reviewed for falls, and injury/entrapment for 6 of 8 sample residents (#s 1-5 and 8) who had side rails. Findings included:</p> <p>1. On 4/20/15 at 1015 am, 2 surveyors noted a sign on the Hall 2 Janitor's Closet door which read, "Hazardous Chemical Storage (Authorized Personnel Only)." When the door knob was pulled, the closet door opened easily. The door knob was locked; however, the locking mechanism was not engaged in the strike bar on the door frame.</p> <p>Four hazardous chemicals connected to a readily</p>	F 323 F 323	<p>Medical records or designee will audit medical record of residents on hospice, for consistent documentation of caregivers per hospice plan of care. These audits will be performed weekly for three months.</p> <p>Medical records will monitor any new orders for BG parameters to ensure that updated policy is followed. Audit will be performed weekly for three months.</p> <p>Audit will begin the week of 6/1/2015</p> <p>Results from audits will be reported to the Quality Assurance Committee monthly.</p> <p><u>Corrective action completed by:</u> 6/9/2015.</p>
(X5) COMPLETION DATE			

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F 323	<p>Continued From page 24</p> <p>accessible Quattroselect wand were found unsecured in the Janitor's closet. The chemicals with the following warnings were:</p> <ul style="list-style-type: none"> * Non-Acid Bowl & Bathroom Disinfectant Cleaner - "Danger. Corrosive. Causes skin and eye burns, harmful or fatal if swallowed." * Stride Citrus HC Neutral Cleaner - "Warning. Causes eye and skin irritation, may be harmful if swallowed." * Virex II 256 - "Danger. Corrosive. Causes skin and eye burns. Harmful or fatal if swallowed. Combustible liquid and vapor." * J-512 Sanitizer - "Danger. Corrosive. Caused irreversible eye damage. Causes eye and skin burns. Harmful if swallowed." <p>On 4/20/15 at 10:35 am, the Maintenance Supervisor (MS) was asked about the unsecured chemicals in the Hall 2 Janitor's Closet. The MS stated, "The door should have been closed." The material safety data sheets (MSDS) for the chemicals were requested at that time and the MS provided them later that morning.</p> <p>On 4/20/15 at 3:55 pm, the Administrator and DON were informed of the issue.</p> <p>On 4/21/15 at 10:40 am, the MS stated, "We have a problem with these doors." He added, "Some staff leave the door ajar. It's a short cut so they don't have to get the key from the nurse to get into some rooms like the Janitor's Closet."</p> <p>2. Resident #7 was admitted to the facility in 2010 with multiple diagnoses including late effects of cerebrovascular disease, senile dementia, generalized muscle weakness and hypertonicity of the bladder.</p>	F 323	<p><u>F 323: FREE OF ACCIDENTS/HAZARDS SUPERVISION/DEVICES</u></p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>No resident specified.</p> <p>Hall 2 janitor closet was assessed, lock found to be functioning properly.</p> <p>Resident #7 (resident #3 misidentified), was assessed for fall risk, interventions were immediately adjusted to meet residents needs per current fall risk assessment.</p> <p>Resident #1-#5 and resident #8 and #9 side rails assessment forms were reviewed, and updated to reflect resident's current status.</p>	

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F 323	<p>Continued From page 25</p> <p>The resident's care plan identified risk for falls related to unaware of safety needs, dementia, anxiety and a history of falls as a focus area in June 2013. Interventions included: bed in lowest position and lipped air mattress, initiated 12/10/2013; floor-mat on each side of bed, revised 1/20/15; body pillow while in bed for positioning, revised 2/10/15; and, "Attach tab alarm to patients [sic] when up in wheel chair and when patient is in bed," initiated 2/16/15.</p> <p>The resident's Fall Scene Investigation Reports (FSI) included 2 "Rolling/sliding out of bed" incidents dated 11/4/14 and 1/20/15.</p> <p>The FSIs contained the following documentation:</p> <p>* 11/4/14 at 10:20 am - An unwitnessed, non-injury fall, the resident said, "I like to lay close to the edge of the mattress and I fell in that tunnel" and "I got too close". An alarm in use at the time of the fall did not alarm, it was "still attached to shirt and magneton [sic] box." "Re-enactment of fall (to be done if Root Cause is NOT determined): Mattress gives (depresses) when weight is put on edge." "What appears to be the root cause of fall? mattress." Interventions to prevent future falls: "Hospice called to replace mattress." Hospice did provide a different mattress that day. However, the alarm failure was not addressed.</p> <p>* 1/20/15 at 4:00 pm - A witnessed, non injury fall, the resident was "unable to explain what happened." "[A]larm was long, did not go off was still attached at time of fall." "What appears to be the root cause of fall? crawls out of bed." Initial interventions to prevent future falls: "...since length of string is long (alarm) - put alarm on (R)</p>	F 323	<p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>All resident have potential to be affected by housekeeping closet door being left ajar. Maintenance supervisor has installed self-closing mechanisms on all housekeeping closet doors.</p> <p>DON and SDC observed all residents with tab alarms, string length found to be at appropriate length.</p> <p>DON and SDC have reviewed all residents with side rails, and have confirmed that side rail safety assessments have been completed.</p> <p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>Starting 5/26/2015 DON and SDC will educate nursing staff on correct placement of tab alarms and the utilization of a second nursing staff member to verify correct placement of tab alarm.</p>

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F 323	<p>Continued From page 26</p> <p>[right] shoulder & shorten the string - so alarm can go off before resident rolls out of bed."</p> <p>The resident was observed in bed on a lipped air mattress on 4/20/15 at 10:12 am and 10:25 am; 4/21/15 at 12:05 pm, 12:35 pm and 4:40 pm; 4/22/15 at 10:05 am, 3:20 pm and 5:50 pm; and on 4/23/15 at 9:35 am.</p> <p>On 4/21/15 at 9:40 am, LN #6 was asked about the resident's falls out of bed. The LN stated, "They are more like rolls off her bed. Her and her daughter have always said she sleeps really close to the edge.</p> <p>The tab alarm issue was not addressed after the resident's first fall out of bed on 11/4/14 and the alarm did not sound when the resident fell out of bed the second time 1/20/15.</p> <p>The Administrator and DON were informed of the issue on 4/24/15 at 5:45 pm. The facility did not provide any other information regarding the issue.</p> <p>3. Resident #4 was admitted to the facility on 4/13/15 with multiple diagnoses which included aftercare healing of traumatic rib fractures, pneumonitis, generalized pain and kyphosis acquired posture (curvature of the spine).</p> <p>The resident's care plan identified the risk for ADL self care performance deficit as a focus area on 4/13/15. Interventions included "bilateral 1/2 sides [sic] rails for bed mobility and repositioning."</p> <p>The resident's Order Summary Report included a 4/14/15 order for bilateral 1/2 side rails for repositioning and bed mobility.</p>	F 323	<p>In the instances where a tab alarm is attached to a resident, a second nursing staff member will confirm appropriate placement of the tab alarm.</p> <p>Starting 6/2/2015 the DON, SDC will in-service LN staff that a side rail safety assessment must be completed prior to installation of side rails on a resident's bed.</p> <p>Starting 6/8/2015 the Nurses Admission Chart Checklist form will be updated to include a Bed Rail Assessment task to remind LNs to complete this step prior to the installation of a side rail.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>Maintenance supervisor or designee will monitor the three housekeeping closet doors to ensure that they are closed and locked. Audits will be performed three times a week for one</p>

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2015
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F 323	<p>Continued From page 27</p> <p>The bilateral 1/2 bed side rails were observed in the raised position 8 times between 4/20/15 and 4/23/15, including when the resident was in bed and not in bed.</p> <p>The right 1/2 side rail only was observed in the raised position twice on 4/22/15 and both times the resident was not in bed.</p> <p>Review of the resident's clinical records revealed that a Bed Side Rail Permission form, which included the risks and benefits of side rails, was signed by the resident's spouse on 4/16/15. However, a side rail safety assessment was not found in the records.</p> <p>On 4/23/15 at 9:30 am, LN #2 was asked to provide the resident's side rail safety assessment.</p> <p>On 4/23/15 at 10:00 am, LN #2 provided a "LN-Restraint / Enabling Device / Safety Device Evaluation" dated 4/24/15. It documented the side rails enhanced the resident's bed mobility, were not a restraint and recommended, "Bilateral 1/4 bed rails for upper body bed mobility". However, the evaluation did not document whether or not the side rails had been assessed to determine if the resident was safe using them.</p> <p>4. Resident #2 was admitted to the facility on 5/29/14 and discharged on 8/4/14, then readmitted on 9/11/14 with multiple diagnoses including chronic airway obstruction, dysphagia, Alzheimer's, dementia without behavioral disturbances, and depression.</p> <p>The resident's care plan identified decreased safety awareness as a focus area on 9/11/14. Interventions included, "[M]inimally participates in</p>	F 323	<p>month and then weekly for two months.</p> <p>The DON, SDC, or designee will audit tab alarm placement on residents with tab alarms three times a week, once on each shift, for the first month. Thereafter will audit tab alarm placement on each shift bimonthly for two months.</p> <p>DON, medical records or designee will audit the chart of any new patient that receives side rails, to ensure side rail safety assessment has been completed.</p> <p>Audits will begin the week of 6/1/15.</p> <p>Results of audits will be reported to the QA Committee monthly.</p> <p><u>Corrective action completed by:</u> 6/9/2015.</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 28 repositioning with assist of 1/2 side rail on rt. [right] side of bed." The resident's Order Summary Report documented the 11/14/14 order, "1/2 siderail to right side up in bed to aid in bed mobility." The resident was observed in bed with the right 1/2 side rail in the raised position on 4/20/15 at 10:45 am., 4/21/15 at 10:00 am and 3:50 pm, and 4/22/15 at 10:35 am. The resident's quarterly "LN- Restraint / Enabling Device / Safety Device Evaluation" dated 4/18/15, did not document whether or not the side rail had been assessed to determine if the resident was safe with the use of the side rail. 5. There were similar findings for Residents #1, #3, #5, #8 and #9 regarding side rail safety assessments. On 4/24/15 at 5:45 pm, the Administrator and DON were informed of the side rail safety assessment issue. No other information regarding the issue was received from the facility.	F 323	<u>F 325: MAINTAIN NURTITIONAL STATUS UNLESS UNAVOIDABLE</u> <u>Corrective action for residents found to have been affected by this deficiency:</u> Residents #2 and #3 did not exhibit any complications related to the lack of notification of the provider, monitoring of the interventions implemented, and monitoring of weight. Reviewed charts of resident #2 and #3, confirmed that provider is aware of weight change and current interventions related to the change in weight. Interventions are being monitored by IDT nutrition committee.		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	<u>Corrective action for residents that may be affected by this deficiency:</u> All residents considered high risk for weight loss have been reviewed to ensure that weights and interventions are being monitored, and that physician has been notified of weight change and interventions.		

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

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F 325	<p>Continued From page 29.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to monitor weight as ordered, monitor the outcome of interventions implemented, notify the physician in a timely manner, and follow up with the physician for adequate direction of care for residents at high nutritional risk. The failed practice had the potential for more than minimal harm for 2 of 3 residents (#s 2 & 3) sampled for weight loss. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 5/29/14 and discharged on 8/4/14, then readmitted to the facility on 9/11/14 with multiple diagnoses including chronic airway obstruction, dysphagia, Alzheimer's, dementia without behavioral disturbances, and depression.</p> <p>The 2-admission and 1 quarterly MDS assessments, dated 6/5/14, 9/18/14 and 3/17/15, documented the resident was severely cognitively impaired with a BIMS score of 3 and extensive assist of one person for eating. *1st admit MDS on 6/5/14: Weight 161 lbs and a height of 63 inches, no nutritional approach, and no weight loss. *2nd admit MDS on 9/18/14: Weight 136 lbs and a height of 68 inches, mechanically altered diet, and no weight loss. *Quarterly MDS on 3/17/15: Weight 119 lbs and a height of 68 inches, mechanically altered diet, and weight loss. Note: The resident's height on 1st admission was</p>	F 325	<p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>Starting 6/1/2015 CDM will monitor weights of residents who are high risk for weight loss to ensure that weights are being recorded per provider order. Significant weight loss will be reported in morning IDT meeting. The effect of nutritional interventions related to weight loss will be reviewed weekly in IDT nutritional meeting review starting 6/4/2015.</p> <p>CDM or SDC will observe nutritional interventions in the dining room to ensure they are being performed and to assess their effectiveness starting 6/8/2015.</p> <p>If a significant weight loss is reported in morning IDT meeting, a nursing note will be sent to the provider by nursing staff communicating weight loss and interventions started, and will be followed by IDT team weekly.</p>	

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

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F 325	<p>Continued From page 30</p> <p>63 inches and when she returned on 9/18/15 the resident's height was 68 inches. On 4/24/15 at 5:40 PM, the surveyors were provided information to reflect the facility re-checked the resident's height that day, and the resident was 64 inches tall.</p> <p>The resident's Weight and Vitals Summary, dated 6/1/14 through 4/2/15, documented the resident experienced a 15.1 pound weight loss (9.3%) on 7/30/14 from her admission weight of 162.2 pounds on 5/29/14. The resident also experienced a 26.2 pound weight loss in a month, from 1/7/15 to 2/3/15 during her 2nd admission, which did not trigger an alert nor a percentage change. The resident's Weight and Vitals Summary documented the dates and weight in pounds, in part, the following:</p> <p>1st admission: 6/1/14 - 159.8 6/5/14 - 161.4 6/12/14 - 155.2 6/25/14 - 148.4 7/2/14 - 150.8* 7.5% change [Comparison Weight 6/5/14, 161.4 lbs, -6.6%, -10.6 lbs] 7/9/14 - 151.8 7/16/14 - 148.6* 7.5% change [Comparison Weight 5/29/14, 162.2 lbs, -8.4%, -13.6 lbs] 7/22/14 - 146* 7.5% change [Comparison Weight 5/29/14, 162.2 lbs, -10%, -16.2 lbs] 7/30/14 - 147.1* 7.5% change [Comparison Weight 5/29/14, 162.2 lbs, -9.3%, -15.1 lbs]</p> <p>2nd admission: 9/11/14 - 139.8 9/12/14 - 140 9/13/14 - 139 9/14/14 - 138.2 9/18/14 - 135.8</p>	F 325	<p>If significant weight loss is reported in weekly nutrition committee, a nursing note will be written regarding amount of weight lost, any interventions started and the nursing note will be communicated to the provider, and will be followed by IDT team weekly.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>Starting 6/1/2015 for all residents who have new onset of significant weight loss DON or designee will audit resident chart to ensure physician is notified, outcomes of interventions are monitored, and weight is monitored as ordered. These audits will be performed weekly for three months.</p> <p>Audits will begin the week of 6/1/2015</p> <p>Results of audits will be reported to the QA committee monthly.</p> <p><u>Corrective action completed by:</u></p> <p>6/9/2015.</p>	

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

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F 325	<p>Continued From page 31</p> <p>9/24/14 - 139.8* 10.0% change [Comparison Weight 5/29/14, 162.2 lbs, -13.8%, -22.4 lbs] 10/6/14 - 142.4* 10.0% change [Comparison Weight 5/29/14, 162.2 lbs, -12.2%, -19.8 lbs] 11/5/14 - 146.4 12/1/14 - 147.2 1/7/15 - 146.8 2/3/15 - 120.6* **26.2 pounds in 1 month with no documented alert triggered.** 2/6/15 - 119 2/7/15 - 119.8 2/8/15 - 120.2 2/10/15 - 120.6 2/18/15 - 123.2 3/3/15 - 118.6 4/6/15 - 123 4/22/15 - 124* 10.0% change [Comparison weight 11/5/14, 146.4 lbs, -15.3%, -22.4 lbs] Note: Weights were changed to weekly on 2/5/15, but the resident did not have the weight monitored on the weeks of 2/23, 3/9, 3/16, 3/23, 3/30, and 4/13/15.</p> <p>The resident's current Care Plan documented, in part: *Focus: Nutritional concerns r/t [related to] diet restrictions. Mechanically altered texture w/ [with] nectar thick liquid. Weight loss. Date Initiated: 9/11/14 Created on: 6/11/14...Revision on: 03/19/15. *Goal: Will tolerate modified texture. Will have no significant weight loss this quarter. Date Initiated: 3/18/15 Created on: 6/11/14...Revision on: 3/19/15. *Interventions: -90 cc 2 cal. TID [three times a day] w/meds. Date Initiated: 9/11/14 Created on: 6/30/14...Revision on: 9/11/14. -Fortified diet. Date Initiated: 9/11/14. Created on:</p>	F 325	<p><u>F 327: SUFFICIENT FLUID TO MAINTAIN HYDRATION</u></p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>Residents #3 and #7s dietary care plan has been modified, so that patient will be served 16 ounces of fluids at meal times. 8 ounce nutritional shakes served BID by staff.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>All residents who are dependent on staff for fluid intake are at risk.</p> <p>Nursing staff have been in-serviced on hydration guidelines and the importance of providing fluids to residents who are dependent on staff for fluid intake.</p> <p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 32</p> <p>6/11/14. Revision on: 9/11/14.</p> <p>-If eats less than 50%, offer meal replacement. Date Initiated: 9/11/14. Created on: 6/11/14. Revision on: 9/11/14</p> <p>-Offer extra fluids during cares and at med pass. Date Initiated: 9/11/14. Created on: 6/30/14. Revision on: 9/11/14.</p> <p>-Provide and serve diet as ordered. Regular. mechanical. soft with nectar thick liquids. Date Initiated: 9/11/14. Created on 6/11/14. Revision on: 9/23/14</p> <p>-Provide assistance or cueing with meals as needed. Date Initiated: 9/11/14. Created on: 6/11/14. Revision on: 9/11/14.</p> <p>-Weekly weights. Date Initiated: 9/11/14. Created on: 6/11/14. Revision on: 2/5/15.</p> <p>Note: Care Plan focus, goals, and interventions did not change from the resident's 1st to 2nd admission. Resident #2 had been on 2 cal three times a day after the 1st weight loss and then was not placed on the 2 cal with the 2nd admission even though she had lost more weight while at the assisted living facility. Resident was then placed back on the 2 cal after the loss of 26 pounds, but then only two times a day.</p> <p>The nutrition report for 1/1 to 1/31/15 documented 89 meals with the following percentage of the meal eaten: 0-25% - 24 meals 26-50% - 25 meals 51-75% - 27 meals 76-100% - 12 meals Refused - 1 meal</p> <p>The resident's Nutrition Alert, dated 3/19/15, documented the resident had lost 43 pounds in 7 months. The interventions listed during the course of the nutritional change were provision of</p>	F 325	<p>LN staff will document in resident chart intakes of nutritional supplements per provider order in milliliters starting 6/1/2015.</p> <p>Starting 6/4/2015, residents who are dependent on staff for fluid intakes the water drop decal will be placed at entry to resident's room to notify staff that they should offer and assist with fluid intake.</p> <p>Water droplet decal will be placed on patient trays at each meal to remind staff of hydration needs and residents dependence on staff for fluid needs starting 6/4/2015.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>CDM, SDC or designee will observe fluid intake during meals for residents who are dependent, each meal weekly for one month and then each meal bimonthly for two months.</p>

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F 325	<p>Continued From page 33</p> <p>snacks, supplements, additional fluids with med pass. The resident had consumed an average of 40% of meals and 1000 ccs of fluid daily over the last 7 days. The resident had accepted nutritional supplements. Possible contributing factors to the weight change included Alzheimer's/Dementia. The resident's advanced directive indicated she wanted hydration support and did not want nutrition support. The form was signed by the Dietitian on 3/19/15. The Physician section did not have any completed information checked for unavoidable weight loss, further comments, or planned interventions and was signed by Physician and dated 3/19/15.</p> <p>Note: The Physician was not provided the Nutrition Alert of the 17% weight loss noted on 2/3/15 until 3/19/15. There was no documented followup from staff with the Physician regarding lack of direction for the resident's care.</p> <p>The RD (Registered Dietitian) provided a timeline with supporting documentation as follows: "Admitted 5/29/14, weight 162.2 # (pounds) on this date" "RD assessment...Eating 50-55%...Not meeting assessed protein needs. Fluid needs not met daily...Interventions per RD recommendations: 1 oz extra protein added to meals. 8 oz Extra Fluid Each Meal/Between Meals" "On 6/25/15 weight was recorded at 148.4#. Triggers for sig loss of 9.2% at 30 days." "RD Assessment on 6/26/14: Loss of 15#/9.2% over approx. 30d. Change in diet texture to Dyph [dysphagia] Mech [mechanical] soft w/ NTL [nectar thick liquids]...52% intake w/ 800-900cc fluid intake at meals...Restorative dining...2.0 sup 90cc TID w/ med pass..." "SOC Note 7/9/14: ...wt has stabilized and intake has been better: She receives 90 cc 2 cal 3 x</p>	F 325	<p>CDM will monitor tray line to ensure water droplet decal is placed on appropriate resident's tray, audits will occur each meal weekly for one month and then each meal bimonthly for two months.</p> <p>CDM, SDC or designee will perform three room observation weekly for one month and then three room observations bimonthly for two months, of those with the water droplet decal to ensure that staff are offering fluids when in the room.</p> <p>Care plans will be updated by LN staff related to water droplet hydration program.</p> <p>DON or designee will monitor intakes of house supplements three times a week for one month and then weekly for two months to ensure intake of fluids.</p> <p>Audits will begin the week of 6/1/2015.</p> <p>The DON will report these findings in the monthly QA meeting.</p> <p>Corrective action completed by: 6/9/2015</p>

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F 325	Continued From page 34 day..." "Resident admit on 9/11/14 after suffering a fall and slowly declining...Weight was 139.8# on 9/11/14. RD assessment 9/18/14: "...SLP [Speech therapy] evaluating, recommends MECH-SOFT NTL [nectar thick liquids]. PO intake avg [average] ...50% with 200 ml at meals. Triggers for significant weight loss at 90 days. Needs assistance and cueing at meals...Recommend 1)Start NEM [nutritional enhanced meals] at all meals. 2)Trial Two Cal supplement 2 oz at med pass and document tolerance. 3) Will review at SOC [Standard of Care meetings]." " Resident's weight remained stable through September, and started to show some gains early October through the first week of January of 2015." "Weight on 2/3/15 was 120.6#: Triggers for significant weight loss of 26#, 17% at one month." "Continues with mech-soft NTL. PO 63% per meal. Fluid intake has improved to 247 ml per meal, continues drinks fluids at HS [at bedtime]. Staff assists at meals and at time resident will allow staff to assist. Suspect weight for Feb is recorded in error, as no change in PO intake noted from early Jan to Feb." "Will add two cal 90 ml BID with med pass and refer to SLP for eval. Change to weekly weights...Adding fortified meals..." "SOC note 2/19/15: Continues with mech-soft NTL. PO 65% per meal, Fluid intake 250 ml per meal...Wt: 123.2# 2/18 and 120.6# 2/10." "SOC note 3/19/15: Mech soft NTL. PO 25-75% per meal. Fluid intake poor, fluctuates from 460 ml to 1510 ml per day. Staff notes she does not take fluids well, thin or nectar thick. Continues to accept two cal per MAR documentation." "SOC note 4/2/15: Wt: 123# 4/1/15...Family decided against hospice at this time. MD signed	F 325	<u>F 328: TREATMENT/CARE FOR SPECIAL NEEDS</u> <u>Corrective action for residents found to have been affected by this deficiency:</u> O2 order for resident #6 updated on MAR to allow for LNs to document liter flow amount per minute and to verify placement of nasal cannula each shift. Resident #4 O2 order has been discontinued. <u>Corrective action for residents that may be affected by this deficiency:</u> A review of residents with orders for oxygen therapy was conducted by the DON and SDC, orders were updated to allow for documentation of liter flow and placement. LN staff instructed 5/26/2015 on proper documentation for oxygen therapy orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/24/2015
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617	
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F 325	<p>Continued From page 35 unavoidable weight loss..." "At this time [Resident's name] weight has remained stable for the last 2 months. She currently is 3# below the low end of her IBWR. RD is monitoring PRN.</p> <p>The resident's March and April 2015 MAR documented Resident #2 was administered the 90 mL of 2 cal with med pass. However, the record did not document the amount of 2 cal the resident consumed.</p> <p>On 4/22/15 at 6:15 PM, during the dinner meal observation the resident was seated at an assistive table with 3 other residents. Each resident had a staff member who assisted them with eating while seated on a rolling stool by their side, except Resident #2 was being assisted by LN#1 whom stood at her side. The LN fed the resident and gave her drinks of fluid while standing for the full meal. Resident #2 did not have a spoon available at the table for her cream of potato soup, so LN#1 inserted a straw into the soup and proceeded to have the resident try to suck the soup up through the straw. The resident was able to consume some of the liquid portion of the soup with the straw, but not the vegetable pieces. Refer to F241 as it relates to Residents Dignity.</p> <p>On 4/22/15 at 6:30 PM, LN#1 was interviewed about the dining assistance provided for Resident #2. LN #1 stated, "I do usually sit." The LN said they had a family visitor at another table and so they did not have any more stools available. The LN said she did not like sitting in the chairs. LN #1 stated, "I don't usually assist [Resident's name], but did tonight. I didn't realize I shouldn't be standing and feeding her." LN #1 said she</p>	F 325	<p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>Starting 5/26/2015 the DON or SDC will provide in-servicing to all staff involved with direct patient care related to oxygen therapy. LN staff educated on correct input of oxygen therapy orders, specific to liters per minute, and accuracy of documentation.</p> <p>Medical records or designee will verify correct transcription of order and ensure order is setup appropriately in the mar to allow for LN documentation, starting 6/1/2015.</p>

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2015
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F 325	<p>Continued From page 36</p> <p>had tried a straw with the soup, instead of getting a spoon. The LN wanted to see if the straw would be helpful for the resident with the thin consistency of the soup and if the straw would "make it faster."</p> <p>On 4/24/15 at 11:11 AM, an interview with the RD with the presence of the Consultant Registered Dietitian (CRD), the RD said the resident came back from an assisted living facility in September after a fall. The resident's weight was low compared to the prior admission. Her weight began to trend up a little bit (139-140's). The resident's diet was mechanical soft with nectar thick fluids. The RD stated, "Mechanically altered diet could be considered at [nutritional] risk, but the judgement is based on the patient." This resident was "considered at risk due to weight history, texture, and etc." "We added nutritionally enhanced meals; reviewed monthly, on high risk RD charting, and looked at meal percentages per day." The CNAs have only 5 options for the meal monitors and those being: 0-25%, 26%-50%, 51%-75%, 76-100%, and refused. The RD stated, "The range is too wide for accurate and meaningful assessments." The CRD stated regarding the resident's 26.2 pound weight loss, "We all know the MD didn't get notified." Note: The electronic medical record system only allowed documentation of the percentage of intake in increments of 25 points. The system did not allow staff to determine the number of calories that a resident consumed in a day when given the ability to choose a variety of food.</p> <p>During the above interview process, the CRD said there were reports of "multiple weight losses of 5 or more pounds in February" for the facility. The facility identified they had a problem in</p>	F 325	<p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>The DON or SDC will conduct audits of all new patients, or existing patients with new oxygen orders, weekly for three months to verify accuracy of liters per minute as ordered and appropriate documentation.</p> <p>Audits will begin the week of 6/1/2015.</p> <p>The DON will report the results of audits monthly to the QA Committee.</p> <p><u>Corrective action completed by:</u> 6/9/2015</p>

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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617	
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F 325	<p>Continued From page 37</p> <p>February 2015, an investigation pursued, and changes had been implemented. The QA determined in April 2015, weight discrepancies and procedural issues were still an issue and corrections were being implemented in regards to obtaining weekly weights timely, the implementation of weight schedule changes, and the need to improve the involvement of residents' physician when weight variances occurred.</p> <p>On 4/24/15 at 5:40 PM, the Administrator, DON, and several other staff members were informed of the weight loss concerns. No additional information was provided to alleviate the issue.</p> <p>2. Resident #3 was admitted to the facility in 10/1/13 with multiple diagnoses including depression, anxiety, muscle weakness, dementia, and contracture of hand joint.</p> <p>The resident's 2/28/15 quarterly MDS coded severe cognitive impairment with a BIMS score of 6, limited one-person assist with eating, no swallowing disorders, no known weight loss or gain in the past 6 months, mechanically altered diet, weight of 133 pounds and height 60 inches.</p> <p>a) Chart review revealed Resident #7's weight declined 12.4 pounds (lbs) from 1/7/15 (145.4 lb) to 2/3/15 (133 lb). This was approximately an 8.5% weight loss in 1 month.</p> <p>The resident's 2/28/15 quarterly MDS did not code significant weight loss. See F278 for details regarding assessment accuracy.</p> <p>A 2/5/15 Interdisciplinary Team (IDT) review documented the resident's severe weight loss and recommended "add weekly weights" and</p>	F 325	<p><u>F 386: PHYSICIAN VISITS REVIEW CARE/NOTES/ORDERS</u></p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>Resident #2 has been seen and assessed by primary care provider. Spoke with resident #2s primary physician and educated provider on expectation of facility to obtain a comprehensive assessment.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>All other residents followed by this provider are at risk.</p> <p>Nursing staff instructed to follow physician during rounds and facilitate a physician review of resident's total program.</p> <p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p>	

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2015
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F 325	<p>Continued From page 38 "Follow up in week."</p> <p>Weekly weights were added to the resident's "nutritional problem" care plan on 2/5/15.</p> <p>However, the documented weights revealed that the resident was not weighed again until 3/3/15. This was 26 days, or 3 and a half weeks after severe weight loss was identified and weekly weights were recommended and care planned.</p> <p>A follow-up IDT review on 2/27/15 documented, "weight continues to trend down with another five pound weight loss in one month ...continue with RNA dining ...Follow up one week." There was no reference to the intervention of weekly weights documented in this note.</p> <p>Weekly weights were not included in the resident's recapitulation of physician orders until 3/6/15.</p> <p>On 4/24/15 at 11:45 a.m., the Dietary Manager (DM) was asked if there were any other weights done for February, after significant weight loss was identified 2/3/15. The DM stated, "No other weights are listed for February. Yes, there was a significant weight loss of 9% at that time. We should have done something."</p> <p>b) Resident #3's care plan included the following interventions for the focus area "nutritional problem related to unplanned weight loss": * Offer assistance as needed and as resident will allow all meals (Initiated: 3/11/15) * Offer health shake BID (twice a day). Likes chocolate. (Initiated: 2/5/15)</p> <p>The resident's recapitulation of physician's orders</p>	F 325	<p>Starting 6/8/2015 during monthly provider rounds, provider will be given list of current resident concerns, vitals, lab work, and med list. LNs will round with provider and provide a verbal update of resident's current condition.</p> <p>LN staff will make follow up nursing note related to provider visit to support issues discussed and course of action related to his visit. LNs in-serviced regarding provider/nursing rounds 5/26/2015.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>Medical records, SDC or designee will review all provider notes after provider's rounds along with the rounding nurse notes to ensure a thorough assessment was documented.</p> <p>Audits will begin 6/1/2015</p> <p>The DON will report audit results in the monthly QA Committee.</p> <p><u>Corrective action completed by:</u></p> <p>6/9/2015</p>

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

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FORM APPROVED
OMB NO. 0938-0391

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F 325	<p>Continued From page 39</p> <p>included a 4/2/15 order for health shakes TID (three times a day). However, the aforementioned care plan did not reflect this change. See F280 for details regarding care plan revisions.</p> <p>On 4/21/15 at 8:30 a.m., Resident #3 was observed in the dining room during the breakfast meal service. Two pieces of toast were on a plate and a bowl of dry cheerios were on the table in front of the resident. In addition, approximately 2 tablespoons of dry cheerios were spilled onto the table. The resident dozed on and off as she sat at the table. Within 1 minute the Staff Development Coordinator (SDC) asked the resident if she was finished eating, then the SDC walked away (the resident's response to the question could not be heard). The resident sat at the table with the food in front of her until 9:57 a.m., almost an hour and a half. However, the resident was not cued or acknowledgement by the staff again during that time. In addition, the resident did not eat any more food during this hour and a half.</p> <p>On 4/22/15 from 5:55 p.m. to 6:40 p.m., Resident #3 was observed in the dining room during the dinner meal service. The resident's food tray was delivered and set-up at 5:55 p.m. Her meal card instructions read "Cueing/partial." The resident ate only potato chips. Twenty-eight minutes later, at 6:23 p.m., CNA #5 cued the resident to eat her sandwich. However, the staff did not cue the resident again and the the resident did not eat anything more after that. The resident was cued to eat only once during 45 minute observation.</p> <p>On 4/23/15 at 10:25 a.m., the Staff Development Coordinator (SDC) was interviewed regarding cueing Resident #3 to eat. The SDC said when staff previously provided one-to-one assistance</p>	F 325	<p><u>F 431: DRUG RECORDS, LABELS/ STORE DRUGS AND BIOLOGICALS</u></p> <p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>Residents #14 and #15 did not exhibit any complications related to labeling of insulin pens. Respective insulin pens were removed and discarded.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>A review of all med carts was conducted by the DON. All medications were appropriately labeled.</p> <p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>Starting 5/26/2015 the DON or SDC will provide in-servicing to LN staff regarding labeling insulin pens in accordance with current policy.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2015
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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	F 460: BEDROOMS ASSURE FULL VISUAL PRIVACY	(X5) COMPLETION DATE
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F 327	<p>Continued From page 41</p> <p>The resident's 2/28/15 quarterly MDS coded a BIMS score of 6 (severe cognitive impairment), limited (one person) assist with eating; no swallowing disorders, extensive assistance of 2+ persons for bed mobility (resident move to and from lying position, turn side to side, positioning body while in bed), and transfer between bed/chair/wheelchair and standing position.</p> <p>On 2/5/15 a Speech Therapy (ST) consultation was ordered when the resident was choking on her medications. The ST's recommendations included "occasional supervision (Patient in a dining room where assistance is provided. Cues and encouragement are recommended.)"</p> <p>On 4/20/15 at 10:20 a.m., the resident was observed in her wheelchair, watching television. The bedside table with fluids on it was on the resident's left side. Note: Chart review and observation revealed the resident had a contracture and functional impairment of her left hand.</p> <p>On 4/21/15 at 9:40 a.m., LN #6 was asked how Resident #3 accessed fluids to drink. The LN said the resident could reach them herself.</p> <p>On 4/21/15 at 10:00 a.m., the Resident was observed in bed. The bedside table was turned perpendicular to the bed with 2 water bottles at the far end of the table. The water was a table's length away, about 3 feet, from the resident. When asked how she got water to drink, the resident said she would call out for help.</p> <p>On 4/22/15 at 9:40 a.m., CNA #5 was also asked how Resident #3 accessed fluids to drink. The CNA stated, "She usually gets it herself."</p>	F 327	<p><u>Corrective action for residents found to have been affected by this deficiency:</u></p> <p>Video monitor removed from resident #7's room.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>No others video monitors are in use in the building.</p> <p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>Update facility policy to discontinue use of video monitoring of residents while in resident rooms.</p> <p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>Monitoring is not necessary, no video monitors in use.</p> <p><u>Corrective action completed by:</u></p> <p>6/9/2015</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617	
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F 327	<p>Continued From page 42.</p> <p>On 4/22/15 at 3:20 p.m., the resident was observed in bed. The bedside table was 3 feet away from the bed with two water bottles on it. CNA #5, who was in the room, was asked about the resident's water. The CNA said the resident "can usually get her water herself" and she pushed the bedside table up to bed.</p> <p>According to the F 327 Interpretive Guidelines, baseline fluid intake is calculated by taking the resident's weight in kg (kilograms) and multiplying by 30 cc (cubic centimeters). One kilogram = 2.2 pounds (lbs).</p> <p>The resident's weights for the month of April 2015 fluctuated but increased from 127 to 132 lbs. Based on the aforementioned calculation, the resident's baseline daily fluid intake should have been between 1740-1800 cc per day.</p> <p>The resident's 4/1-22/15 "Fluid intake" documentation, in addition to the April 2015 MAR documentation, revealed the resident's daily fluid intake fell under baseline by 400-700 cc for 14 of 22 days in April (62% of days). In addition, the resident's total intake was documented as only 200 cc on 4/5/15.</p> <p>On 3/24/15 at 6:00 p.m., the Administrator and DON were notified of the resident's inadequate fluid intake for the month of April. The facility did not provide any further information on this issue.</p> <p>2. Resident #7 was admitted to the facility 2010 with multiple diagnoses including senile dementia, muscle weakness, and dysphagia.</p> <p>Resident #7's most recent quarterly MDS</p>	F 327	<p><u>F 498: NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS</u></p> <p>Residents #2 and #7 did not exhibit any complications related to gait belt placement. CNAs who worked with residents #2 and #7 were reeducated on proper gait belt use.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>All residents on side 2 being assisted by the observed CNA were at risk. None of the residents on side 2 were found to have complications related to gait belt placement. All CNAs on side 2 were reeducated on proper gait belt use. No further issues related to gait belt use were identified.</p> <p><u>Measures that will be put into place to ensure that this deficiency does not recur:</u></p> <p>Gait belt competency checklist started 5/3/2015, and will be utilized to ensure that current and newly hired CNA staff are able to use a gait belt competently. Starting 5/13/2015 CNA staff have been assessed for correct use of gait belt.</p>

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2015
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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617
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F 327	<p>Continued From page 43</p> <p>documented long and short term memory problems, moderately impaired cognition, and no swallowing disorders. It also documented the resident required extensive assistance of 2+ persons for bed mobility (resident moving to and from a lying position, turn side to side, positioning body) and transferring (moving from one surface to another or standing).</p> <p>Resident #7's care plan for eating dated 6/11/14 documented "requires extensive assistance of one staff to eat." Interventions included, "offer nectar thick liquids often during the day to increase fluid intake."</p> <p>Review of the recapitulation of physician orders revealed the following order started 6/1/11, "LNs are to offer 8 oz (ounces) fluids with each medication pass."</p> <p>The resident's MARs for March and April 2015 documented 8 oz of fluids with each medication pass was documented only one day during those months, on 3/24/15 and 4/19/15.</p> <p>On 4/20/15 at 10:13 a.m. and 12:50 p.m., the resident was observed lying in bed. No fluids were present on the resident's side of the room. Three similar observations were made on 4/22/15.</p> <p>On 4/22/15 at 3:20 p.m., the resident said "yes" when asked if she ever got thirsty. When asked how she got water, the resident said she did not know.</p> <p>At 4:35 p.m., CNA #5 confirmed that no fluids were available for the resident to drink and that no fluids were in the resident's room when she</p>	F 327	<p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>The DON, SDC or designee will observe nursing staff use of gait belt during transfers for each shift, week for one month and then each shift bimonthly for two months.</p> <p>The DON will report these findings monthly in QA Committee.</p> <p>Audits will begin the week of 6/1/2015</p> <p><u>Corrective action completed by:</u></p> <p><u>6/9/2015</u></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 327

Continued From page 44 started her shift at 2:00 p.m.

On 4/23/15 the Staff, Development Coordinator (SDC) was asked how Resident #7 got fluids to drink between meals. The SDC stated, "We offer her sips when we pass by and I remind all aides of that. Water is supposed to be at the bedside. Bedside water and the snack cart [with fluids] are standard for the house."

On 4/24/15 at 10:00 a.m., the DON said the order, "LNs are to offer 8 oz (ounces) fluids with each medication pass," was "basically a PRN [as needed order]" and "The nurse decided to document that she did it that day." When asked if the order should read PRN if it was suppose to be PRN, the DON stated, "it could be added, yeah."

F 327

F 514: RECORDS- ACCURATE/COMPLETE/ ACCESSIBLE

Residents #2 height reassessed and verified by two nurses, weight is being monitored weekly by nutrition committee.
Resident #5s BG parameter order symbol were adjusted to reflect provider order.

Corrective action for residents that may be affected by this deficiency:

All residents with BGs parameter orders where checked and confirmed to accurately reflect provider order.

Measures that will be put into place to ensure that this deficiency does not recur:

Starting 6/8/2015 residents who are readmitted to the facility, MDS to check previous documentation to ensure consistency and accuracy of current documentation.

F 328
SS=D

483.26(k) TREATMENT/CARE FOR SPECIAL NEEDS

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced

F 328

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2015
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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 328	<p>Continued From page 45</p> <p>by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure oxygen (O2) was administered and monitored per physician orders for 2 of 4 residents (#s 4 & 6) reviewed for respiratory care. These failures created the potential for increased respiratory problems when Resident #4's O2 was administered at the wrong liter flow rate and not documented as administered continuously as ordered; and, when Resident #6's O2 was not checked for proper placement and liter flow as ordered. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 4/13/15 with multiple diagnoses which included aftercare healing of traumatic rib fractures, pneumonitis, generalized pain and kyphosis acquired posture (curvature of the spine).</p> <p>The resident's 4/13/15 Transfer Orders/Instructions to the facility included an order for O2 at 1 liter per minute (LPM) continuously via nasal cannula.</p> <p>The resident's facility Order Summary Report included a 4/13/15 order for O2 at 1 liter per minute (LPM) continuously via nasal cannula.</p> <p>The resident's care plan documented "Has Oxygen Therapy r/t [related to] Respiratory illness...recovering from pneumonia" as a focus area. One Intervention was, "Oxygen settings: O2 via nasal cannula @ [at] 1L [liter] continuously."</p> <p>a) On 4/20/15 at 3:20 pm, and 4/21/15 at 9:20 am, the resident was observed with an O2 nasal cannula in place and connected to an O2 concentrator that was set at 1.5 LPM.</p>	F 328	<p>5/26/2015 updated the Nursing Policy and Procedures manual to include the Official "Do Not Use" List document for abbreviations, acronyms and symbols. Within this document is the direction to use "greater than" or "less than" words instead of < > symbols for BG parameters.</p> <p>Starting 5/26/2015 the DON or SDC will in-service LN staff on new policy and procedure of entering BG parameters using words instead of symbols.</p> <p>Starting 6/4/2015, for new BG orders, the parameters will be spelled out "greater than, less than" instead of using symbols, " > or <".</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2015
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F 328	<p>Continued From page 46</p> <p>On 4/21/15 at 9:20 am, while LN #2 was in the resident's room she was asked what O2 liter flow rate was ordered for the resident. The LN quickly said "two." When asked what the O2 LPM was on the concentrator, the LN looked at the O2 concentrator and initially said "two" then changed her response to "maybe not." The LN then adjusted the O2 concentrator up to 2 LPM.</p> <p>On 4/21/15 at 12:10 pm, Resident #4 was observed with the nasal cannula in place while seated in a wheelchair (w/c) in his room. The nasal cannula was connected to an O2 companion tank at the back of the w/c. The O2 companion tank was set at 3 LPM.</p> <p>On 4/22/15 at 2:45 pm, the resident was observed with a nasal cannula in place that was connected to an O2 concentrator. The O2 concentrator which was set at 2 LPM.</p> <p>On 4/22/15 at 4:00 pm, LN #2 was asked to look up the residents order for O2 in the computer. When the LN read the order, she stated, "Oh, it's one." The LN then accompanied the surveyor to Resident #4's room where she confirmed the O2 was set at 2 LPM. The LN immediately changed the O2 concentrator to 1 LPM.</p> <p>b) Resident #4's April 2015 MAR included the order for O2 via nasal cannula at 1 LPM continuously. However, an "X" was documented every day from 4/1 through 4/30/15.</p> <p>Progress Notes (PN), dated 4/13/15 through 4/22/15 at 10:58 am, contained 5 entries that documented the resident's O2 was at 2 LPM and 5 entries that did not include the LPM.</p>	F 328	<p><u>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</u></p> <p>DON or SDC will review all new BG parameter as ordered by provider to ensure accuracy.</p> <p>LCSW will review the MDS of any new residents that are readmitting to the facility to ensure that information is consistent and accurate.</p> <p>The DON will report the results of these audits to the monthly QA Committee.</p> <p>Audits will begin the week of 6/1/2015.</p> <p><u>Corrective action completed by:</u> 6/9/2015.</p>	

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2015
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
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F 328	<p>Continued From page 47</p> <p>On 4/24/15 at 10:00 am, the DON was interviewed about Resident #4's O2. The DON was asked to provide evidence that the O2 was administered as ordered. The DON said that inclusion of O2 on the MAR was an FYI (for your information). He then said that no other documentation was required because the O2 was care planned and staff followed the care plan. When informed of the aforementioned observations of the O2 at the wrong LPM, however, the DON did not respond.</p> <p>2. Resident #6 was originally admitted on 12/14/12 and then readmitted to the facility on 7/11/13 with multiple diagnoses including chronic airway obstruction, dysphagia, atrial fibrillation, cerebrovascular disease, and dementia with behaviors.</p> <p>The resident's Physician's Orders, dated 12/14/12, documented, "Oxygen @ [at] 2 L/Min [liters per minute] via N/C [nasal cannula] Lic [licensed] nurse to check proper placement and liter flow."</p> <p>Resident #6's April 2015 Care Plan documented as a focus, "Has oxygen therapy r/t [related to] COPD [chronic obstructive pulmonary disease]...", "with a goal of, "will have no s/sx [signs/symptoms] of poor oxygen absorption...", and the interventions documented as, "Monitor for s/sx of respiratory distress and report to MD...", and, "Oxygen settings: O2 via nasal prongs @ 2 L continuously. Humidified..."</p> <p>The resident's March and April 2015 MAR documented, "Oxygen @ 2 L/MIN via N/C Lic nurse to check proper placement and liter flow..."</p>	F 328			

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2015
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F-328	Continued From page 48 The MAR contained boxes for each day of the month for monitoring of the oxygen placement and liter flow rate. The resident's oxygen was not documented daily on the 3/15 and 4/15 MAR as being monitored, except for the days of 3/4/15 and 4/19/15. On 4/20/15 at 10:20 AM and 1:30 PM, 4/21/15 at 10:05 AM, 12:37 PM, 1:50 PM, and 3:53 PM, and 4/22/15 at 10:50 AM, the resident was observed in her room, the hall, and the dining room. The resident had her oxygen in place via N/C and the liter flow rate was set at the correct rate of 2 L/min. On 4/21/15 at 10:05 AM, the resident was interviewed regarding her oxygen use. Resident #2 stated, "I am dependent on the oxygen and I can tell when the tank is empty." The resident said the staff had been good in keeping her portable oxygen tank full. No additional information was provided to alleviate the concerns of failure to monitor residents' oxygen administration as ordered by the physician.	F 328		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	F 386		

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

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F 386	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure physician's visits included a review of the resident's total program of care. This was true for 1 of 8 sampled residents (#2) reviewed for physician's visits. The deficient practice had the potential for more than minimal harm when it was not documented the residents received a thorough assessment from their primary care provider. Findings included: Resident #2 was readmitted to the facility on 9/11/14 with multiple diagnoses including chronic airway obstruction, dysphagia, Alzheimers, dementia without behavioral disturbances, and depression. Resident #2's Physician's Progress Notes for 7 months documented, in their entirety: -10/15/14: "90 y/o [year old] dementia pt [patient]from [name of assisted living center] & [name of local hospital] p [after] GLF [ground level fall] & pelvic fx [fracture]. Marked dementia but calm & cooperative-PT [physical therapy]." -11/11/14: "Doing well p fx pelvis-does not appear uncomfortable-marked dementia-stable." -12/12/14: "Fx pelvis. No discomfort apparent marked dementia-Stable." -1/7/15: Mild URI [upper respiratory infection] Sx [symptoms] s [without] + PO [by mouth]-sl [slight] nasal congest [congestion] - Flu like illness in facility but this is milder-marked/mod dementia." -2/18/15: "Calm & cooperative-very confused-URI resolved." -3/19/15: "Smiling-comfortable-good PO-marked	F 386			

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2015
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F 386	Continued From page 50 dementia." -4/14/15: "Comforted by folding laundry-No discomfort-Marked dementia." On 4/24/15 at 1:30 PM, the DON was asked about Resident #2's assessments and the progress notes from the physician regarding those comprehensive assessments. The DON stated, "He wrote stable, so he was assessing her." The DON said the physician did have the residents' charts when rounds were being done, but this physician did not have a nurse go on the rounds. The DON stated, "I don't know what he does on rounds," The DON was asked, if other residents with the same provider were reviewed what would their assessment documentation look like and the DON replied, "It would be very similar." On 4/24/15 at 1:51 PM, the CRN was asked about the resident's physician's progress notes and she acknowledged the documentation was insufficient. The facility did not provide any other information regarding the issue.	F 386			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431			

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

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F 431	<p>Continued From page 51</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure time sensitive medications such as insulin pens were dated with an opened date and/or expiration date and were not available for residents' use if expired. These failures increased the risk for compromised medication stability, efficacy, and safety for 2 random residents (RR#s 14 & 15) if they were to have received expired insulin. Findings included:</p> <p>On 4/23/15 at 10:22 AM, during inspection of Med</p>	F 431			

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

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F 431	Continued From page 52 Cart #1 and #2 with LN#2 present, the following medications were found: *An opened Novolog Flexpen for RR#14 which did not have an opened date and handwritten on the label that the medication expires in "14 days."; and, *An opened Lantus Solostar pen for RR#15 which did not have an opened date and handwritten on the label that the medication expires in "28 days." LN #2 acknowledged the above findings and said the insulin "should have been marked when opened." The staff would not know when the Novolog Flexpen and Lantus Solostar were expired, without the opened date being documented. The LN said, "These [the Novolog Flexpen and Lantus Solostar] get tossed."	F 431			
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to assure full visual	F 460			

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2015
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F 460	<p>Continued From page 53</p> <p>privacy for 1 of 12 sample residents (#7). Lack of the ability to withdraw from public view while in bed caused the potential for harm when the resident's privacy was violated. Findings included:</p> <p>Resident #7 was admitted to the facility in 2010 with multiple diagnoses including senile dementia and anxiety.</p> <p>The resident's care plan for falls documented unaware of safety needs, dementia, anxiety, and history of falls. On 1/2/15, the intervention "video monitor when in bed to alert staff to increased movement and need for assist" was initiated in the fall care plan.</p> <p>On 4/20/15 at 10:13 a.m., a small web cam type camera was observed on Resident #7's bedside table. The camera was pointed at the resident who was lying in bed. A corresponding monitor was noted on the desk at the hall 2 nurse's station and the resident was observed on the monitor screen as she laid in bed on her right side.</p> <p>On 4/21/15 at 8:30 a.m., LN# 6 was asked about the camera and monitor. The LN said the camera/monitor was "for her falls." The LN stated, "When I sit here [at the nurse's station in front of the monitor] if I see her about to roll and I can zip in there."</p> <p>Note: Chart review revealed the resident had 2 falls out of bed on 11/4/14 and 1/20/15. Refer to F323 for details on these falls.</p> <p>On 4/23/15 at 10:05 a.m., the Staff Development Coordinator (SDC) was asked about the camera/monitor. When asked what interventions</p>	F 460			

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

PRINTED: 05/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2015
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F 460	<p>Continued From page 54</p> <p>had been tried, other than the video camera, the SDC said 15 minute and 30 minute checks have been done. The SDC was asked how the resident was monitored when staff were not at the nurses' station. She stated, "The monitor generally goes on the nurse's cart when she is out and about." The SDC added, "There is no set schedule to check on the monitor." The SDC confirmed that when the monitor was at the nurses' station that staff checked the monitor only if they happened to be at the nurse's station.</p> <p>On 4/23/15 at 2:20 p.m., the Director of Social Work was asked about the monitor. She stated, "It's a nanny cam. It broadcasts the image from the resident's room so we can see her when she's in bed. It's for her [pointed at resident]. Right now it's pointed at the corner because she's not in her room. They point it away for cares but when she's in bed it's on so we can see her." When asked if she knew if the image being transmitted was secure, she stated she did not know.</p> <p>On 4/23/15 at 2:20 p.m., it was observed that from the north end of the 200 hallway toward the nurse's station, the monitor screen was clearly visible from the hallway.</p> <p>On 4/24/15 at 9:30 a.m., the SDC was asked to provide the facility's policy & procedures for the use of the camera/monitor, and evidence based support for use of the camera.</p> <p>On 4/24/15 at 10:20 a.m., the SDC said the facility had evidence based support for use of video monitoring. The SDC confirmed that the evidence based support was not available in the facility before 4/24/15.</p>	F 460			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 460	Continued From page 55 On 4/24/15 at 10:50 a.m., the Administrator provided an undated "Electronic Monitoring" policy. The Administrator said there was no implementation date for the policy. The policy read: "POLICY: Electronic monitoring in patient rooms may be used by this facility with the consent of the resident or responsible party. PURPOSE: Electronic monitoring may be used as a tool to improve the security, safety and quality of care of patients. TERMS: 1. Consent must be obtained from patient or responsible party. 2. Surveillance should not be used while staff administers personal cares. 3. Staff will take appropriate steps to prevent non employees from viewing monitor. 4. Electronic monitoring will not record audio or video. 5. Employees who misuse electronic monitor will be subject to disciplinary action, up to and including termination." Note: The policy did not address how the resident would be assured the means of withdrawing from public view while in bed. On 4/24/15 at 6:00 p.m., the Administrator and DON were notified of this issue. The facility did not provide any other information regarding the issue.	F 460			
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able	F 498			

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

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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
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F 498	<p>Continued From page 56</p> <p>to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure Nurse Aides were competent using a gait belt to transfer residents. This was true for 2 of 4 residents (#3 and #7) during observations of gait belt transfers. The failure put the residents' safety at risk when the gait belt was used inappropriately during transfers. Findings include:</p> <p>Regarding the use of gait belts, Successful Assistant Nursing Care (2002, Diana Dugan) stated, "A gait belt or transfer belt is a heavy-duty belt with a strong buckle that is wrapped around a resident's waist and over clothes, and then secured ...the gait belt is not used to lift a resident; it is used to have greater control of the movement of the resident."</p> <p>1. On 4/21/15 at 12:35 p.m., CNA #4 was observed as she transferred Resident #7 from the bed to the wheelchair. The CNA sat the resident on the side of the bed then she applied the gait under the resident's armpits and above the resident's breasts. After that, the resident wrapped her arms around the CNA's neck and the CNA stood the resident up and swung her around into the wheel chair. During the transfer, the CNA grabbed hold of the gait belt with one hand and the waist of the resident's pants with the other hand.</p>	F 498			

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F 498	<p>Continued From page 57</p> <p>Immediately afterward, CNA #4 was interviewed about the transfer. When asked about the use of the gait belt, the CNA stated, "I would put it around her middle but it [the resident's middle] is big. So I put it [gait belt] up here [points to armpits] and use her pants plus have her hold me around the neck because she could get woozy and fall."</p> <p>Note: A gait belt transfer of the same resident by a different CNA with proper use of the gait belt around the resident's waist was later observed.</p> <p>2. On 4/22/15 at 11:10 a.m., CNA #4 was observed as she transferred Resident #3 from her wheelchair to her bed. The CNA placed the gait belt under the resident's arm pits. The CNA then used the gait belt to lift the resident to a standing position and pivot transfer her onto the bed.</p> <p>On 4/23/15 at 3:00 p.m., the Director of Rehabilitation was interviewed. He was asked if a gait belt should ever be positioned under the armpits. He said that in general, a gait belt should be positioned around the waist unless the resident had a tube or surgical site at the waist line and then it should be placed above the waist line but as low as possible. He said a gait belt should not be placed under the armpits and if the resident had large breasts the belt should go underneath the breasts.</p> <p>On 4/23/15 at 3:30 p.m., the Staff Development Coordinator (SDC) was asked about staff competency regarding gait belts. The SDC said that skills checks (including proper gait belt use) were done annually, on hire, and randomly. The SDC provided the facility's "Basic Short</p>	F 498			

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F 498	Continued From page 58 Orientation Pack" which documented that CNA #4 had been trained on "Gait belt use/body mechanics ..." on 1/27/15. The SDC said there was no skills checklist or step-by-step list for gait belt training. The SDC added, "We would never go right under the arms. But if we had a surgical site or something we would go as low as possible but not under the arms." When informed of the 2 aforementioned gait belt transfer observations, the SDC confirmed the technique to transfer Resident #7 with the gait belt was incorrect.	F 498		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure each resident's medical record completely and	F 514		

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F 514	<p>Continued From page 59</p> <p>accurately documented care provided. This was true for 2 of 12 sample residents (#s 2 & 5) reviewed for clinical records. This created the potential for medical decisions to be on based on inaccurate information. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 5/29/14 and discharged on 8/4/14, then readmitted to the facility on 9/11/14 with multiple diagnoses including chronic airway obstruction, dysphagia, Alzheimer's, dementia without behavioral disturbances, and depression.</p> <p>The 2 admission and 1 quarterly MDS assessments, dated 6/5/14, 9/18/14 and 3/17/15, documented the resident was severely cognitively impaired with a BIMS score of 3 and extensive assist of one person for eating.</p> <p>*1st admit MDS on 6/5/14: Weight 161 lbs and a height of 63 inches, no nutritional approach, and no weight loss.</p> <p>*2nd admit MDS on 9/18/14: Weight 136 lbs and a height of 68 inches, mechanically altered diet, and no weight loss.</p> <p>*Quarterly MDS on 3/17/15: Weight 119 lbs and a height of 68 inches, mechanically altered diet, and weight loss.</p> <p>Note: The resident's height on 1st admission was 63 inches and when she returned on 9/18/15 the resident's height was documented as 68 inches. On 4/24/15 at 5:40 PM, the surveyors were provided information to reflect the resident's height measurement was determined to be 64 inches as that date.</p> <p>2. Resident #5 was readmitted to the facility on 6/7/14 with multiple diagnoses including diabetes mellitus (DM), peripheral angiopathy, below the knee lower limb amputation, and depression.</p>	F 514			

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F 514	Continued From page 60 The resident's Physician Orders and the MAR documented: a) "2 hour post prandial BG [blood glucose] after meals for DM. Notify physician if BG < [less than] or if BG > [greater than] 60...Order Date-12/23/14" *The < and > symbols were backwards on how they should have been documented. b) "Fasting BG one time a day for DM. Notify physician if BG <400 or if BG >60...Order Date-12/23/14" *The < and > symbols were backwards on how they should have been documented. On 4/22/15 at 3:35 PM, the DON was interviewed regarding the symbol > representing greater than and the symbol < representing less than respectively. The DON acknowledged it was an "input error" and they were backwards. On 4/24/15 at 5:40 PM, the Administrator, DON, and SDC were notified of the issue. No further information was provided by the facility.	F 514			