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

Monica K. Brutsman, Administrator
Trinity Mission Health & Rehab of Holly, LLC
2105 12th Avenue Road
Nampa, ID 83686-6312

Provider #: 135094

Dear Ms. Brutsman:

On **April 24, 2015**, a survey was conducted at Trinity Mission Health & Rehab of Holly, LLC by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 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*.

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

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

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

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

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

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

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

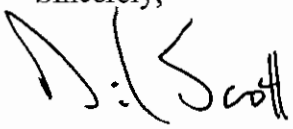
- BFS Letters (06/30/11)

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

This request must be received by **May 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,



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

DS/dmj
Enclosures

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

PRINTED: 05/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135094		04/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY MISSION HEALTH & REHAB OF HOLLY	2105 12TH AVENUE ROAD NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Sherri Case, BSW, LSW Amy Barkley RN, BSN Becky Thomas, RN Becka Watkins, RN The survey team entered the facility on April 20, 2015 and exited on April 24, 2015 Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CDM = Certified Dietary Manager CNA = Certified Nurse Aide DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligram ml = milliliter PRN = As Needed	F 000	Preparation and submission of this plan of correction by, Trinity Mission Health & Rehab of Holly LLC, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter	F 155	F155 SPECIFIC RESIDENT 1. On 4-27-15, Social Services met with Resident # 6 and confirmed that Resident #6 wished to remain a full code. Resident #6 also requested to continue to have the power of attorney sign on her behalf.	

RECEIVED
JUN 19 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] NHA | TITLE: Administrator | (X6) DATE: 6-19-15

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

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F 155	Continued From page 1 related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, it was determined the facility failed to directly communicate with residents prior to changing code status from a Full Code to Do Not Resuscitate (DNR). This was true for 1 of 11 (#6) sampled residents. This deficient practice had the potential to cause harm if the resident had life-saving. Findings include: The resident was admitted to the facility on 6/30/14 with multiple diagnoses to including acute respiratory failure, tracheostomy, and functional quadriplegia. The most recent Quarterly MDS, dated 1/28/15, coded the resident was able to see and hear without difficulty; sometimes understood and usually understands others; and cognitively intact with a BIMS of 15. NOTE: Resident #6 was able to communicate	F 155	OTHER RESIDENTS 2. On 5-5-15 the Licensed Social Workers interviewed current residents, who make decisions for themselves, to identify updates or changes that were needed to their code status. No requests for changes to code status were made. SYSTEMIC CHANGES 3. Root cause analysis reflected that Licensed Social Worker (L.S.W.) needs to document residents participation in decision regarding code status. L.S.W will review code status changes made by residents that are capable of signing for themselves and when there are code status changes signed by anyone other than the resident, to verify that the resident consented to those changes. L.S.W will then document the resident's code status desire. On 5-5-15 facility licensed staff were reeducated, by the Administrator, on the process for residents or Legal Representative to sign code status changes on the facility forms and to notify LSW of changes being made to determine if any additional follow up is needed. MONITORING 4. Beginning the week of 5-29-15 LSW or designee will audit changes made to residents code status weekly for 4 weeks, then every other week	

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F 155	Continued From page 2 with nods/shakes of the head and non-verbal forms of communication, including use of a communication board. The resident's Advanced Directive care plan, dated 6/16/14 and 10/16/14, documented, "I have chosen to be a FULL CODE." Resident care conference notesd, dated 10/29/14, documented, "Full code," and "Family, will speak with patient about possible change to DNR." The family member's signature was included on the document. Social Services progress notes, dated 10/30/14, documented "Pt [patient] is a full code though [family member] is going to speak with resident about possible change." A facility faxed communication form, dated 12/8/14, documented, "Pt's [family member - POA] would like to change [Resident #6's] code status to DNR/DNI. [Family member] told nursing and social services that he feels like they have had good discussions about this change, and is comfortable with the understanding of cares provided." The response section documented, "Ok to change the code status," and included a signature physician's section. On the resident's Advanced Directive care plan, dated 12/8/14, "Full Code" was crossed out and "DNR" was hand written on the care plan. The resident's social progress note, dated 1/28/15, documented, "She is a DNR and has advanced directives on file." Physicians orders for 12/30/14 documented a	F 155	for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that the resident or legal representative who have made changes to code status sheets, have the resident's involvement of changes documented. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Administrator is responsible for monitoring and follow-up. Date of Compliance: 5-29-15	

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F 155	Continued From page 3 code status change from Full Code to "DNR." The resident's medical record did not document the resident's physician nor any other staff had spoken directly with the resident prior to changing code status. On 4/22/15, Resident # 6 confirmed she wanted chest compressions started if her heart stopped beating and wanted staff to help her start breathing if she stopped. The resident confirmed she wanted measures taken to save her life and confirmed the facility did not directly ask her these questions. On 4/23/15, at 10:15 AM, the LSW stated she reviews all the residents' code statuses quarterly and asks the residents, "If your heart stops beating and you stop breathing do you want the facility to call 911 and have an ambulance come." The LSW stated she had not directly interviewed the resident related to changing her code status from Full Code to DNR, and said the residents family member talked to the resident for months prior to changing it. The LSW said it could be a difficult conversation for family to have with residents and stated this had been "distressing" for Resident #6's family member. On 4/23/15, at 10:30 AM, the LSW stated she had just spoken with Resident #6, who confirmed she wanted staff to perform chest compressions if her heart stopped beating and wanted staff to help her start breating if she stopped.	F 155		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and	F 164	F 164 SPECIFIC RESIDENTS 1. On 4-24-15 the Staff Development Coordinator completed an audit of Medication carts to ensure that medical information for residents residing on 300 and 500 halls to include residents #3, #12, #14, and #23 was being kept confidential per HIPAA requirements. OTHER RESIDENTS 2. On 4-28-15 the Staff Development Coordinator completed an audit of facility medication carts to ensure that resident medical information was being kept private per HIPPA requirements; no concerns were identified.	

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F 164	Continued From page 4 confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to protect residents' personal medical information during the medication pass observation. This was true for 2 of 16 sampled residents (#s 3 & 14) , 1 random resident (#23), and 12 random residents listed on the report sheet for Halls 300 & 500. This failed practice created the potential to negatively affect the residents' psychosocial well-being for those	F 164	SYSTEMIC CHANGES 3. On 4-27-15 a root cause analysis was completed by the Director of Nursing and Licensed staff and it was determined that in this isolated situation the Licensed Staff was nervous while being followed by a surveyor and normally compliant with protecting patient confidentiality and privacy. There is a system in place for staff to follow for protecting patient information. On 4-21-15 a 1:1 reeducation was completed by the Director of Nursing with the specific Licensed Staff member on HIPAA and privacy compliance. On 4-28-15, the Licensed Staff on were re-educated by the Staff Development Coordinator on HIPPA compliance and procedure for securing health information when away from their Medication Carts.	

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F 164	Continued From page 5 who may not have wanted their medical information made public. Findings included: On 4/21/15 at 8:55 AM, during the medication pass observation, LN #3 was observed to leave Resident #23's MAR, located on the top of medication cart in the 300 Hall, in full view for anyone passing in the hallway to see. Resident #23's MAR, dated April 2015, revealed the resident's name, resident number, room number, date of birth, admission date, nine diagnoses, and the physician's name and phone number. Additionally, a report sheet for Halls 300 and 500, which documented notes pertaining to the names of Resident #s 3, 14, and 23, along with 12 random resident names, was left on top of the medication cart. On 4/21/15 at 9:00 AM, LN #3 stated, "Did I leave that open, I thought I turned it over." On 4/22/15 at 10:20 AM, the DNS was shown a copy of Resident's #23's MAR and the report sheet for Halls 300 & 500. She stated, "These should have been covered." On 4/21/15 at 4:25 PM, the Administrator and DNS were made aware of the medication pass observation. No further documentation was provided by the facility.	F 164	MONITORING 4. Beginning the week of 5-29-15, Staff Development Coordinator or designee will complete audits of 5 Medication carts weekly for 4 weeks, then every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that patient medical information and privacy is being maintained. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Director of Nursing will be responsible for ongoing monitoring and follow up. Date of compliance: 5-29-15	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be	F 246	F 246 SPECIFIC RESIDENT 1. On 4-23-15, the Maintenance Director replaced a clip on resident #21's call light chord, to enable it to be placed securely within Resident #21's reach. On 4-24-15 the Unit Manager checked call light of resident #2and	

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F 246	Continued From page 6 endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure resident call lights were within reach for one random resident (#21). The deficient practice had the potential to cause harm if the resident's needs were not met. Findings included: On 4/20/15 at 11:35 AM, Resident #21 was observed in her wheelchair in her room with a cup in her hand. She waved with her other hand to get the surveyor's attention and said she needed ice. When asked where her call light was located, she stated she could not find it. The call light was observed to her right and attached to her bed side rail. The surveyor then went to the hallway and asked Occupational Therapist #1 (OT) for assistance. On 4/20/15 at 11:40 AM, OT #1 was asked about the call light and she stated, "It was hanging over the bed where she couldn't reach it." On 4/23/15 at 5:00 PM, the Administrator, DNS, and Clinical Service Coordinator were informed of the issue. No further information was provided by the facility.	F 246	the clip remained in place to keep secure within the reach of resident; no concerns were noted. OTHER RESIDENTS 2. On 5-8-15 a facility wide review of call light chords was completed by the Maintenance Director to ensure that call lights are functioning and within reach; concerns were addressed at that time. SYSTEMIC CHANGES 3. On 4-24-15 the Director of Nursing completed a root cause analysis and determined that the call light was not transferred to the wheelchair when resident # 21 was transferred from the bed. This resulted in the light to fall out of reach from Resident # 21. On 5-5-15 facility staff were re-educated by the Staff Development Coordinator on the need to have call lights within reach of the resident and secured in place and to notify Maintenance Director of call light concerns. MONITORING	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and	F 248	4. Beginning the week of 5-29-15, during walking rounds, the Maintenance Director or designee, will complete 10 audits of call lights weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that call lights are within reach, and functions have a clip if	

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F 248	Continued From page 7 the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to provide an on-going program of activities designed to meet the activity interests and needs for 2 of 16 residents reviewed for activities (#s 12 and 15). This failure placed the residents at risk for boredom and decreased enjoyment in their daily routine and had the potential to negatively impact their emotional well-being. Findings include: 1. Resident #12 was admitted to the facility 1/28/15 with diagnoses which included cerebrovascular accident and hypertension. The resident's 2/3/15 Admission MDS documented the resident was moderately cognitively impaired and totally dependent on staff for transfers and moving about the facility. The activity assessment documented the resident enjoyed listening to music, being around animals, keeping up with news, religious activities and participating in group activities. The resident's 1/28/15 Activity Care Plan directed staff to encourage the resident to participate in activites of cards/groups, Bingo, arts and crafts, musicals, baking, and special events. An Admission Activity Evaluation documented the resident "loves animals" and listed current interests as cards, games, crafts (cross stitch), music, reading/audio books, spiritual activities,	F 248	needed, call light clips are readily available for staff at each nurse's station if needed. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Administrator will be responsible for ongoing monitoring and follow-up. Date of Compliance 5-29-15 F248 1. On 4-28-15 the Activity Director completed an assessment on resident # 12 and # 15. The plan of care was updated to reflect resident's interest and goals The Activity participation sheet will be completed daily to monitor resident's progress based on the goals set per plan of care. The plan of care will be updated as needed. OTHER RESIDENTS 2. Beginning 5-1-15, the Activity staff met with residents residing in the facility about their activity interests and assessed for changes. Activity care plans were updated as needed by the activity staff, to ensure that the facility was meeting activity interest to promote attendance; concerns were addressed as needed.	

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F 248	Continued From page 8 being outdoors, watching the Hallmark station on television, movies, attending parties/social events, and keeping up with the news. The resident's 4/8/15 Resident Care Conference meeting form documented the resident enjoyed group activities, musicals, special events, religious groups, socials, and visits. On 4/22/15 at 9:30 a.m., the resident was observed sitting in her wheelchair in her room with her back to the television, no music playing in the resident's room. The resident stated there was not enough to do at the facility and she was not invited to activities. The resident stated she thought she would enjoy Bingo and would be interested in trying "Rocking RNA." The resident stated someone had given her the bead bracelet on her arm, and she would enjoy making one similar or participating in other craft projects. When asked if she would liked to attend church at the facility, she stated she "might." The resident stated she enjoyed going to the theatre at the facility, but had only been there on two occasions. Resident #12's Individual Activity Participation Record (APR) for February documented the resident had been independent in activities (television, music, family, and reading) for 19 of 28 days. The APR did not document what the independent activity included or how long the resident participated in the activity. The APR for February 2015 also documented the resident attended the following: 2 of 7 religious activities 1 of 24 current event activities 3 of 14 sensory stimulation activities 1 of 6 music activities	F 248	F248 SYSTEMIC CHANGES 3.On 5-15-15 a root cause analysis was completed and it was determined that the Activity staff were not clearly documenting refusals by the residents. The following systemic changes were implemented to meet the resident's activity interests and needs. Activity Participation sheets will be completed timely. Activity Director or designee will evaluate Activity Participation Record weekly and as necessary to ensure that resident's activities interests are evaluated based on assessment and participation to update as indicated. The IDT will also review the plan of care quarterly and update as needed. On 5-1-15 the Activity staff were re-educated by the Administrator on documentation related to the activity participation sheet to reflect	

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	135094		04/24/2015

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F 248	Continued From page 9 2 of 21 Rock n RNA 1 of 11 Bingo activities Beauty shop 2 times 2 social events (birthday party and Sweetheart Ball) The APR for March 2015 documented the resident attended activities 8 of 31 days. The resident attended: 0 of 7 religious activities but had a 1:1 visit regarding religion 1 of 26 current event activities 1 of 18 sensory stimulation activities 1 of 6 music activities 1 of 8 musical activites Note: The facility did not have records for the months of February 2015 or March 2015 documenting the resident had refused to attend an activity. On 4/23/15 at 10:35 a.m., the Activities Director (AD) stated there were music activites at least once a week in which the resident could participate. The AD stated the resident required a staff assistant to attend group activities or to be involved in independent activities. When told the resident was observed facing the wall instead of the television which was on, the AD stated the resident should have been facing the television. The AD was informed the resident had expressed an interest in attending religious activities and craft activites such as making the bracelet, but was not invited. When informed that the resident stated she enjoyed going to the facility's theatre, but had only been there twice, the AD stated the resident had not gone to the theatre "very often." The AD stated the facility failed to document the resident had participated in "enough" activities.	F 248	when a resident chooses to not attend an activity of their interest and to communicate to staff to encourage resident to participate in activities of interest per care plan. Revised 7-22-15 EB for Monica Bustamante	

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F 248	Continued From page 9 2 of 21 Rock n RNA 1 of 11 Bingo activities Beauty shop 2 times 2 social events (birthday party and Sweetheart Ball) The APR for March 2015 documented the resident attended activities 8 of 31 days. The resident attended: 0 of 7 religious activities but had a 1:1 visit regarding religion 1 of 26 current event activities 1 of 18 sensory stimulation activities 1 of 6 music activities 1 of 8 musical activites Note: The facility did not have records for the months of February 2015 or March 2015 documenting the resident had refused to attend an activity. On 4/23/15 at 10:35 a.m., the Activities Director (AD) stated there were music activites at least once a week in which the resident could participate. The AD stated the resident required a staff assistant to attend group activities or to be involved in independent activities. When told the resident was observed facing the wall instead of the television which was on, the AD stated the resident should have been facing the television. The AD was informed the resident had expressed an interest in attending religious activities and craft activites such as making the bracelet, but was not invited. When informed that the resident stated she enjoyed going to the facility's theatre, but had only been there twice, the AD stated the resident had not gone to the theatre "very often." The AD stated the facility failed to document the resident had participated in "enough" activities.	F 248	MONITORING 4. Beginning the week of 5-29-15 the Activity Director or designee will interview 5 residents and audit 5 activity sheet documentation weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that tracking of participation is complete, and residents are satisfied with the variety and amount of activities being offered. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Administrator is responsible for monitoring and follow-up. Date of compliance: 5-29-15	

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F 248	Continued From page 10 2. Resident #15 was admitted to the facility on 8/5/13 with diagnoses which included epilepsy, Down's Syndrome, and dysphagia. The resident's 4/10/15 quarterly MDS assessment documented the resident was severely cognitively impaired and was totally dependent on staff for transfers and moving about the facility. The resident's 2/12/15 Resident Care Conference form documented the resident preferred a quiet and calm environment, had always been a music lover and in the past liked to color and bowl. The resident's 4/8/15 Activity Evaluation documented the resident had a current interest in music, attending religious activities, watching television/radio and attending parties/social events. The resident's 8/16/13 Activity Assessment documented the resident enjoyed ice cream, coloring with crayons, looking at maps and watching the television show "Bonanza." The resident's Care Plan for activities, revised on 7/8/15, documented the resident was to be encouraged to attend musicals, had a past interest in watching Bonanza, had bowled in the past, enjoyed sitting in his recliner with the newspaper or magazines, and had toy blocks on the bedside table in front of him. Resident #15's Individual Activity Participation Record documented the resident enjoyed the independent activity of television, however the record did not include the resident's enjoyment of	F 248		

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F 248	Continued From page 11 the television show Bonanza. A 4/10/14 Quarterly Note by the AD documented the resident "continues to attend/observe musicals and sensory. Staff turns music/tv on while he is in his room." The February APR documented the resident participated in group and/or assisted activites 6 of 28 days. The March APR documented the resident participated in group and/or assisted activities 9 of 31 days. Both the February and March APRs documented the resident participated in independent activities every day. The documentation did not include what the independent activity was, who assisted the resident with the activity, or the length of time the resident was involved in the activity. On 4/23/15 at 1:45 p.m. and 3:20 p.m. the resident was observed asleep in bed with the television on. On the morning of 4/24/15, the AD stated she needed to post signs by each resident's television listing which shows the resident enjoyed and the station to which the television should be set. When asked if the observation of the resident asleep with the television on would have been documented as an independent activity, the AD stated it was possible. The AD stated the resident's care plan had been revised to include 1:1 visits with the activity staff due to lack of documentation the resident had participated in activities.	F 248		

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F 248	Continued From page 12 On 4/23/15 at 5:00 p.m. the Administrator and the DON were informed of the above concerns. The facility provided no further information.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to recognize continued and worsening signs of depression; develop and implement resident-specific care plans to address signs and symptoms of depression; and to identify key psychosocial issues and support systems to resolve concerns. This was true for 1 of 11 (#6) sample residents. This failed practice had the potential for harm when the resident expressed ongoing feelings of depression; staff did not notify and/or refer the resident to a qualified professional; and did not develop an individualized care plan to address these feelings. Findings include: Resident #6 was admitted to the facility on 6/03/14 with multiple diagnoses, including acute respiratory failure following surgery, encephalopathy, functional quadriplegia, speech disturbance, tracheostomy, and speech disturbance.	F 250	F250 SPECIFIC RESIDENT 1. On 4-28-15 resident #6 was interviewed by Licensed Social Worker (LSW) to assess if resident # 6 continued to have bad feelings. Resident #6 did not express any concerns or bad feelings at that time. Resident specific interventions were listed for staff to follow if Resident # 6 verbalized having "bad feelings" by the LSW. OTHER RESIDENTS 2. On 4-29-15, Licensed Social workers completed a facility wide review of mood/behavior care plans and behavior monitoring sheets, for specific interventions listed for staff to follow. Concerns were addressed at that time. On 4-29-15 Interviewable residents were assessed by the Licensed Social Workers for any outside service needs; no concerns noted. SYSTEMIC CHANGES 3. On 5-15-15 a root cause analysis was identified by the IDT that changes from one assessment to another assessment need to have interventions addressed in the care plan and that follow- up documentation that resident was	

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F 250	Continued From page 13 The resident's Admission MDS assessment, dated 6/10/14, coded the resident was moderately - to cognitively intact, was not feeling tired/having little energy, and did not have bad feelings about herself. The resident's Quarterly MDS assessment, dated 1/28/15, coded the resident was cognitively intact, was feeling tired or having little energy for 7-11 days, and was feeling bad about herself for 2-6 days during the assessment period. The resident's Mood care plan, dated 6/16/14, documented the resident had "frustration over limited communication r/t respiratory issues and recent health decline" and on 1/25/15 the following concern was added, "Bad feelings about self r/t health." The following Approaches were listed; "My [family member] provides good support; I enjoy watching TV and visits with my family; ask me yes/no questions and assist with providing emotional support, reassurance and comfort; assess the situation, if response is rational, use empathy to encourage the client to interpret the anxiety [symptoms] as normal; ... if the response is irrational, offer client accurate information and encourage them to talk about the meaning of the events contributing to the anxiety. Intervene when possible to remove sources of anxiety." The care plan did not identify how the resident exhibited "bad feelings about self." Additionally, the facility did not review and revise the care plan to ensure current interventions were appropriate for the newly identified concern, however the facility indicated it would identify what was rational or irrational for Resident #6.	F 250	offered outside services as needs are determined. Licensed Social workers were re-educated on 5-5-15 by the Administrator, on providing resident specific reassurance interventions for the staff to follow and assessing for the need for outside services. MONITORING 4. Beginning 5-29-15 Licensed Social Worker or designee, will complete 5 care plan audits weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that specific interventions are in place and being followed and identified needs for outside services are being offered upon assessment. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Administrator is responsible for monitoring and follow-up. Date of compliance: 5-29-15	

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F 250	Continued From page 14 A Social Progress Note, dated 1/28/15, documented, "...resident reports feeling tired and bad feelings about self d/t health. [Family member] is supportive and visits often." It could not be determined if the facility followed-up with these concerns as there was no documentation in the resident's record to indicate the concerns had been addressed. A Social Progress Note, dated 3/27/15, documented, "The resident stated she feels tired, bad feels [sic] about self due to 'my health' waving her had over self, and troubles with concentration." A Social Progress Note, dated 4/24/15, documented, "...mood stable during visit." The Social Service Notes reviewed from 1/28/15 through 4/24/15 did not document the facility had assessed and validated the resident's feelings and or notified and obtained input from the physician. On 4/24/15 at 10:30 AM, the LSW was asked if she was aware the resident had verbalized, "having bad feelings about herself." The LSW stated the resident had just recently expressed those feelings to her 4 days prior on 4/20/15 and "I haven't had time to do anything about it. I can't make a note each time I meet with a resident, we have over 100 residents in the facility and there is only two of us." When asked what would be done now to address the resident's concerns, the LSW said, "I will visit with her and provide reassurance and support. I could refer her to a counselor, but I doubt she will go." The LSW stated she visits with residents quarterly and as needed when she is alerted to a concern. On 4/24/15 at 11:30 AM, the Administrator was notified about the above concern and no further	F 250		

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F 250	Continued From page 15 information was provided. On 4/27/15 at 3:56 PM, additional information sent by the facility was reviewed, however it did not resolve the concern.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to develop interim care plans which reflected the current status for 2 of 11 sampled residents (#s 8 and 2). The facility failed to address Resident #8's bowel incontinence and Resident #2's range of	F 279	F279 SPECIFIC RESIDENT 1. On 4-28-15 the care plan for resident #2 was reviewed and updated by the Director of Nursing to reflect Range of Motion needs. Resident's #11 no longer resides in the facility. OTHER RESIDENTS 2. Beginning 4-28-15, care plans for residents requiring range of motion or leg compression pumps, were reviewed and updated by the MDS staff to reflect patient current status and needs. SYSTEMIC CHANGES 3. Root cause analysis revealed need for training Interdisciplinary staff on developing care plans based on assessment needs. On 4-28-15 the MDS staff were re-in-serviced by the R.N. Clinical Reimbursement Specialist on developing comprehensive care plans. On 4-28-15 the interdisciplinary team was re-educated by the Director of Nursing on developing comprehensive care plans on admission.	

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F 279	Continued From page 16 motion (ROM) program. These failures created the potential for residents' assessed needs not to be met due to lack of direction in their care plans. Findings included: 1. Resident #11 was admitted to the facility on 4/3/15 with diagnoses which included chronic kidney disease, cellulitis of the leg, and pneumonia. The resident's 4/3/15 admission orders included an order for the SCD, however the resident's interim care plans did not include any information regarding the use of the SCD. On 4/20/15 at 2:05 p.m., the resident was observed laying on her bed with the SCDs on her legs. The resident stated the SCDs were to be put on twice each day to massage her legs and remove excess fluid. On 4/23/15 at 10:10 a.m., the DON stated the facility failed to develop a care plan for the use of the SCDs. On 4/24/15 at 2:50 p.m., the Administrator and the DON were informed of the above concern. The facility provided no further information. 2. Resident #2 was admitted to the facility on 6/16/08, and re-admitted on 7/26/13, with multiple diagnoses including multiple sclerosis, muscle weakness, and contractures. The resident's most recent annual MDS Assessment, dated 1/28/15, documented the resident was moderately cognitively impaired; required total assistance of at least 2 persons for transfers, eating and toilet use; total assistance of 1 person for locomotion on- and off the unit,	F 279	MONITORING 4. Beginning the week of 5-29-15 MDS staff will complete 5 audits of care plans weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that the care plan is comprehensive and addresses resident specific needs. A report will be submitted to the Quality Assurance Performance Improvement committee for three moths. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Director of Nursing will be responsible for monitoring and follow up. Date of Compliance: 5-29-15	

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F 279	Continued From page 17 dressing, eating, personal hygiene and bathing; and extensive assistance of at least 2 staff for bed mobility. Additionally, the MDS documented the resident had functional limitation in range of motion with bilateral impairment in his upper and lower extremities. Physician Orders for April 2015 documented a 3/19/15 order that read, "RNA [Restorative Nursing Assistant] Program: ROM, Calf Stretches, Hip Flexion, Knee Extention, Hip Abduction 6-7 X [times] [for] 8 weeks." The Restorative Nursing Care Flow Record, dated 4/11/15, documented, "Goal: To maintain current range of motion." The flow record included a Monthly Summary Evaluation Note which documented, "Continue current RNA Program. Pt [patient] actively participating in program, doing well with all exercises." Resident #2's care plan did not document a care plan had been developed for the problem of limited Range of Motion. The resident's ADL care plan, initiated 12/22/08, included an intervention which documented, "RNA PROGRAM: As ordered." On 4/23/15 at 1:20 PM, the DNS stated, "I could not find a care plan for the problem of Range of Motion." On 4/23/15 at 5:00 PM, the Administrator and DNS were made aware of the concerns regarding care plans. No further information was provided by the facility.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 18 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to revise care plans for 2 of 16 sampled residents (#s 2 & 7). The care plans: *contained information related to the flu vaccine, an antibiotic and a respiratory infection, which were no longer applicable, and *contained information related to communication needs, which was no longer in use. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in their care plans. Findings included:	F 280	F280 SPECIFIC RESIDENT 1. On 4-29-15, Resident # 7's care plan was reviewed and updated by MDS staff, to accurately reflect Tamiflu as resolved. On 4-29-15, Resident #2 care plan was reviewed and updated by the MDS staff to reflect the resident's current communication needs. OTHER RESIDENTS 2. On 5-28-15 an audit of facility residents' care plans was completed by the MDS staff to ensure care plans are reflective of the resident's current needs; concerns were addressed at that time SYSTEMIC CHANGES 3. Root cause analysis showed that the Interdisciplinary team had not been consistently updated and resolving care plan problems. Systemic changes were implemented for the revisions of the residents' plan of care timely. An Immediate plan of care (IPOC) will be developed timely on onset of change condition. The IPOC will be reviewed weekly and as necessary to during Clinical meeting and Risk meeting ensure	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 19 1. Resident #7 was readmitted to the facility on 5/31/13 with multiple diagnoses, including acute respiratory failure. The resident's Temporary Care Plan documented the following: -4/14/14: Problem - "Fever WBC [white blood count] [up]," with approaches of, "Chest X-ray...Med[ication]s as ordered...Levaquin X[times] 10 days." -4/17/14: Problem - "URI [upper respiratory infection]" with a short term goal of, "Will be resolved within 14 days," and approaches of, "ABT [antibiotic treatment] as ordered X 10 days...[increase] fluid intake...Notify MD if needed." -10/10/14: Problem - "Potential for [side effects] to flu vaccine," with approaches of, "Monitor Temp[urature]...Notify MD if needed." On 4/23/15 at 10:05 AM, MDS Coordinator #9 was interviewed, with the Clinical Reimbursement Specialist present, regarding the care plan. She said the temporary care plans were used to reflect issues which were considered short term in nature. When looking at the three problems mentioned above, she said they should have been discontinued and "crossed out." 2. Resident #2 was admitted to the facility on 6/16/08, and re-admitted on 7/26/13, with multiple diagnoses, including multiple sclerosis, muscle weakness, and contractures. The resident's most recent annual MDS Assessment, dated 1/28/15, documented the resident was moderately cognitively impaired with a BIMS Score of 10.	F 280	that plan of care has been updated, revised or resolved. The IDT will review plan of care quarterly and as needed to ensure plan of care has been updated, revised or resolved. On 5-5-15 the Director of Nursing re-educated the IDT on updating and resolving care plan problems. MONITORING 4. Beginning the week of 5-29-15 the Director of Nursing or designee will complete audits of 5 care plans, weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that they are current and reflect residents changing needs. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Administrator is responsible for monitoring and follow up. Date of compliance: 5-29-15	

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F 280	Continued From page 20 The resident's care plan for communication, initiated on 2/22/12, documented, "Vocal hygiene program: at least 64 oz water/day. Cannot self hydrate; Staff must assist with every encounter. NOTE: Every cup of coffee/high sugar drink = 1 glass [no specific measurement given] H20." On 4/23/15 at 1:20 PM, the DNS stated the above mentioned intervention was discontinued on 6/26/14 and the care plan should have been updated. On 4/23/15 at 5:00 PM, the Administrator and DNS were made aware of the concern regarding care plans. No further information was provided by the facility.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were not initialed as given on the Medication Administration Record prior to the administration of the medications.This was true for 2 of 11 (#s 5 & 13) sampled resident and 1 of 4 (#20) random residents observed during the medication pass. This failed practice had the potential for harm if residents did not receive prescribed medications for medical conditions and the physician was not notified. Findings include:	F 281	F281 SPECIFIC RESIDENT 1. Resident #5 no longer resides in the facility. Resident # 20 is receiving Physician ordered medication in accordance with Idaho Board of Nursing Standard. OTHER RESIDENTS 2. On 5-19-15 Medication pass observations were completed by the Staff Development Coordinator of the Licensed Nurses during medication pass; no concerns were noted.	

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F 281	Continued From page 21 Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do." On 4/21/15 the following observations were made: * 9:15 AM: LN #13 was observed to pre-initial Resident #5's medications including, "Symbicort 160/4.5 MG (milligrams) 2 inhalations twice daily," on the MAR, (Medication Administration Record) prior to actual administration of the medication. * 9:30 AM: LN #13 attempted to administer the Symbicort to Resident #5, however the resident was unable to follow directions for the medication. LN #13 told the resident, "I am going to need to talk to your doctor about you not taking it." * 9:35 AM: LN #13 was asked and confirmed she had initialed Resident #5's medication prior to administering it. When asked to explain the facility's policy, she stated she was taught to initial the MAR when medications were dispensed, administer the medications and then circle any medication not taken by the resident and write the explanation on the back. LN #13 then stated she had also been trained to place a dot on the MAR when the medication was dispensed, administer the medication, and then initial the appropriate box on the MAR after the medication was	F 281	SYSTEMIC CHANGES 3. Root cause analysis showed that two specific Licensed Staff were in need of additional training regarding medication pass technique meeting Idaho Board of Nursing Standard. On 4-28-15 the Licensed Staff were re-educated by the Director of Nursing and Staff Development Coordinator on standards for required documentation of medication administration. MONITORING 4. Beginning 5-29-15 Staff Development Coordinator, or Designee, will observe medication pass and complete audits of medication administration and documentation of 3 licensed nurses weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that medication administration is documented and according to Idaho Nursing Standard. A report will be submitted	

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F 281	Continued From page 22 administered. * 9:45 AM: Copies of the MAR documented the 8:00 AM Symbicort was administered. The medication reconciliation section on the back of the form was blank. * 4:30 PM: The resident's MAR still documented the 4/21/15 8:00 AM dose of Symbicort was administered and then discontinued. On 4/21/15 at 4:35 PM, the Administrator and DNS were notified of the above observation. The facility offered no further information. On 4/21/15 at 3:55 PM, during the medication pass observation, LN #4 was observed to pre-initial the following medications, prior to actual administration of the medication, on Resident #20's MAR (Medication Administration Record): *Calcium Citrate 500 mg; *Metoprolol 25 mg, 1/2 tab; *Zantac 15 mg/5 ml, 5 ml; and, *Flonase 50 mcg, 2 inhalations to each nostril. The LN stated she had been taught to sign off the medications when punched from the medication card. Note: The facility's policy and procedure for Medication Administration General Guidelines, Section 7.1, dated 9/2010, page 5, documented, "The individual who administers the medication dose, records the administration on the resident's MAR following the medication being given. On 4/22/14 at 4:25 PM, the Administrator and DNS were made aware of the pre-initialing observation. No further information was provided	F 281	to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. Director of Nursing will be responsible for monitoring and follow up. Date of compliance: 5-29-15	

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F 281	Continued From page 23 by the facility.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident's dialysis communication was received. This affected 1 of 16 (#14) sampled residents. This failure created the potential for the resident to experience complications and/or compromised medical status. Findings included: Resident #14 was admitted to the facility on 1/17/13, and readmitted on 4/17/15, with multiple diagnoses, including chronic kidney disease Stage V. The resident's April 2015 MAR documented an order, dated 4/17/15, for hemodialysis on Tuesdays, Thursdays and Saturdays at a local dialysis center. The resident's Nurse's Notes documented the resident went to dialysis on 4/18/15 and 4/21/15. On 4/23/15, the resident's medical record was reviewed; the resident's Hemodialysis	F 309	F309 SPECIFIC RESIDENT 1. Resident # 14 had current dialysis sheets located and placed in the chart by Medical Records. OTHER RESIDENTS 2. Currently resident #14 is the only dialysis patient residing in the facility. A review of Resident's 14 record was completed by the Director of Nursing to ensure that the dialysis communication record was available; no concerns were noted. SYSTEMIC CHANGES 3. Root cause analysis showed that Licensed Staff did not ensure that the dialysis sheets on 4-18-15 were returned timely and completed. On 4-24-15 Licensed Staff were re-educated by the Staff Development Coordinator on completing dialysis communication sheets and following	

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F 309	Continued From page 24 Communication form for 4/18/15 was not found in the chart, there were no nursing notes indicating the form was requested by the facility from the local dialysis center, and the notes did not indicate there was any exchange of information between the facility and the center. Note: Interpretive Guidance at F309 related to dialysis documented when a resident went to an offsite dialysis center there must be an "interchange of information useful/necessary for the care of the resident." On 4/23/15 at 11:00 AM, Resident Care Manager (RCM) #2 was interviewed. She said the dialysis center did not always send back the communications form. When asked what staff should do if the form was not sent back, she stated, "I would call." On 4/24/15 at 8:15 AM, the resident's Hemodialysis Communication form for 4/18/15 was found in the medical record with a "noted" date of 4/23/15. On 4/24/15 at 8:35 AM, when shown the 4/18/15 communication form, the DNS said it appeared the facility had received the form on 4/23/15.	F 309	up with dialysis unit if sheets are not returned completed to the facility after dialysis. MONITORING 4. Beginning 5-29-15 Medical Records or designee will audit dialysis communication sheets weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that the dialysis communication sheets have been completed and returned to the facility. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Director of Nursing will be responsible for monitoring and follow up. Date of compliance: 5-29-15	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	F314 SPECIFIC RESIDENT 1. Resident #5 discharged on 4-23-15 to the hospital and returned on 4-27-15. Resident #5 was re-assessed by the Registered Nurse and care plan was reviewed and revised to meet resident #5 current needs.	

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F 314	Continued From page 25 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure residents at risk for skin alterations received planned interventions for preventing pressure ulcers. This was true for 1 of 3 residents (#5) reviewed who developed a pressure ulcer while at the facility. This failed practice created the potential for harm if the pressure ulcer worsened, became infected or caused the resident pain. Resident #5 was admitted to the facility with multiple diagnoses, including Clostridium Difficile, urinary tract infection, acute respiratory failure, pneumonitis, dementia, and low body weight/failure to thrive. The resident's Significant Change MDS assessment, dated 3/4/15, coded the resident required extensive assistance of one person for bed mobility, had weight loss, was severely cognitively impaired, and was at risk for developing pressure ulcers. The skin care plan, dated 3/4/15, documented the resident was at risk for skin breakdown related to low weight status, poor safety awareness and incontinence. Care plan interventions included assistance with toileting as needed, and maintaining the head of bed not greater than 30 degrees. On 3/30/15, handwritten documentation identified the resident had increased erythema (redness) to buttocks. On 4/20/15, handwritten	F 314	OTHER RESIDENTS 2. On 5-28-15 an audit was completed by the IDT of resident's skin care plans to ensure interventions were in place and changes to plan of care were communicated to the direct care staff via the C.N.A. care card; concerns were addressed at that time. 3. Root cause analysis showed that the direct care staff were not trained on changes in care needs for resident #5 when he readmitted from the hospital after a change of condition. Resident #5's current care needs and an updated toileting plan had not been initiated on readmission or communicated clearly. The following systemic changes were implemented: the facility will identify skin concerns through skin assessments and skin risk evaluations, the skin concerns and risk will be reviewed in the morning clinical meeting. Skin concerns that are identified will be reviewed by the IDT to ensure a	

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F 314	Continued From page 26 documentation identified the resident was at risk for skin breakdown related to perspiration and moisture. Note: The facility identified the resident's skin breakdown was related to moisture from incontinence, however the resident was not on a toileting program and the bladder evaluation was incomplete. Fax communication forms to the physician documented the following: 4/1/15 - abraised area on left upper inner gluteal crease. 4/20/15 - continued periodic erethyema/chaffing to buttocks 4/22/15 - superficial open area to left of coccyx, elongated in shape, approximately 1.5 (cm) centimeters x 0.5 (cm) x 0.1 (cm) A pressure notification form documented: 4/22/15 - developed a pressure ulcer consistent with moisture/friction left of coccyx An in-service counseling record, dated 4/9/15, documented the resident had red areas on the spine, was to be rotated every 2 hours from side-to-side, was not to be on his back at any time, was last down last up and should be kept dry to prevent skin breakdown. The following observations were made during the survey process: * 4/20/15 - from 11:40 AM to 2:20 PM: Resident #5 layed in bed on his back. LN #15, CNA #17, RN #19, and LN #20, were observed at the nurses station, which offered a clear view of the resident laying on his back during that 2-hour and 40-minute period of time.	F 314	plan of care has been developed, and interventions are communicated to direct care staff via the C.N.A. care card. Residents identified with skin concerns will be reviewed weekly and PRN to ensure; monitoring for decline and progress, notification of MD for changes in skin condition, evaluation of the effectiveness of the plan of care developed. C.N.A. care card will be updated as needed to communicate resident care needs to direct care staff. Licensed Staff were re-educated by the Director of Nursing on 5-18-15 on completing an evaluations for readmissions and putting interventions in place based on the evaluations, and ensuring direct care staff are trained promptly on those evaluations.	

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F 314	Continued From page 27 *4/20/15 - 2:20-2:30 PM: CNA #6 performed peri care on the resident. When the surveyor identified that the resident's coccyx was excoriated (skin missing) and exhibited white sluff with a dark purple surrounding area, CNA #6 stated the resident had redness because he was incontinent, but that she would apply cream to the reddened area. CNA #6 stated the bed did not have a mechanism to measure the head-of-bed angle, but that staff "eye ball it" to keep the bed no higher than 30 degrees. Resident #5 was positioned on his back after CNA #6 provided cares. *4/21/15 - 8:21 - 9:20 AM: Resident #5 was positioned on his back. At 8:55 AM, LN #15 walked into the resident's room and told CNA #16, "When [Resident #5] is done eating make sure the bed is no more than 30 degrees. CNA #16 stated the bed does not have degree indicators on the bed and stated, "I just eye-ball it, I have been doing it for so long." * 4/22/15 - LN #15 stated she was about to change the resident's treatment to the coccyx because the area was now open. 4/23/15 - 9:45 AM: Blue tape was observed on the resident's bed, which was not there on any previous day of survey. RN #19 and CNA #17 stated they did not know what the blue tape was for, but LN #19 stated the blue tape was placed to ensure that the head-of-bed was not greater than 30 degrees. On 4/23/15, at 5:00 PM, The Administrator was notified of the findings. No further information was provided.	F 314	MONITORING 4. Beginning 5-29-15 the R.N. supervisor or designee will audit 5 charts of residents at high risk for skin weekly for 4 weeks, every other week for 4 weeks, and monthly for 2 months and quarterly thereafter to ensure that residents have completed assessments, evaluations and interventions in place for the direct care staff, that toileting evaluation form is complete and interventions put in place, that high risk pressure ulcer residents have been assessed and interventions communicated with direct care staff. A report will be submitted to the Quality Assurance Performance Improvement committee for 3 months then quarterly thereafter. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Director of Nursing will be responsible for monitoring and follow up. Date of compliance 5-29-15	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 28 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to assess residents who were incontinent of bladder to determine if toilet training would be beneficial. This was true for 2 of 16 (#s 4 & 5) residents sampled for urinary incontinence and created the potential for harm if residents experienced a loss of bladder function due to incomplete assessments. Findings included: 1. Resident #4 was readmitted to the facility on 7/2/14 with multiple diagnoses, including acute and chronic respiratory failure and muscle weakness. The resident's 2/9/15 annual MDS assessment documented the resident: *Was always incontinent of bladder; *Totally dependent on staff for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing; and, *Was cognitively intact with a BIMs of 15. The resident's Elimination care plan, dated 9/1/10, documented:	F 315	F315 SPECIFIC RESIDENT 1. On 4-23-15 Resident #4's bladder assessment with recommendations, was completed by the MDS staff. On 4-27-15, Resident # 5 bladder assessment was completed by the MDS staff and reflected toileting with check and change needs. OTHER RESIDENTS 2. On 5-5-15 MDS staff reviewed residents residing in the facility to ensure a completed bladder assessment was in place and that a toileting plan was identified; concerns were addressed at that time. SYSTEMIC CHANGES 3. Root cause analysis showed that bowel and bladder assessments were not complete and care plans did not reflect a toileting plan. On 4-28-15 the IDT was re-educated by the Director of Nursing, on assessing and completion of the bladder assessment tools and implementing a toileting plan identified based on the assessment. New admission charts will be reviewed by the Nurse Managers during the facility Persons at Risk (P.A.R) meeting to ensure bladder assessment sheets are complete and toileting plans are in place. 4. Beginning the week of 5-29-15 Assistant Director of Nursing or designee will audit new admission	

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F 315	Continued From page 29 * A problem of, "[Resident's Name] is currently incontinent of urine...;" and * An approach of, "Assist with perineal hygiene for incontinence of urine. Resident is lethargic at times and may not recognize need to void. Provide incontinence products as needed." A Bladder Evaluation form, dated 2/18/15, had a handwritten line drawn diagonally over the section titled "Evaluation For Bladder Program Potential." The page was blank, except for the nurse evaluator's signature and date. On 4/22/15 at 3:30 PM, the DNS was interviewed and was shown the form. The DNS stated, "It doesn't seem very complete ... she didn't finish filling it out." On 4/23/15 at 5:00 PM, the Administrator, DNS and Clinical Service Coordinator were informed of the issues. No further information was provided by the facility. 2. Resident #5 was admitted to the facility with multiple diagnoses to include femur neck fracture, muscle weakness, and dementia. The resident's Significant Change MDS assessment, dated 3/4/15, coded: * Required extensive assistance of one person for bed mobility, transfers, and toileting; * Always incontinent of bladder and bowel; * Did not have a urinary toileting program attempted; * A bowel toileting program was not being used; and * He was severely cognitively impaired.	F 315	bladder assessments weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that assessments are complete and include a toileting plan. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. MDS coordinator will be responsible for monitoring and follow up. Date of compliance: 5-29-15	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 30 The resident's Elimination care plan, dated 2/9/15, documented, the resident was "presently" incontinent of bladder and bowel. Approaches included following the facility's protocol for bowel care and providing perineal hygiene as needed. "Please assist with the urinal or bathroom" had been lined through, but not dated. A undated, incomplete Bladder Evaluation form documented the resident was unable to to participate in a [toileting] program. A handwritten note on the form documented, "re-admit 3/24/15," and the reason for non-participation in the program was related to "severe dementia - will work with OT to see if able to participate in training program." An Occupational Therapy note, dated 3/24/15, documented OT was working with the resident on his toileting transfers, management of clothing during toileting, and toileting hygiene. The note did not document that OT had or was planning on evaluating the resident for a toileting program. On 4/23/15 at 5:00 PM, the Administrator, DNS, and Clinical Service Coordinator were informed of the issues. No further information was provided by the facility.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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F 318	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure a resident received interventions to prevent a decrease in range of motion (ROM). This was true for 1 of 11 (#7) residents reviewed for ROM, who had the potential to sustain harm when she did not receive services necessary to prevent the deterioration of existing ROM limitations. Findings included: Resident #7 was readmitted to the facility on 5/31/13 with multiple diagnoses, including hemiplegia and muscle weakness. The resident's annual MDS assessment dated 1/30/15, documented the resident: * Had upper extremity ROM limitations to both sides, and, * Was totally dependent on staff for dressing, eating and personal hygiene. The resident's Physician's Telephone Orders, dated 3/10/15, documented orders for active and passive ROM exercises, which also included, "... Apply Palmer Rolls [hand contracture reduction device] in both hands, remove to eat." The resident's Temporary Care Plan, dated 3/10/15, documented, "Initiate RNA [Restorative Nursing Aide] program ..." Note: The care plan did not include the application of Palmer Rolls. The resident's April 2015 Restorative Nursing Care Flow Record documented a goal of, "To	F 318	F318 SPECIFIC RESIDENT 1. On 4-28-15 resident #7 was assessed by Director of Therapy for continued need of devices to hands and devices are being used per Physician order. The care plan was reviewed by the DON and updated to reflect residents current interventions OTHER RESIDENTS 2. On 5-5-15 Residents residing in the facility that receive treatment for contractures or receive range of motion were reviewed by the IDT to ensure that devices were available, and the care plans were updated to reflect current needs to ensure physician orders are care planned and are being followed. SYSTEMIC CHANGES 3. Root Cause analysis revealed that the hand contracture reduction device was sent to laundry to be cleaned and the replacement was not available The following systemic changes were implemented; managing range of motion interventions and care for residents with contractures. The resident that are identified with contractures will be screened, evaluated, treated by rehab as necessary per physicians order. Plan of care will be developed for resident with contractures based on Rehab and/or nursing evaluation and assessment and resident's needs for	

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F 318	Continued From page 32 prevent skin breakdown in bilateral palms," and an intervention of, "Apply Palmer rolls in [bilateral] U[pper] E[xtremities] to be worn at all times except for hygiene and eating." The flow sheet also contained sections where RNA staff would record when the resident was observed wearing the Palmer Rolls. There were blanks or zeros for 4/5, 4/11, and 4/19 through 4/21/15, indicating the resident had not worn the device. On 4/21/15 at 12:25 PM, the resident was observed without the Palmer Rolls or any other protective device in her hands. When asked about wearing the Palmer Rolls, the resident indicated by nodding her head that staff had not placed them in her hands for several days. Note: The resident had a tracheostomy and could not verbally voice her responses to the surveyor's questions. On 4/21/15 at 2:05 PM, and on 4/22/15 at 8:00 AM, the resident was observed without any device in her hands. On 4/23/15 at 9:00 AM, when asked about the resident's Palmer Rolls, CNA #7 stated she had occasionally found the resident without them on and had noticed on those occasions that the resident exhibited stiff hands. On 4/23/15 at 9:40 AM, CNA #8 said that since the resident moved to her current room, the Palmer Rolls had been missing and the resident had been observed without the rolls. CNA #8 also said staff had substituted rolled up washcloths when the rolls were discovered missing. Note: The resident had changed rooms on 4/8/15.	F 318	use of contracture reduction devices and range of motion exercises. C.N.A. care card will be updated timely for use of contracture reduction devices and range of motion exercises The residents that participate in a restorative program will have an R.N.A. flow record will be completed timely. The restorative nurse will be review the plan of care weekly and PRN to ensure effectiveness. The IDT will complete routine rounds to ensure resident's interventions for contractures are in place. Residents will have additional contracture reduction devices available for laundering purposes. The restorative nurse will audit the documentation of placement of device to ensure that devices are provided. On 5-5-15 Nursing staff were re-educated by the Director of Nursing on following Physician orders and ensuring contracture reduction devices are in place as care planned, and that alternate devices are available when items are being laundered.	

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F 318	Continued From page 33 On 4/23/15 at 9:45 AM, the RNA Supervisor was interviewed. When shown the temporary care plan and asked why the Palmer Rolls were not on the care plan, she stated, "That's got to be on her plan, obviously." She said the rolls were to reduce hand contractures. She was also informed the resident was observed multiple times without the device in her hands. On 4/23/15 at 5:00 PM, the Administrator, DNS and Clinical Service Coordinator were informed of the issues. No further information was provided by the facility.	F 318	MONITORING 4. Beginning the week of 5-29-15, the Director of Therapy and the Restorative Nurse will complete 5 audits of residents needing contracture reduction devices weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that residents with adaptive equipment needs have them in place according to the Physician order and are documented. A report will he submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Restorative Nurse will be responsible for monitoring and follow up. Date of compliance: 5-29-15	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and review of Incident/Accident Reports, it was determined the facility failed to ensure a hoyer sling was properly attached to the mechanical lift prior to transferring a resident and the facility failed to ensure adequate safety and supervision were provided to a resident with severely impaired cognition who fell multiple times, sustained a hip fracture and dislocation to his fractured hip. This was true for 2 of 4 (#s 2 &	F 323		

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F 323	Continued From page 34 5) residents sampled for falls. Resident #2 was injured when he fell out of the hoyer sling and sustained a laceration to the back of his head and Resident #5 was harmed when he fractured his hip requiring surgical intervention. Findings include: Resident # 5 was admitted to the facility on 1/27/15, and most recently re-admitted on 4/17/15, with the multiple diagnoses, including left femur fracture, dislocation of the left hip, subarachnoid hemorrhage, left facial bone fracture, and dementia. The Quarterly MDS assessment, dated 1/27/15, coded the resident was sometimes understood and sometimes had the ability to understand others; his cognitive skills for decision making were not assessed; he required supervision for bed mobility, transfers, walking, dressing, toileting, and personal hygiene; he had no impairment to the upper/lower bilateral extremities; and his fall history was not assessed. The Significant Change MDS, dated 3/4/15, coded the resident was severely cognitively impaired; inattentive and experienced psychomotor retardation [slow movements]; he was extensive assist of one person for bed mobility, transfers, dressing, toileting, and personal hygiene. The resident did not walk during the assessment period. On 2/11/15, the resident fell at the facility, and was transported and admitted to the hospital, where he was diagnosed with a subarachnoid hemorrhage, frontal contusion, and orbital fracture.	F 323	F323 SPECIFIC RESIDENTS 1. On 4-27-15 Resident #5 was re-assessed by the DON for safety and supervision and interventions were implemented to meet the resident's needs. On 4-27-15 Resident #2's Hoyer equipment was inspected by the Maintenance Director; no concerns were identified. On 4-27-15 the DON reassessed Resident #2 for safety and supervision to ensure interventions were current to meet resident's needs. OTHER RESIDENTS 2. On 5-4-15 residents that have had a fall in the last quarter or have a history of falls were reassessed by the Director of Nursing to ensure that adequate supervision and safety interventions are in place and care planned. On 5-4-15 audits were completed of staff using the Hoyer lifts to ensure they are used and inspected to ensure safety devices are in place.	

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F 323	Continued From page 35 Nurse's Notes, dated 2/15/15, documented the resident was to receive Physical Therapy interventions, including gait training, a bedside sitter, and bed and chair alarms, related to the 2/11/15 fall. Nurse's Notes, dated 2/23/15 through 3/2/15, documented the resident was to receive 15-minute checks by staff related to the fall. NOTE: The facility did not provide requested documentation that the PT interventions, including gait training, were provided; nor were these interventions included in a revised care plan. Note: The resident was re-admitted on 2/14/15, discharged to a local hospital on 2/15/15 with diagnoses of aspiration pneumonia, and re-admitted to the facility on 2/18/15. The Care Plan, dated 2/19/2015, documented the resident was at risk for falls due to muscle weakness, cognitive deficit, decreased mobility, and history of falls. Additionally, the resident "did not remember to use [his] call light or alert staff when [he] needed to go to the [bathroom]." Interventions included an alarm to the resident's bed and wheelchair. Nurses notes documented the following: 3/15/15 - 9 PM: Alert with confusion, fall risk, pressure alarm on wheelchair and bed 3/16/15 - 2 PM: Confused to person, place, time 3/16/15 - 9 PM: Fall risk, pressure alarm on bed and wheelchair, incontinent, and 1 person assist 3/17/15 - 4 AM: Alert with confusion, fall risk, alarm in bed related to poor safety awareness, 1 person assist for transfers and mobility An Incident/Accident Report, dated 3/17/15 at	F 323	SYSTEMIC CHANGE 3. Root cause analysis revealed that direct care staff did not inspect the Hoyer lift for safety clips prior to transferring resident in the Hoyer and the need of continued assessment and interventions of resident who have changes in condition. The following systemic changes were implemented; For residents requiring the use of mechanical lift: prior to use of the mechanical lift, the staff will check the device for functioning safety clips. Mechanical lift will be removed from unit use if functionality of the mechanical device is in question. The Maintenance Director will check mechanical lift/clips weekly and as needed to ensure that device is safe for resident's use. Maintenance Director will perform preventative maintenance on mechanical lift monthly and as needed. For the residents requiring increased supervision: Residents identified as requiring increased supervision will be reviewed during morning clinical meeting. Residents identified to be high risk for injury and require increased supervision may be placed on 1:1 if indicated by IDT assessment. Residents who require increased supervision will be assessed by the IDT and interventions will be care planned and communicated to direct care staff on the C.N.A. eare card.	

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F 323	Continued From page 36 8:15 PM, documented, "Resident not steady on his legs, weakness noted. Resident trying to get up, got up and fell on the floor. Res[ident] has dementia, poor safety awareness." Interventions added after fall included a concave mattress and anti-rollbacks on the wheelchair, however it could not be determined how anti-rollback breaks were an appropriate intervention when the resident was not in his wheelchair when he fell. A physician visit report, dated, 3/18/15, documented the physician was notified the resident fell on his right hip. The physician's evaluation documented the resident was able to bear some weight on his right hip, some pain at the left hip, some tenderness of the left knee, and pain with hip flexion. The resident was transferred to the hospital, where he was admitted on 3/18/15 and discharged back to the facility on 3/24/15 after a "left hemiarthroplasty" for his left hip fracture. A Nurse's Note, dated 3/19/15, when the resident was still in the hospital, documented, "Res[ident] cont[inues]to be in a room at nurses station for [increased] observation. Alarms in place. Res[ident had been [with] sitters, but had weaned off r/t [related to no] evidence of need." NOTE: On 4/20/15, from 1:55 PM to 2:20 PM, six staff at the nurses station and ten staff members walking past the resident's room were observed not to perform any type of check on the resident. The following interventions were added to the resident's Fall care plan: 3/24/15 - 24-hour sitter, discontinued 3/27/15 3/24/15 - Concave mattress, discontinued 3/30/15 3/27/15 - Change sitter to 8 PM -8 AM,	F 323	The primary nurse will be responsible for following the care plan. The unit managers will complete routine rounds to ensure supervision and interventions are followed. On 4-28-15 Nursing staff and the Maintenance Director were re-educated by the DON on checking the Hoyer lift for safety clips prior to using for resident transfer and to report concerns to the Administrator. On 4-28-15 Nurse Managers were re-educated on continued assessing, implementing, and documenting identified needed changes to safety interventions for high risk for fall residents including monitoring residents who require increased supervision or frequent visual checks. On 5-18-15 facility staff was re-educated on the increased observation needs of high fall risk residents and frequent visual checks of cognitively impaired fall risk residents.	

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F 323	Continued From page 37 discontinued 3/26/15 (date discrepency not explained) 3/29/15 - 15 minute checks between 8 AM-8 PM, discontinued 3/31/15 3/30/15 - Mat next to bed 3/31/15 - "Change 15 minute checks to 24 hours day..." [No specific description or times provided by the facility] Nurses Notes, dated 3/24/15, documented, "Resident is at baseline mentation, which is confused ... Concave mattress in place. Will do [sic] 1:1 sitter [for] 72 hours but review daily regarding safety. A physician's note, dated 4/15/15, documented, "The patient was seen today acutely in follow up of left hip pain. The patient has been working with therapy and seemed to be doing fairly well. He was noted yesterday, but particularly this morning, to have some increased pain in the left hip. He is guarding the area. There is some increase in swelling and abduction. The patient does not allow for any movement of the leg due to the discomfort." On 4/15/15 at 5:50 PM, the resident was transported to the hospital and diagnosed with a dislocation of the left hip related to a fall. A Hospital Consultation note documented the 4/15/15 hospital admission was related to a fall, which resulted in a dislocated left hip verified by X-ray in the emergency room. The physician documented, "The patient was sent in from [the facility] after [he] had a fall ... the patient was taken to the OR [operating room] for a closed reduction [surgical repair]."	F 323	MONITORING 4. Beginning 5-29-15 Maintenance Director or designee will complete audits of 3 Hoyer lifts and the DON or designee will audit 5 charts and perform visual observations of cognitively impaired residents who have a history of falls weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that the Hoyer bar have safety clips in place and are functional, and to ensure that residents that are high risk for falls, interventions for safety and supervision meet the residents needs. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Maintenance Director and the Director of Nursing will be responsible for monitoring and follow- up. Date of Compliance: 5-29-15	

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F 323	Continued From page 38 Facility Incident and Accident Reports from 11/20/14 to 4/20/15 did not include a report for the hospital-identified fall on 4/15/15. On 4/23/15 at 11:05 AM, the DNS was interviewed about the identified concern and asked to provide a timeline for the resident's falls that included interventions implemented after each fall. On 4/24/15 the timeline was received, which did not resolve the identified concern. On 4/24/15 at 11:15 AM, the Administrator was notified of the concern. Additional information received from the facility on 4/27/15 did not resolve the concern. The facility failed to ensure a resident with a subarachnoid hemorrhage who developed significant medical and cognitive decline received adequate care and supervision to prevent multiple falls which resulted in fractures of the resident's left facial bone and left hip fracture, and a subsequent dislocation of the left hip. 2. Resident #2 was admitted to the facility on 6/16/08, and readmitted on 7/26/13, with multiple diagnoses including multiple sclerosis, muscle weakness, and contractures. The resident's most recent annual MDS Assessment, dated 1/28/15, documented the resident was moderately cognitively impaired and needed total assistance of at least 2 staff for transfers and toilet use, and had experienced a fall with injury.	F 323		

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F 323	Continued From page 39 An undated Fall Risk Assessment documented the resident was at high risk for falls. The fall care plan, initiated on 12/22/08, documented interventions that the resident required a Hoyer (mechanical) lift with the assistance of 2 staff for transfers. An Incident Report (IR), dated 1/11/15 at 1:45 PM, documented Resident #2 fell when the front left loop of the Hoyer came off as staff were lifting the resident. The IR documented the safety latch that held the loop was missing from the Hoyer and the resident was lowered to the floor by two CNA's. The resident experienced a 1 cm laceration to the back of his head as a result of the fall. The IR documented the incident could have been prevented and the Hoyer was taken out of commission until the safety clip could be replaced. An Incident Witness Account by CNA #6, dated 1/11/15, documented the use of the Hoyer lift when transferring the resident to his bed, and that the sling strap slipped off the hook due to missing safety clip on the Hoyer. The facility provided an undated Safe Lifting and Movement of Residents policy which documented guidelines for appropriate techniques and devices to lift and move residents. The policy documented: * "9. Maintenance staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order.; and, * 11. Safe lifting and movement of residents is part of an overall facility employee health and safety program, which: A. Involves employees in	F 323		

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F 323	Continued From page 40 identifying problem areas and implementing workplace safety and injury-prevention strategies...D. Continually evaluates the effectiveness of workplace safety and injury-prevention strategies." On 4/22/15 at 3:00 PM, the DNS stated the Hoyer had six hooks and the latch was to prevent the Hoyer sling from coming out of the hook. She stated the safety loop should have been in place. The DNS stated, "I think they [staff] use the Hoyer so much they don't necessarily look at the whole thing from top to bottom. This incident was brought through the QA Process, maintenance did a 100% audit check and there was 1:1 training with the CNA's involved." On 4/24/15 at 11:30 AM, the Administrator and DNS were made aware of the concern regarding falls. On 4/27/15 at 4:32 PM, the facility provided additional information, which included a 1/12/15 Root Cause Analysis that documented, "The hoyer sling hooks were all hooked up to hoyer hooks. The resident was in his chair, which leaves some slack in the sling for the top hooks. The CNA's that were doing the transfer didn't notice that when they began to raise the resident up that one of the sling hooks was coming off the hoyer hook. The hook came all the way off during the transfer. The CNA's reacted as quickly as they could and attempted to guide his shoulders down. If [sic] was only his upper body that was falling back. They slowed his fall but could not prevent his head from touching the ground and the resident sustained a small abrasion to the back of his head...There was discovered to be a missing clasp for one of the top hooks which	F 323		

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F 323	Continued From page 41 prevents the sling from coming off the hook even with slack." The information provided by the facility on 4/27/15 did not resolve the fall concern for Resident #2.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, it was determined the facility did not ensure 1 of 14 residents (#5) was provided with sufficient hydration. This deficient practice had the potential for harm if the resident developed increased confusion, cardiac abnormalities, acute renal failure, and/or skin breakdown. Findings include: Resident #5 was admitted to the facility with multiple diagnoses, including Clostridium Difficile, urinary tract infection, acute respiratory failure, pneumonitis, and dementia. The resident's Significant Change MDS assessment, dated 3/4/15, coded the resident required extensive assistance of one person for eating and was severely cognitively impaired. The Hydration care plan, dated 3/4/15, documented the resident was at risk for dehydration related to dementia and decreased mobility. Interventions included offering 120 ml	F 327	F 327 SPECIFIC RESIDENTS 1. On 4-28-15 Resident #5 was re-assessed by Occupational Therapy, for impaired functional ability, and interventions were initiated and care planned. On 4-29-15 the DON reassessed resident for hydration needs and concerns were addressed at that time. OTHER RESIDENTS 2. On 5-5-15, residents requiring assistance with eating and drinking were visualized by Occupational Therapy to determine if functional limitations were impeding their ability to get adequate fluids no concerns were identified. On 5-22-15 the Assistant Director of Nursing (ADON) reviewed other resident's hydration needs; concerns were addressed at that time.	

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TRINITY MISSION HEALTH & REHAB OF HOLLY	2105 12TH AVENUE ROAD NAMPA, ID 83686

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F 327	Continued From page 42 [milliliters] of fluid with each medication pass and documenting the amount taken. The following observations were made during the survey process: * 4/20/15 - from 11:35 AM to 3:20 PM: Resident #5's 650 ml water mug was full, but out of the resident's reach. The resident's lips were dry and chapped, his head was tipped back and mouth open, and his tongue was dry and enlarged. * 4/20/15 from 11:35 AM to 3:20 PM: CNA #6, LN #14, and LN #15 were observed working with the resident, however none of these staff offered fluids before, during, or after cares. *4/21/15 - 8:21 AM: Resident #5's 1000 ml water mug was full and on the dresser behind the bed and out of the resident's reach. The resident's lips were chapped and cracked, and his mouth was open and visibly dry. * 4/21/15 - from 9:15 - 9:30 AM: LN #14 and LN #16 served fluids to the resident with total assist and cues to open mouth, drink and swallow. LN #14 said the water jug was too heavy for the resident to pick up. LN #14 said resident took 3 small sips of water. At the end of cares, 240 ml of water and hot cocoa were placed on the bedside table and LN #14 left the room. * 4/21/15 - 9:35 AM: The resident's mouth was open. The bedside table was over the resident in a high position. When asked, the resident was unable to lift his arms, locate the water, or pick it up when asked. * 4/21/15 - 11:20 AM: Residents mouth was open during Occupational Therapies and his hands had sunken areas between the bones of his hands. 4/21/15 - 2:30 PM: 1000 ml mug was full, on the bedside table at the end of the resident's bed and out of reach. The resident's mouth was open, visibly dry, and his lips were cracked.	F 327	SYSTEMIC CHANGES 3. Root cause analysis revealed staff did not recognize risk factors for poor hydration on Resident #5 and limitations for residents to obtain hydration related to resident's change of condition from re-admission on 4-17-15. The IDT/Supervisor will complete routine rounds to ensure that the resident's water picture is in reach. The following systemic changes were implemented: Residents identified that require assistance with hydration will be provided fluids through: Med pass, Hydration rounds, meals, activities, and C.N.A.s to offer fluid before or after provision of care. Water pitcher will be placed accessible to residents identified to be able to drink fluids without assistance or supervision. Estimated daily fluid intake will recorded on C.N.A. ADL Sheets. Meal and fluid intake will be evaluated quarterly and PRN by the Registered Dietician (RD). Plan of care will be updated as needed. On 5-5-15 admission nurses and IDT were re-educated by the Director of Nursing on assessing residents for adequate hydration and limitations that can impede residents from obtaining or maintaining adequate hydration and care planning those interventions to include fluids	

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F 327	Continued From page 43 4/22/15 - from 8:15 - 8:45 AM: The resident was falling asleep while LN #13 offered the resident his chocolate shake. The resident's orange juice and water was not offered. The resident was taken back to his room and LN #13 stated the resident was falling asleep because "he got pretty good pain medication management this morning." 4/23/15 - 9:03 AM: CNA #17 stated, the resident's mug was too heavy for him to pick up and it had to be handed to him for him to drink from it. CNA #17 offered the resident his water and the resident stated, "I don't like cold." CNA #17 said she knows when the resident needs fluids by "just looking at him, if his mouth is open," and stated the resident is given "just what he will drink." When asked how it is identified if the resident is receiving too little or too much fluid, CNA #17 stated there was not a reference form identifying how much to offer. 4/23/15 - 9:45 AM: The resident asked CNA #17 for coffee, which the CNA brought; CNA #17 did not offer the coffee to the resident, but rather placed it on the resident's bedside table, which was across the room and out of the resident's reach. CNA #17 then exited the room. On 4/22/15, RD #18 stated Resident #5's fluid intake should be 1700-2350 ml a day, she was at the facility just once a week, and the most recent calculated daily average she had for Resident #5's fluid intake was 440 ml. RD #18 stated she attends risk management meetings, where she presents her findings, and from there the DNS completes resident care plans. On 4/23/15, at 5:00 PM, The Administrator was notified of the findings. No further information was provided.	F 327	offered by therapy and the licensed nurse with medication pass. Also to communicate changes in resident's hydration needs with changes of condition. Facility staff were re-educated on 5-5-15 by the Staff Development Coordinator on encouraging hydration, ensuring fluids are available at the bedside within reach, and assisting residents with fluid intake and reporting concerns to the licensed nurse. 4. Beginning 5-29-15 an audit of 5 charts will be reviewed by interdisciplinary team. The IDT/Supervisor and will complete routine walking rounds week to ensure fluids are available and with in reach, the Staff Development Coordinator or designee will complete rounds 3 times a week and observe that fluids are being offered during cares weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that resident's fluid intake meets hydration needs and physical impairments that would limit their ability to obtain adequate fluids is addressed and interventions are care planned, updated and communicated with noted changes of condition. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time.	

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F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to provide care and maintenance of a C-PAP mask for 1 of 11 sample residents (#11). The deficient practice had the potential to cause more than minimal harm if the resident developed infections from improper cleaning. Findings included: Resident #11 was admitted to the facility on 4/3/15 with diagnoses which included pneumonia and chronic kidney disease. The resident's 4/3/15 - 4/21/15 Medication Administration Record (MAR) included direction to staff to, "Wipe out C-PAP (continuous positive airway pressure) Mask daily." The MAR documented the mask had been wiped out 7 of the 19 days. On 4/23/15 at 10:10 a.m., the DON stated the facility had failed to ensure the mask was cleaned on a daily basis.	F 328	The Director of Nursing will be responsible for ongoing monitoring and follow up. Date of compliance: 5-29-15 F328 SPECIFIC RESIDENT 1. Resident # 11 no longer resides at the facility. OTHER RESIDENTS 2. On 4-28-15 Residents receiving CPAP treatments were reviewed by the SDC to ensure that CPAP cleaning schedule was completed and documented; concerns were addressed at that time SYSTEMIC CHANGES 3. Root cause analysis revealed Licensed staff did not document cleaning of the CPAP mask on the Medication Administration Record (MAR). The following systemic changes were implemented to ensure cleanliness of CPAP equipment. The Unit Mangers will complete routine audits of the CPAP mask to ensure that they are clean. The "Incoming nurse" will check MAR of the "outgoing nurse" during change of shift to ensure that the documentation is complete.	

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F 328	Continued From page 45 On 4/24/15 at 2:50 p.m., the Administrator and the DON were informed of the above concern. The facility provided no further information.	F 328	The SDC or designee will audit the MARs weekly to ensure that the documentations is complete. An Omission report will be completed for MAR omission identified. Omission report will be reviewed by DON or designee to address issues identified. On 4-28-15 Licensed Staff were re-educated by the SDC on cleaning CPAP mask and documenting routine scheduled cleaning of CPAP equipment on the MAR.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure each resident's drug regimen had adequate indications	F 329	MONITORING 4. Beginning the week of 5-29-15 Staff Development Coordinator or designee will audit 3 MAR's with the need to clean CPAP mask weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure CPAP mask cleanliness, and routine cleaning is documented per plan of care. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Director of Nursing is responsible for monitoring and follow-up. Date of compliance 5-29-15	

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F 329	Continued From page 46 for medication use. This was true for 2 of 4 (#s 3 and 9) residents sampled for behavior symptoms. Additionally the facility failed to ensure 2 of 7 sampled residents (#s 8, and 10) were reviewed for gradual dose reductions and failed to provide physician justification for duplicate therapy for resident #8. These failed practices placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included: 1. Resident #3 was admitted to the facility on 7/24/08, and readmitted on 7/23/13, with diagnoses which included pneumonia, depression and dementia. The resident's medical record included a 4/10/15 physician telephone order to increase Remeron to 30 mg at bedtime for depression with agitated features. The resident's 7/2/09 Behavior care plan documented a history of verbal aggression and delusions "associated with confusion, and repression related to diagnosis of dementia," and depression. Note: The care plan did not include how the behavior was exhibited or the nature/presentation of the resident's delusions. The Approach section of the care plan documented staff should encourage the resident to "relax and be tolerant" of other residents when irritated by noises; try to determine with the resident what triggered the behavior and "reinforce this" so he can begin a "new pattern of behavior;" discuss more acceptable ways/behavior; explain all procedures; provide	F 329	F329 SPECIFIC RESIDENT 1. On 4-27-15 Resident #3's care plan and Behavior Monitoring forms were updated to reflect current "specific" behavior triggers and current "specific" staff interventions. The care plan problems to include history of specific behaviors and delusions by the Licensed Social Worker (LSW). On 4-27-15 Resident #9's care plan was revised to current "specific" signs and symptoms of behaviors, mood/depression and the outdated interventions were resolved by the LSW. Resident #8 no longer resides at the facility. Resident #10 had a medication review by his primary care physician and Depakote reduction was implemented 4-22-15. On 4-27-15 the ADON reassessed Resident # 10 for recent decrease of Depakote related to report of increased behaviors. On 5-12-15 resident was assessed to have continued increased behaviors by the IDT and reviewed by the Physician on 5-13-15 and new orders were followed related to failed reduction of Depakote.	

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F 329	Continued From page 47 diversional activites; redirect away from other residents when verbally aggressive; aid in expressing feelings; and provide physical activity. If the resident were to become delusional, staff were directed to re-orient and reassure the resident and, when necessary, remove the resident from situations that triggered combative behavior Note: The care plan directed staff to encourage the resident to be tolerant of noise and to remove the resident from situations that triggered combative behavior. However it did not instruct staff to ensure he was in a quiet area as noise was an antecedent of the behavior, or to identify what would "trigger" combative behavior. The Psycho-Pharmalogical Record (behavior monitor) included: * Re-direct away from others * Attempt to determine cause of agitation and resolve * Offer reassurance/emotional support. * Allow space/time to calm himself. Neither the Approach section in the care plan nor the behavior monitor explained how staff were to encourage the resident to relax (such as soothing music, offering food or drink, etc.), or how to determine what triggered the targeted behavior. The care plan did not include what "a new pattern of behavior" was or what to say to reassure the resident if he was delusional. The care plan also did not identify a description of any previous delusions. On 4/23/15 at 10:30 a.m., the Social Service Designee (SSD) stated the behavior of verbal aggression was directed at staff and residents,	F 329	OTHER RESIDENTS 2. On 5-28-15 residents receiving psychoactive or duplicate medications were reviewed by the IDT for required GDRs and the need for supporting justification of duplicate therapy and concerns were addressed at that time. On 4-29-15, Licensed Social workers completed a facility wide review of mood/behavior care plans and behavior monitoring sheets, for specific interventions listed for staff to follow; concerns were addressed at that time. SYSTEMIC CHANGES 3. Root Cause analysis reveals that primary care physician's notes do not reflect justification for duplicate therapy and/or no GDR attempts. Facility was not reviewing non-psychoactive medications during the Psychotropic IDT review meeting, also it noted that the LSW was using vague terminology to describe behaviors and interventions. On 5-5-15 Director of Nursing educated the IDT on following medications being used for mood/behavior related diagnoses through psychotropic IDT review. This will now include non-	

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F 329	Continued From page 48 and consisted of using profanity and racial slurs. When asked how staff were to reassure the resident, the SSD stated another care plan directed staff to tell the resident he was safe. However, when asked where that care plan was located, the SSD stated she could not find it. When informed that the care plan for residents with dementia must include specific interventions, and then asked what the intervention "to allow space" meant, the SSD stated the resident would be required to go to his room or the dining room for about 15 minutes and then staff would reapproach. When asked to define a "poor mood," the SSD stated the resident would not respond to greetings or would not joke with staff. Additionally, the SSD stated diversional activities would be listed on the activity care plan, however the care plan did not include specific interventions that were readily available to save staff from flipping through numerous care plans to know how to intervene with the resident. 2. Resident #9 was admitted to the facility on 7/7/13 with diagnoses which included dementia with behaviors, anxiety, and glaucoma. The resident's 3/9/15 quarterly MDS assessment documented the resident was moderately cognitively impaired, had poor decision making, and required extensive assistance of 1 staff for transfers or to move about the facility. The resident's April 2015 Physician Orders (recapitulation) included orders for Sertraline 100 mg daily for depression with a start date of 11/21/14. The resident's 7/17/13 care plan for Mood/Psychosocial care plan documented the	F 329	psychotropic medications (Tegretol/Depakote, etc.). Also educated that audits of primary care physician notes will be reviewed to determine if contraindication is listed and supporting documentation is identified in the dictated notes on residents being reviewed through Psychotropic IDT review. Education provided that pain medication report will be reviewed weekly to audit for duplicate therapy. On 5-5-15 the LSWs were re-educated by the Administrator on the need to be specific on describing specific behaviors and interventions for direction to staff and to assist in determining effectiveness of medications used for behaviors. MONITORING 4. Beginning 5-29-15 the Assistant Director of Nursing and LSW or designee will complete audits of 5 chart weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure psychotropic medication and anticonvulsants used to treat a behavior or psychiatric diagnosis to ensure physicians notes to justify use are present, of duplicate therapy and or reason for GDR (contraindications) have supporting documentation. Unit Manager will review pain medication report to ensure any duplicate treatments are justified in the physician notes or requests for reductions will be made and the	

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F 329	Continued From page 49 potential for a decrease in mood. The care plan's "Approach" section directed staff to provide the resident with emotional support and reassurance as needed, and to assist the resident to activities the resident enjoyed. The Psycho-Pharmacological Record (PPR) documented signs and symptoms indicating the resident was depressed were exhibited by tearfulness, decreased appetite, and self isolation. Note: It was unclear how the resident would self-isolate as the resident was totally dependent on staff to move about the facility. The PPR documented staff were to provide reassurance and emotional support, and to redirect the resident to a diversional activity. The PPR did not include direction to staff regarding statements of reassurance (reminding the resident they were safe, of family support etc.) The care plan did not include what constituted a diversional activity. On 4/23/15 at 10:30 a.m., the SSD stated the resident exhibited signs of depression by being tearful and not responding to staff. The SSD, when informed if staff were not using the same criteria to document behaviors it would not be possible to evaluate if the medication was effective, stated diversional activities for the resident would include sensory stimulation and Rock'n RNA. On 4/24/15 at 11:05 a.m., CNA #10 and CNA #11 stated the nurses documented behaviors on the PPR. Both CNAs stated the CNA would	F 329	LSW mood and behavior care plans and interventions provide direction to staff to determine the effectiveness of the medication. The Assistant Director of Nursing Licensed and Social Worker will be responsible for monitoring and follow up. Date of Compliance: 5-29-15	

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F 329	Continued From page 50 document the behaviors on the back of the ADL sheet for the residents, but they did not know if the nurse reviewed the ADL sheets. On 4/24/15 at 11:15 a.m., LN #12 stated behaviors were documented on the PPR when CNA's "would tell " the nurse of the behaviors. LN #12 stated he/she was familiar with the resident and would know if a resident demonstrated a behavior by observing the resident. Note: Without identifying specific behaviors or consistently documenting specific behaviors, it would not be possible to determine whether the medication was effective. The Administrator and the DON were informed of the above concerns on 4/24/15 at 2:50 p.m. The facility provided no further information. Federal Guidance at F329 documented, "Duplicate Therapy refers to multiple medications of the same pharmacological class/category or any medication therapy that substantially duplicates a particular effect of another medication that the individual is taking." 3. Resident #8 was admitted to the facility on 2/24/14 with diagnoses which included end stage renal disease, bipolar disorder, anxiety, depression, and chronic pain. The resident's 11/10/14 Quarterly- and 2/9/15 Annual MDS Assessments documented the resident was cognitively intact and took antipsychotic, antianxiety and antidepressant medication daily.	F 329		

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F 329	Continued From page 51 a. Physician's Orders for April 2015 (Recapitulation Orders), documented the following: *9/18/14 - Clonazepam 0.25 mg (Benzodiazepine) take by mouth once daily at noon for anxiety; *9/22/14 - Clonazepam 0.5 mg take by mouth twice daily for anxiety; *3/11/15 - Xanax 0.25 mg (Benzodiazepine) take by mouth once daily for anxiety; *3/26/14 - Norco 10/325 mg take by mouth every 4 hrs PRN pain, do not give within 2 hrs of any routine pain med; *5/8/14 - Methadone 10 mg take by mouth three times daily for pain; *6/9/14 - Tylenol 325 mg take by mouth 1 to 2 every 4 hrs PRN for pain/temp; *9/9/14 - Norco 10/325 mg take by mouth once daily at 10 AM for pain; *9/22/14 - Norco 10/325 mg take by mouth once daily at 4 PM for pain; and, *3/27/15 - Morphine Sulfate Suspension 20 mg/ml give 0.5 to 1 ml SL (sublingually) every 1 hr PRN pain/shortness of breath. The resident's record did not include physician documentation for the justification of duplicate therapy for Benzodiazepine or pain medications. On 4/23/15 at 1:45 PM, the DNS was asked if there was physician justification for a long acting and short acting Benzodiazepine for Resident #8. The DNS stated, "I do not have physician justification for two Benzodiazepines or multiple pain medications." Federal Guidance at F-329 documented, "The purpose of tapering a medication is to find an	F 329		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY MISSION HEALTH & REHAB OF HOLLY	2105 12TH AVENUE ROAD NAMPA, ID 83686

(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 329	Continued From page 52 optimal dose or to determine whether continued use of the medication is benefiting the resident. During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated." b. Physician's Orders for April 2015 (Recapitulation Orders), documented the resident took Tegretol 500 mg twice daily for the diagnosis of bipolar disorder, with a start date of 5/22/14. The resident's record did not include documentation by a physician a gradual dose reduction (GDR) had been attempted or addressed for Tegretol, an Anticonvulsant medication, used to treat bipolar disorder. On 4/24/15 at 8:05 AM, the DNS stated the facility still had a month to try a GDR. However, when the surveyor explained the facility should have attempted to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated, the DNS stated, "I understand." 4. Resident #10 was admitted to the facility on 12/27/13 with diagnoses which included paralysis agitans, dementia with behaviors, and psychosis. The resident's 12/24/14 Annual- and 2/20/15 Quarterly MDS Assessments documented the	F 329		

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F 329	Continued From page 53 resident was severely cognitively impaired and took antipsychotic medication daily. Physician's Orders for April 2015 (Recapitulation Orders), documented the resident took Depakote Sprinkles 500 mg twice daily for the diagnosis of dementia with mood disorder, with a start date of 3/12/14. Record review did not include documentation by a physician a gradual dose reduction had been attempted or addressed for Depakote, an Anticonvulsant, used to treat dementia with mood disorder. On 4/23/15 at 4:15 PM, the DNS stated, "I don't see that a GDR for Depakote was attempted." On 4/23/15 at 5:00 PM, the Administrator and DNS were made aware of the concerns with duplicate therapy and gradual dose reductions. No further information was provided by the facility.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on Resident Council Meeting minutes, the Resident Group interview, test tray evaluation and staff interview, it was determined the facility failed	F 364	F364 SPECIFIC RESIDENT 1. On 4-27-15 the repairs to the plate warmer were completed and the Hall trays have maintained appropriate temperatures. On 5-1-15, 200 Hall cart meal trays were monitored by the Certified Dietary Manager (CDM) and were within temperature requirements for palatability. OTHER RESIDENTS 2. On 5-28-15 the CDM interviewed residents who were able to express their likes and preference for food related to the temperature of the food; no concerns were noted. SYSTEMIC CHANGES 3. A root cause analysis revealed the plate warmer needed repair and CDM had not communicated need	

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F 364	Continued From page 54 to prepare palatable food and provide a resident requested meals. This affected 3 of 7 residents who attended the Resident Group interview and had the potential to affect all residents who dined in the facility. This failed practice created the potential to negatively affect the residents' nutritional status and psychosocial well-being related to unpalatable food. Findings included: The 1/5/15 Resident Council meeting minutes documented, under the section Complaints/Concerns, "Cold Hall Trays/[CDM Name] has been made aware and stated to the residents that she is working on this issue." The 2/2/15 Resident Council meeting minutes documented, under the section Last Month's Complaints/Concerns: Follow Up/Issues Resolved, "Cold Hall Trays/This issue has been resolved." On 4/21/15 at 3:00 PM, during the Resident Group interview, 3 of 7 residents said breakfasts were still often served cold. On 4/22/15 at 8:19 AM, a breakfast meal test tray was evaluated by the survey team and by the CDM. The test tray included mechanical soft sausage with a temperature of 91-degrees Fahrenheit (F) and the CDM stated, "It's 91-degrees, so it's going to be cold." The pureed sausage had a temperature of 103 F, pureed eggs had a temperature of 105 F, and scrambled eggs, the temperature of which was not measured. The mechanical soft and pureed sausage, and the pureed eggs were determined not to be hot and were unpalatable. On 4/22/15 at 8:23 AM, the CDM was asked what	F 364	for repair to the Maintenance Director. The following systemic changes were implemented for food palatability, to maintain preferred food temperature and honor food preferences. Resident who consumes < 50% meal will be offered alternate food, Resident Food Preferences will be reviewed quarterly and PRN. The Administrator will meet with the residents on Resident Forum every 2 weeks and as needed to obtain and discuss resident's feedback and concerns related to food. The Resident Forum will provide an ongoing communication for residents' concerns and feedback. The Dietary Staff were re-educated on 5-5-15, by the Administrator on reporting equipment in need of repair to the Administrator timely. On 5-5-15 dietary staff were re-educated by the Dietary Manager on palatability of foods and the routine use of the plate warmer to maintain food temperatures and palatability. MONITORING 4. Beginning 5-29-15 the Administrator or designee will receive and audit the last tray served from the last hall cart, and the dietary manager will conduct weekly resident interviews regarding palatability and temperatures weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that the food is at the required	

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F 364	Continued From page 55 she thought of the pureed eggs and she stated, "It could be warmer." She also said the scrambled eggs looked "to be too watery." She said she thought the facility had fixed the food temperature issue, however there was a recent issue with the plate warmer not working correctly. On 4/22/15 at 4:25 PM, the Administrator, DNS, and Clinical Service Coordinator were informed of the issues. No further information was provided by the facility.	F 364	temperature for palatability. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Administrator will be responsible for monitoring and follow-up.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure food was prepared in a sanitary environment. This had the potential to affect 16 out of 16 sampled residents (#s 1-16) and any resident who ate their meals in the facility. This created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included: On 4/20/15 at 2:00 PM, the Dietary Manager	F 371	Date of compliance 5-29-15 F371 SPECIFIC RESIDENT 1. On 4-20-15 Dietary Manager added sanitation solution to the QUAT bucket to the required concentration (150-200 ppm). Dietary Manager applied hair net immediately upon awareness that net had not been applied earlier. On 4-22-15 the 6 burner stove was degreased and buildup on the burners removed by the Dietary Manager. On 5-22-15 the CDM inspected the 6 burner stove for cleanliness, and the sanitation concentration were within the guidelines as required; no additional concerns noted. On 5-22-15 the CDM and other dietary staff were monitored for use of hair net by the DON and hair net was noted to be in use as required.	

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F 371	Continued From page 56 (DM) accompanied the surveyor during the initial tour of the kitchen. The following was determined: 1. One of 2 red plastic buckets, located at the double sinks, contained what appeared to be sanitizing solution. The DM placed a test strip into the solution located in Bucket #1. The test strip did not change color and registered at "0" concentration. The DM stated the quaternary sanitizing solution should register a minimum of 150 parts per million (ppm) and needed to be re-mixed. She stated she would do an in-service with her staff. Federal guidance at F371 documented, "... the recommended sanitization concentrations are...QAC space (Quaternary) 150-200 ppm concentration ..." 2. The six-burner stove top was observed to have a build-up of black and brown grease and grime on each of the six burners. The DM stated the condition of the six-burner stove top was unacceptable. She stated the stove top burners were heavy, which made them difficult to clean and thought they had last been cleaned approximately two weeks prior. The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris...(5) At any time during the operation when contamination may have occurred." Subpart 602.13, Nonfood-Contact Surfaces, indicated, "Nonfood-contact surfaces of equipment shall be	F 371	OTHER RESIDENTS 2. On 5-22-15 the residents residing in the facility were reviewed by the ADON for concerns by the nurse managers related to receiving items from the kitchen; no concerns were noted. SYSTEMIC CHANGES 3. Root cause analysis revealed dietary staff did not add quaternary to sanitation to 1 of 2 buckets being used. Stove top cleaning was not on a documented cleaning schedule. Dietary Manager was preoccupied with obtaining information being asked for during the survey, was nervous and forgot to apply hair net upon entrance into the kitchen. On 4-21-15 and 5-22-15 the dietary staff were re-educated by the Dietary Manager on documenting and monitoring the required cleaning of the 6 burner stove. On 4-21-15 and 5-22-15 the dietary staff were re-educated on wearing hair nets and monitoring co-workers to ensure hair nets are worn whenever staff are beyond the red sanitation line. On 4-21-15 and 5-22-15 dietary staff were re-educated by the Dietary Manager on required procedure for adding sanitation solution to the QUAT bucket daily and procedure for checking and documenting the QUAT concentration levels before use. Beginning 5-4-15 the dietary staff will sign off and have supervisor initial that the 6 burner	

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F 371	Continued From page 57 cleaned at a frequency necessary to preclude accumulation of soil residues." On 4/22/15 at 7:45 AM, the DM was observed in the kitchen at the double sinks without a hairnet. She stated, "I know I should have a hairnet on." The 2009 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles." On 4/22/15 at 4:25 PM, the Administrator was informed of the findings. The facility did not provide any additional information.	F 371	stove is in a clean condition at the end of the day or before use in the mornings. Beginning 5-4-15 the dietary staff will have two staff document and sign off on the QUAT levels in the sanitation bucket. MONITORING 4.Begining the week of 5-29-15 the Dietary Manager or designee will visualize and complete 3 audits of the signed cleaning schedule for the 6 burner stove, complete 3 audits of the documented sanitation bucket QUAT levels, and the Administrator or designee will perform 5 audits for hair nets being worn by the staff behind the sanitation line weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that the stove is clean and has no grease build-up that the Quat concentration in the sanitation bucket is being maintained as required, and that hair nets are being worn consistently as required . A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. Ensure. The Dietary Manager and the Administrator will be responsible for monitoring and follow up. Date of compliance: 5-29-15	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425		

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F 425	Continued From page 58 supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility's consulting pharmacy did not ensure psychopharmacological medications had been reviewed for gradual dose reductions (GDRs) during the first year of initiation. This was true for 2 of 11 residents (#s 8 & 10) sampled for pharmacy services. This deficient practice had the potential to cause more than minimal harm should residents continue to receive a higher dosage of medication than necessary. Findings included: 1. Resident #8 was admitted to the facility on 2/24/14 with diagnoses which included end stage renal disease, bipolar disorder, anxiety, depression, and chronic pain. The resident's 11/10/14 Quarterly- and 2/9/15 Annual MDS Assessments documented the resident was cognitively intact and took antipsychotic, antianxiety, and antidepressant	F 425	F425 SPECIFIC RESIDENT 1. Resident # 8 no longer resides at this facility. Resident # 10 has had his medication list reviewed by the primary physician and a dose reduction made to Resident #10's Depakote. On 4-27-15 the ADON reassessed Resident # 10 for recent decrease of Depakote related to report increased behaviors. On 5-12-15 Resident #10 was assessed to have continued increased behaviors by the IDT and reviewed by the Physician on 5-13-15 and new orders were followed related to failed reduction of Depakote. OTHER RESIDENTS 2. On 5-22-15 the nurse managers reviewed residents for required GRDs and resident's receiving duplicate therapy to ensure that requirements are met; concerns were addressed at that time. SYSTEMIC CHANGES 3. Root Cause Analysis shows that the pharmacist consultant did not recommend dose reductions timely and the facility did not reduce the medication or provide documented justification for no reduction. The following systemic changes were	

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F 425	Continued From page 59 medication daily. Physician's Orders for April 2015 (Recapitulation Orders), documented Resident #8 received Tegretol 500 mg twice daily for the diagnosis of bipolar disorder, with a start date of 5/22/14. The resident's record did not include documentation a gradual dose reduction (GDR) had been attempted or addressed for Tegretol, an anticonvulsant medication used to treat bipolar disorder. 2. Resident #10 was admitted to the facility on 12/27/13 with diagnoses which included paralysis agitans, dementia with behaviors, and psychosis. The resident's 12/24/14 Annual- and 2/20/15 Quarterly MDS Assessments documented the resident was severely cognitively impaired and took antipsychotic medication daily. Physician's Orders for April 2015 (Recapitulation Orders), documented the resident took Depakote Sprinkles 500 mg twice daily for the diagnosis of dementia with mood disorder, with a start date of 3/12/14. The resident's record did not include documentation by a physician a gradual dose reduction had been attempted or addressed for Depakote, an anticonvulsant, used to treat dementia with mood disorder. On 4/23/15 at 5:05 PM, the facility's pharmacy consultant acknowledged gradual dose reductions had not been attempted as stipulated in the federal regulation. The pharmacist stated, "Yes, you are right."	F 425	implemented related to completing GDRs timely as required. The pharmacy consultant will track residents utilizing out of class psychotropic medication for mood and behaviors, to complete reviews and recommendations timely. Residents utilizing out of class psychotropic medication will be identified by the IDT. The ADON will track psychotropic medication and compare to the monthly pharmacy report to ensure GDR recommendations are followed as required. The IDT will monitor usage, effectiveness of use, including gradual drug reduction quarterly and PRN. On 5-5-15 the DON re-educated the IDT on reviewing resident's drug regimen for necessary reduction or need for justification of duplicate therapy of medication as required. On 5-21-15 the contracted pharmacy consultant was re-educated by the contracted Clinical Operations Manager on the requirement for monitoring and recommendations for GDRs and duplicate therapy. MONITORING 4. Beginning 5-29-15 the ADON or designee will audit pharmacist consultant recommendations and compare to facility GDR review schedule and resident on duplicate therapy weekly for 4 weeks, every other week for 4 weeks, then monthly for 2 months and quarterly	

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F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 431	thereafter to ensure that medications that require GDR or justification for duplicate therapy are reviewed and recommendations from the pharmacist are followed. The Assistant Director of Nursing is responsible for monitoring and follow up. Date of compliance 5-29-15 F431 SPECIFIC RESIDENT 1. On 4-22-15, Staff Development Coordinator removed the 2 expired medications from the medication cart and disposed of and/or replaced with non- expired medications. On 5-5-15 the DON complete another audit of medication cart; no concerns were noted. OTHER RESIDENTS 2. On 5-5-15 the DON complete another audit of medication carts; no concerns were noted. SYSTEMIC CHANGES 3. Root cause analysis revealed licensed staff did not notice 2 expired medications with the inspection of the mediation carts and remove and replace medications that were expired at that time. The following systemic changes were implemented to monitor for expired medications: The night nurse will check medication cart for expired medication weekly. Expired medication will be discarded and replaced as indicated. The unit managers will also check the medication cart for expired medications weekly.	

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F 431	Continued From page 61 determined the facility failed to ensure expired medications were not available for administration to residents. This created the potential for sub-optimal efficacy for any resident who could have received the expired Ferrous Gluconate tablets or Systane Ultra Lubricant Eye Drop vials for Random Resident #24. Findings included: On 4/22/15 at 11:20 AM, during an inspection of the Team 2 Medication Cart with LN #5 in attendance, a box containing 78 single dose tablets of Ferrous Gluconate used for general administration was found to have an expiration date of 2/2015. Additionally, a box of Systane Ultra Lubricant Eye Drops containing 4 vials for Random Resident #24 was found to have an expiration date of 10/2014. LN #5 stated, "I missed these as I was checking my cart." On 4/22/15 at 12:20 PM, the DNS was made aware of the expired medications in the Team 2 Medication Cart and stated, "Those should not be in the cart." On 4/22/15 at 4:25 PM, the Administrator and DNS were made aware of the concern regarding expired medications. No further information was provided by the facility.	F 431	Over the counter medication expiring in 30 days or less will be discarded and replaced by the nurse managers Medication such as single dose vials; single dose tablets that get separated from original container will be discarded and replaced by the nurse managers. On 5-18-15 Licensed Staff were re-educated by the Staff Development Coordinator on monitoring medication expiration dates and removing expired medications from the medication carts prior to expiration date. On 5-18-15 the night shift Licensed staff were re-educated by the Staff Development Coordinator regarding inspection of each medication cart for expired medications and storing medications as required. MONITORING 4.Beginning 5-29-15 Nurse Managers will audit facility medications carts weekly for 4 weeks, then every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that staff are inspecting carts and removing medications prior to expiration date as required. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Director of Nursing is responsible for monitoring and follow up. Date of compliance 5-29-15	

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Bureau of Facility Standards

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STREET ADDRESS, CITY, STATE, ZIP CODE: 2105 12TH AVENUE ROAD, NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the annual State licensure and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Sherri Case, BSW, LSW Amy Barkley RN, BSN Becky Thomas, RN Becka Watkins, RN	C 000	C 295 State Tag 1. Dietary Manual for the front nurse's station was placed at the nurse's station on 5-1-15. 2. Residents residing on the 100 and 200 hall have the potential to be effected. 3.On 5-1-15 the Dietary Manager was reeducated by the Administrator to ensure that dietary manuals are readily available at nurse's stations and in the kitchen. 4.Beginning 5-1-15 the Dietary manager will audit the kitchen and nurses stations weekly for 4 weeks, then every other week for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure that a diet manual is present. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. Dietary Manager is responsible for monitoring and follow-up. Date of compliance: 5-29-15	
C 295	02.107,04,d Current Diet Manual d. A current diet manual approved by the Department and the patient's/resident's physician shall be available in the kitchen and at each nursing station (the Idaho Diet Manual is approved by the Department). This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a diet manual was located and available for use at the front nurses station. This affected 10 sampled residents (#s 2,3,5,8,9,10,12,13,15, & 16) and had the potential to affect all resident on the 100 and 200 halls. Findings included: On 4/22/15 at 9:45 AM, the surveyor asked for the front nurses station copy of the diet manual. The ADON stated, "I'm not finding it; I'm told our dietary manual is in the kitchen." On 4/22/15 at 9:50 AM, the DM stated, "I have never personally seen it in the front nurses station."	C 295		

RECEIVED
JUN 22 2015
FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 6-19-15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MDS001260		04/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY MISSION HEALTH & REHAB OF HOLL	2105 12TH AVENUE ROAD NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 295	Continued From page 1 On 4/22/15 at 4:25 PM, the Administrator and DNS were made aware of the concern. No further information was provided by the facility.	C 295		

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
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FILE COPY

May 20, 2015

Monica K. Brutsman, Administrator
Trinity Mission Health & Rehab of Holly, LLC
2105 12th Avenue Road
Nampa, ID 83686-6312

Provider #: 135094

Dear Ms. Brutsman:

On **April 24, 2015**, an unannounced on-site complaint survey was conducted at Trinity Mission Health & Rehab of Holly, LLC. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted on April 20-24, 2015.

The following observations were completed:

- One resident was observed for tube feedings.

The following documents were reviewed:

- The entire closed medical record of the identified resident;
- A potential abuse investigation for the identified resident;
- 16 other resident's records were reviewed for quality of care concerns;
- The facility's grievance file from November 2014 to April 2015;
- Resident Council minutes from December 2014 to April 2015;
- The facility's Incident and Accident reports from November 2014 to April 2015; and,
- The facility's Allegation of Abuse reports from November 2014 to April 2015.

The following interviews were completed:

- The Director of Nursing Services was interviewed regarding tube feedings, as well as other Licensed Nurses and Certified Nurse Aides working in the facility.

The complaint allegations, findings and conclusions are as follows:

Complaint #6954

ALLEGATION #1:

The complainant stated the facility did not provide appropriate care for tube feedings, which included not having feeding pumps available. The complainant stated the facility overfed residents with using a gravity administration method, which caused residents to aspirate liquid nutrition, leading to one resident's death.

FINDINGS #1:

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

The identified resident's closed medical record documented the resident was admitted on hospice with multiple diagnoses, which included pneumonia, chronic airway obstruction and a history of recurrent aspiration pneumonia.

The physician's admission orders for the identified resident, documented the resident was to receive liquid nutrition at the rate of 70 milliliters per hour on a continual basis. However, the nurses' notes and allegation of abuse Investigation Summary documented when the resident was admitted, the facility did not have a working tube feeding pump to deliver the liquid nutrition as ordered. The resident's spouse had brought a tube feeding pump with him/her and offered to have the facility use it, but the nurse declined the offer due to lack of staff training with that particular pump.

The notes and investigation also documented the resident's spouse informed the nurse that he/she recently used bolus or gravity feedings for the resident and told the nurse the amount he/she used. The next morning, the same nurse learned there was still no tube feeding machines available for the resident and upon hearing this information, the nurse clarified the tube feeding order without physician's oversight. The clarified order documented to administer five cans of nutrition in the morning and two cans in the afternoon via bolus feeding. This amount equaled the original ordered amount of liquid nutrition.

The resident's medical record, notes and investigation documented the resident received five cans of nutrition at 8:30 a.m. and then two cans at 2:00 p.m. via bolus, the day of the clarified order. The documentation also indicated at approximately 10:30 a.m. and 3:00 p.m., the resident had vomited a small amount of what appeared to be nutritional liquid.

The notes and investigation documented, the resident was found to be expired at approximately

3:00 p.m. that same day. The resident's death certificate documented the resident's cause of death was from hypoxemia (oxygen deficiency) due to respiratory arrest, due to "aspiration likely."

The Director of Nursing Services was interviewed regarding the tube feeding issues. She said the nurse in question, who was no longer employed at the facility, should have clarified the order with the identified resident's physician and not the resident's spouse. She said the facility would have had plenty of tube feeding machines available and said the hospice agency may not have had a machine available, but the resident could have used one of the facility's tube feeding machines in the interim. She acknowledged the resident had received 24 hours' worth of liquid nutrition or seven cans in the two feedings, within an approximately six-hour period. She said the resident would have felt full but did not say the resident was overfed. She said residents who were on tube feedings and who vomit were always a concern. When asked if the resident aspirated in this case, she said it was hard to say due to the resident's pneumonia and other medical conditions and medications given.

The facility was not cited for the deficient practice because the incident occurred prior to the facility's last annual Recertification and State Licensure survey.

CONCLUSIONS:
Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the facility used Foley catheter bags to administer tube feeding liquid nutrition.

FINDINGS #2:

The closed medical record for the identified resident and one other resident, who resided in the facility, were reviewed for tube feeding supplies. The records did not document Foley catheter bags had been used for tube feedings.

Tube feeding and tube feeding supplies were observed for a resident who resided in the facility. Foley catheter bags were not observed to be used for the resident's continuous tube feedings.

The Director of Nursing Services was interviewed regarding the use of Foley catheter bags for tube feedings. She said she the facility would never use Foley bags used for tube feedings and said the connectors were different and they physically would not be able to be connected.

Based on observations, records review and staff interview, it was determined this allegation could not be substantiated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated resident beds were not elevated high enough during tube feedings.

FINDINGS #3:

The closed medical record and a potential abuse investigation for the identified resident were reviewed for bed height during tube feedings. One other resident's medical record, who resided in the facility, was reviewed for bed height during tube feedings. The records indicated the head of the beds were elevated at or above the 30-degree standard for tube feedings and/or the residents were sitting up on the bed or in a chair.

The bed and wheelchair elevations were observed for a resident who resided in the facility and who required continuous tube feedings. The resident was observed multiple times and the bed and/or wheelchair elevation was at or above 30 degrees each time.

The Director of Nursing Services was interviewed and she said the notes and investigation documented the identified resident's bed was at or above 30 degrees or the resident was sitting up on the bed or in a chair.

Based on observations, records review and staff interview, it was determined this allegation could not be substantiated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

NS/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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PHONE 208-334-6626
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May 15, 2015

Monica Brutsman, Administrator
Trinity Mission Health & Rehab of Holly, LLC
2105 12th Avenue Road
Nampa, ID 83686-6312

Provider #: 135094

Dear Ms. Brutsman:

On April 24, 2015, an on-site revisit of your facility was conducted to verify correction of deficiencies noted during the survey of February 5, 2015. Trinity Mission Health & Rehab of Holly, LLC was found to be in substantial compliance with health care requirements as of **March 5, 2015.**

Your copy of a Post-Certification Revisit Report, Form CMS-2567B listing the deficiencies that have been corrected is enclosed.

Thank you for the courtesies extended to us during our follow-up revisit. 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,

D. Scott

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

DS/dmj
Enclosures