IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

May 29, 2015

G. David Chinchurreta, Administrator
Sunny Ridge
2609 Sunnybrook Drive
Nampa, ID 83686-6332

Provider #: 135102

Dear Mr. Chinchurreta:

On **May 8, 2015**, a survey was conducted at Sunny Ridge 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 **June 11, 2015**. Failure

to submit an acceptable PoC by **June 11, 2015**, may result in the imposition of civil monetary penalties by **July 1, 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 **June 11, 2015**. If your request for informal dispute resolution is received after **June 11, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

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

NS/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135102		05/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY RIDGE	2609 SUNNYBROOK DRIVE 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	F 000		
	The following deficiencies were cited during the annual federal recertification survey and complaint surrvey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Amy Barkley, RN, BSN Becka Watkins, RN, BA The survey team entered the facility on May 4, 2015 and exited on May 8, 2015. Definitions: Survey Definitions: ADL = Activities of Daily Living BID = Twice per day BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NPE = Nurse Practice Educator PRN = As Needed WC = Wheelchair			
F 226 SS=G	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		7/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/10/2015

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

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F 226	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews; record review, review of abuse policies and procedures, and review of abuse investigation reports, it was determined the facility failed to thoroughly document an investigation of a resident complaint of staff misconduct. This was true for 1 of 10 (#10) sampled residents. Resident #10 experienced psychosocial harm when the resident became tearful and expressed fearfulness that her reports of staff misconduct would result in a forced room change, or cause staff to be fired. The facility did not investigate each time the resident reported conflict with a specific staff member. Findings included: Resident #10 was originally admitted to the facility on 3/23/12 and readmitted on 4/1/13 with multiple diagnoses which included anxiety, rheumatoid lung, acute and chronic respiratory failure, and chronic airway obstruction. The resident's most recent Annual Assessment, dated 3/3/15, documented the resident was cognitively intact with a BIMS score of 15 and had minimal depression. The resident needed extensive assistance of one person for bed mobility, transfers, locomotion on unit, dressing, toilet use and bathing. The resident needed supervision and set up for eating and personal hygiene. The resident's care plan for the focus of distressed mood symptoms as evidenced by anxiety, tearfulness, fretful, excessive worrying related to anxiety and COPD, initiated 9/10/14, documented the following interventions: *"Allow time for expression of feelings with	F 226	¿This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Sunny Ridge does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.¿ F 226 Residents Identified Resident # 10 was assessed by social services designee (SSD)and Licensed Social Worker (LSW) consultant on 6/5/15 for psychosocial harm related to allegation of staff misconduct. Resident denied allegation at time of interview and no negative findings were noted. Family and MD were notified of allegation by Director of Nursing (DON) on 5/11/15. No new orders at time of notification and no concerns stated by family. DON self-reported allegation of potential abuse on or before 5/11/14. Investigation	

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F 226	Continued From page 2 empathy and reassurance; *Allow time for verbalization of feelings/needs and attempt to resolve area of being upset; *Empower [name of resident] by involving in all aspects of care; *Encourage [name of resident] to seek staff support when fearful; and, *Non-pharmacological intervention: Provide 1:1 visits for support, reassurance, and allow her time to verbalize feelings, escort her to her room to reduce stimuli, offer to lie her in bed or sit her in recliner." On 5/7/15 at 1:10 PM, Resident #10 told the surveyor CNA #16 had complained to the resident she (the resident) was not getting ready fast enough in the morning. The resident thought CNA #16 was teasing and told this to CNA #2. The resident stated she realized CNA #16 was not teasing when CNA #2 "backed up" what CNA #16 said. The resident teared up and stated she was told she could get CNA #16 fired and would have to move out of her room. On 5/8/15 at 12:40 PM, the SSD stated, "This resident requires a lot of attention and tries to manipulate the staff." She stated CNA #16 and Resident #10 would have a great relationship for a while, then the resident will get upset over something and they will switch CNA #16 out for another CNA to work with Resident #10. However, within a week the resident will ask for CNA #16 to come back to assist her. The SSD stated CNA #16 and the resident have had an up and down relationship and this situation had repeated itself. The SSD stated she told CNA #16 to take another CNA with her when going into Resident #10's room as a way to protect herself.	F 226	was completed and allegation was unsubstantiated through staff and resident interview. Resident #10 was assessed by the licensed counselor on 5/12/15. The IDT reviewed and updated Resident #10 plan of care on or before 6/12/15 to include psychosocial support for resident and instructions to staff in how to respond to resident allegations. The SSD was educated by the center social services consultant on 6/5/15 on how to respond to resident grievances and abuse allegations including documentation requirements. Potential Residents. Other interviewable residents residing in the center were interviewed by SSD on or before 5/19/15 to ensure safety of resident with no potential allegations of abuse. Residents interviewed all stated they had no allegations of any type of abuse. No concerns have been made by families of residents that were unable to interview. A resident council meeting was held on or before 6/12/15 with administrator and DON. Any concerns stated will be immediately followed up and investigated by members of the interdisciplinary team. Systematic Changes and Education.	

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F 226	Continued From page 3 The SSD stated this particular situation, as described by Resident #10 on 5/7/15, happened "a couple of weeks ago", and the SSD had been made aware of it at that time as CNAs #16 and #2 had come to her office to inform her of the incident right after it occurred. The SSD stated she spoke with Resident #10 about the incident and told her, "As a last resort we might need to move her to a different room so she had different aides." The SSD stated she told the resident she wanted her to be happy, comfortable and for her needs to be met. Resident #10 then told the SSD she was just kidding and that they got along fine. The SSD stated she told Resident #10 the staff were very concerned about losing their jobs. The SSD stated she brought the CNAs back to Resident #10's room and had the resident apologize to them. The SSD could not explain how her approach of telling the resident she may have to move to a different room, informing the resident staff could lose their jobs due to her reports, or how asking the resident to apologize to the staff were consistent with the resident's care plan. The SSD stated, since the CNAs had reported the incident immediately, and she had spoken with the resident about the incident, she felt she had taken care of the situation. When asked to provide documentation of her discussion or investigation of the incident, the SSD stated she did not document the incident or fill out an incident report since she had immediately taken care of the situation. However, the SSD did not explain how the CNA's actions were consistent with the resident's care plan. The SSD stated she felt her actions constituted a thorough investigation of the resident's concerns.	F 226	SSD was re-educated on 6/5/15 by LSW consultant regarding investigating allegations of potential abuse and to document findings, investigation, and conversations in the medical record. Center management team re-educated by Regional Vice President of Operations on grievance and abuse policy on 6/5/15. Center staff including CNA #10 were re-educated by DON or designee on 6/4/15 regarding how to respond to resident with grievances or allegations of abuse. SSD will review allegations of potential abuse with IDT for investigation and self-reporting guidelines to ensure resident safety and document in resident record any follow up that was completed including but not limited potential psychosocial harm to resident. LSW will do follow behind assessments for residents with suspected abuse for potential psychosocial distress.	

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F 226	Continued From page 4 The facility's Abuse Prohibition Policy, dated 7/1/13, documented: "[Corporate Name] will prohibit abuse, mistreatment, neglect, involuntary seclusion, and misappropriation of property for all patients through the following: Screening of potential hires; training of employees (both new employees and ongoing training for all employees); Prevention of occurrences; Identification of possible incidents of allegations which need investigation; Investigation of incidents and allegations; Protection of patients during investigations; and Reporting of incidents, investigations, and Center response to the results of their investigations." Additionally, the policy documented: "Process 1. The Administrator, or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect, involuntary seclusion, injuries of unknown origin, and misappropriation of property." On 5/8/15 at 2:30 PM, the Administrator stated, "In hindsight, 20/20, we know these residents and know if they feel intimidated, or have concerns. If we filled out an incident report for every grievance, we would have a book this big [lifting his right arm off his desk approximately 20"]. We talk to residents and then go from there. Confirmed grievances and/or incidents and accidents related to concerns of abuse are not always filled out. We take concerns of abuse very serious here." However, the Adninistrator could not show how Resident #10's concerns had been documented or addressed. On 5/8/15 at 4:00 PM, with the Administrator in attendance, the SSD stated she did not feel the aforementioned incident was an event, since this was the resident's normal routine. The SSD	F 226		

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F 226	Continued From page 5 agreed this incident should have been documented, and stated, "That was my slip up, and I should have, but I know my residents." On 5/8/16 at 6:25 PM, the Administrator and DON were made aware of the aforementioned concern. No further information was provided by the facility.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to maintain residents' dignity when they were pulled backwards in their wheelchairs. This was true for 3 out of 10 (#s 13, 15, & 16) residents. This failed practice created the potential for residents to experience a lack of dignity and decreased self-esteem. Findings included: 1. On 5/5/15 at 12:30 PM, Random Resident (RR) #13 was observed sitting in her wheelchair in the Small Dining Room. CNA #10 walked behind the resident and was observed to tilt the wheelchair in a downward motion so the front wheels were off the floor and the resident was tilted backwards and her feet were elevated off the floor. CNA #10 was observed to wheel the resident backwards from the Small Dining Room to the resident's room, which was across the hall.	F 241	F 241 Residents Identified Resident # 13, 15, and 16, and were assessed for psychosocial harm by SSD on 5/29/15 related to being pushed/pulled backward in wheelchair. No signs of distress noted at time of assessment. Potential Residents Other residents residing in the facility requiring the use of a wheel chair were observed by the DON or designee on or before 6/12/15 to ensure all were being assisted in a forward motion to include no tipping. No corrections were needed at time of review.	7/23/15

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F 241	Continued From page 6 The resident had a startled look on her face and CNA #10 smiled and stated to the surveyor, "Kinda nice isn't it?" as she wheeled the resident backwards to her room. On 5/5/15 at 12:50 PM, the NPE (Nurse Practice Educator) was informed of the aforementioned observation and stated, "The only time that is acceptable is when positioning, but not down the hall. I personally wouldn't want to be pushed backwards." 2. On 5/7/15 at 4:10 PM, RR #16 was observed sitting in her wheelchair in the hallway across from room #207. RNA #1 walked up behind the resident, did not speak to the resident and in a rushed manner pulled the resident backwards down the hall past three rooms and then backed her up in her wheelchair and left her at the nurses station. The resident was wide eyed, startled, had a furrowed brow and frown on her face. Additionally, the resident was observed to tightly grip the arms of her wheelchair as she was pulled backwards down the hall. RNA #1 was then observed to walk away from the resident without providing an explanation of what had just occurred. 3. On 5/6/15 at 11:30 AM, a similar observation was made involving CNA #10 and RR #15. On 5/7/15 at 6:05 PM, the Administrator and DNS were notified about the above observations. No further information was provided.	F 241	Systematic Changes and Education Center staff including identified certified nursing assistants (CNA) were re-educated by nurse practice educator (NPE) on or before 6/12/15 regarding dignity related to not pushing or pulling residents backward down hallways and not tipping wheelchairs to position residents. Center staff competencies were completed by nurses practice educator on or before 6/12/15 demonstrating correct procedure for wheel chair locomotion assistance. Corrections made at time of competencies as indicated. Ongoing Monitoring Beginning the week of 6/15/15, DON or designee will review 10 residents to ensure that staff assist residents in wheel chairs in a forward motion and that wheelchair locomotion is safe and dignified weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed at center's performance improvement committee for a minimum of 3 months DON responsible for compliance.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or	F 242		7/23/15

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F 242	Continued From page 7 her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and group interview it was determined the facility failed to recognize and honor residents individuality regarding bathing choices. This was true for 2 of 10 (#s 11 & 14) sampled residents and for 1 of 4 residents in the group interview. This failed practice had the potential for harm if residents developed skin breakdown or began to self isolated due to concerns related to hygiene odor. Findings include: 1. On 5/5/15 at 3:20 PM, Resident #11 was asked about the facility's bathing schedule. The resident said, she was not asked how many showers she took at home and how many she wanted while at the facility and was told her shower days were on Tuesdays and Thursdays. She said she was not offered a choice of times during the day and was told she would get her shower around 10:00 AM or 10:30 AM. She said she had to sit around in her night clothes on shower days and wait because she was not going to get dressed and get undressed to take a shower. Additionally, she stated she was never offered a choice between a shower or a bath. She stated she was a person that, "wanted to get up first thing in the morning take her shower and get things done." 2. On 5/5/15 at 10:15 AM, during the group interview, 1 of 4 residents in attendance stated	F 242	F 242 Residents Identified Resident #11 and 14 were interviewed by DON or designee on or before 5/29/15 on their bathing preferences including whether they would prefer a shower or bath and the time of day that they would prefer bathing to be completed. Care plans and Kardex updated at time of review by DON or designee. Resident #14 was assessed by the Director of Nursing or designee on 6/9/15 for any adverse effect due to missed showers with none noted. Potential Residents Other residents residing in the center were interviewed on or before 5/29/15 by DON or designee on bathing preference. Shower schedules, care plans, and Kardex were updated as indicated at time of interviews. Residents with missed showers or baths during the last 30 days were assessed by the Director of Nursing or designee on 6/9/15. Follow up showers were completed as indicated.	

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F 242	Continued From page 8 she was not offered a choice between taking a shower or bath; she was not given the opportunity to choose what time of day she wanted her shower; and she was not asked how many showers she would like to take during the week. The resident stated if she missed her shower on her "scheduled" day the staff did not offer to make the shower up and she had to wait until her next "scheduled" day. On 5/7/15 at 11:30 AM, CNA #2 was asked the following questions: * What days of the week were showers/baths given and were the residents offered a choice of days - The CNA stated, showers were given only on Mondays, Tuesdays, Thursdays, and Fridays; Zone 1 and Zone 2 residents received showers on Mondays and Thursdays and Zone 3 and Zone 4 residents received showers on Tuesdays and Fridays. * Were residents offered a choice between a shower or bath - The CNA stated the residents were not given a choice between a shower or bath, residents received showers unless otherwise directed by the nurse. * Were different times during the day offered - The CNA stated residents were not given the option to choose what time of day they wanted their shower and some residents had verbalized wanting their showers in the evening before bed. The CNA stated she had notified the nurse about it, "knowing that nothing would come if it, and nothing did. This is the only place I have worked where residents are not able to have showers in the evening."	F 242	Systematic Changes and Education Nursing staff were re-educated on or before 6/12/15 regarding interviewing at time of admission on bathing schedule preferences. Resident satisfaction with bathing type and schedule will be reviewed by the SSD or designee with the resident at least quarterly at the residents scheduled care plan conference. New admissions charts will be reviewed by the DON or designee in center morning clinical meeting to ensure bathing schedule is according to resident preference and included on bath schedule and Kardex. Ongoing Monitoring Beginning the week of 6/15/15 DON or designee will review 4 resident records including but not limited to new admission records weekly for 4 weeks and monthly for 2 months to ensure bathing schedule is according to resident preference and completed. Results of audits will be discussed in center monthly interdisciplinary performance improvement committee for a minimum of 3 months or until compliance sustained. DON is responsible for compliance.	

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F 242	Continued From page 9 On 5/7/15 at 6:05 PM, the Administrator and DNS were notified about the identified concern and no additional information was provided. 3. On 5/7/15, at 11:55 AM, Resident # 14 stated, he had not been out of bed all week. The resident stated, "Sure I would get out of bed, I was a military man, was active." The resident was asked if he got out of bed to bathe and he responded, "I wait for staff to ask me." The resident 's ADL (activities of daily living) record identified the following: * For the month of 2/2015 - the resident had a total of 5 bathing episodes and had gone 6 days without being bathed on 2 different occassions. * For the month of 3/2015 - the resident had a total of 5 bathing episodes and had gone 6 days without being bathed and then 13 days without being bathed. * For the month of 4/2015 - the resident had a total of 5 bathing episodes and had gone 12 days without being bathed and then 6 days without being bathed. On 5/7/15, at 12:30 PM, SDC#4 Stated, "(Resident #14) will get up for hair cuts and showers. On 5/7/15 at 6:05 PM, the Administrator and DNS were notified about the identified concern and no additional information was provided.	F 242		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		7/23/15

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F 246	Continued From page 10 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility failed to ensure call lights were accesible to residents. This was true for 7 of 19 residents. The deficient practice had the potential for harm if residents needed assistance but were unable to alert staff. Findings included: On 5/4/15, at 10:05 AM, Resident #7 was observed sitting on the edge of the bed. The call light cord was stretched from the wall socket, tied to the left bed rail and wedged between the bed rail and the mattress. The call light button was hanging below the bed 1 inch from the floor. The resident was asked to locate the button. The resident looked next to her, under the sheets, patted the bed, and asked, "Where is it, I can 't find it? On 5/4/15, at 10:30 AM, Resident #19, was observed in bed. The call light cord, the bed control cord, and the light switch cord were tied to the right bed rail. The resident was asked to locate the call light. The resident pulled at the entangled cords and stated, "I cannot find it, I have been looking for it."	F 246	F 246 Residents Identified Resident # 2,5,7,8,9, and 18 (resident #19 not included in resident identifier list), were observed with call light within reach on 6/4/15 by DON or designee. Residents were also assessed by SSD on or before 6/2/15 for signs and symptoms of psychosocial harm related to call light not within reach on a previous date. No signs of distress noted at time of assessment. Residents Having the Potential to be effected Other residents residing in the center were reviewed by DON or designee on 6/9/15 for call lights within reach. Call lights were observed to be within reach and no corrections needed at time of review. Systematic Changes and Education Center staff was re-educated on or before 6/12/15 by DON or designee regarding need for call light to be within reach.	

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F 246	Continued From page 11 On 5/4/15, at 10:35 AM, Resident #18, was observed sitting in a wheelchair in the living room area of the resident 's. The call light cord was stretched from the wall of the resident's room, through the doorway, into the next room, then woven through the wheel of her chair and tied to the right armrest. The call light was hanging below the armrest with the activation button pointed down toward the ground. The resident was observed attempting to untie the cord from the armrest. The resident attempted twice and both times dropped the cord only to have to locate it again. On 5/5/15, from 8:45 - 9: 30 AM, Resident #2 was observed lying in bed with the head of the bed 45 degrees. The call light cord, the bed control cord, and the light switch cord were tied to the left bed rail. The call light cord was wedged between the rail and the mattress behind the resident 's head. The call light cord then hung below the resident's bed with the activation button touching the floor. The resident was asked if she had a call light and stated, "Yes," then looked around and asked, "Where is it? " On 5/6/15, the following observations were made: From 7:09 - 7:30 AM, Resident #5 was in her home, was able to be heard from the nurses station 20 feet away and had called out the following: - " I'm so cold,"and then in a louder tone called out, "Nurse, Nurse," for a total of 10 times. - "Nurse come and help me," for a total of 7 times - " Nurse, I'm still cold, help me help me." - " Nurse come put me in my bed," Note: At the moments when the resident was calling out, LN #5 was 20 feet away on 3	F 246	Staff competencies were completed on or before 6/12/15 by center NPE on call light placement including but not limited to being within resident¿s reach. Clips were added to the call light cords by center maintenance director on or before 6/12/15 to ensure lights did not fall out of residents reach or become wedged. Ongoing Monitoring Beginning the week of 6/15/15 DON or designee will review 10 residents for call light placement within reach weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed at center¿s performance improvement committee meeting monthly for a minimum of 3 months or until compliance sustained. DON is responsible for compliance.	

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F 246	Continued From page 12 occassions and had looked observingly down the hall on two of the occasions. CNA #6 was observed to walk down the hall, past the residents room on 3 occassions. On one occassion, the DNS was 20 feet away at the same nurses station and CNA #7 was observed to interact with a second resident in the hallway just to the right of Resident #5 's main room doorway. The staff identified above, did not investigate where the voice was coming from. At 7:20 AM, Resident #5 was observed to be parked in her wheelchair in the middle of the main room, the call light was not within the residents reach. From 7:30 - 7:40 AM, CNA #9 was asked to assist the resident. CNA #9 stated, Resident #5 was not supposed to be in the main room and should be either in the bed or in the dining room and a call light should have been within the residents reach. The call light was tied to the right bed rail in the bedroom which was behind the main room. On 5/7/15 at 6:05 PM, the Administrator and DNS were notified about the identified concern and no additional information was provided. X. Resident #8 was admitted to the facility on 8/8/14 with diagnoses which included late effects of cerebrovascular disease (stroke), artificial opening of digestive tract, aphasia (condition which affects the ability to speak, write or understand language), and dysphagia (swallowing difficulty) due to cerebrovascular disease, and contracture of hand joint. The resident's most recent Quarterly MDS Assessment, dated 2/7/15, documented the resident was rarely/never understood and staff assessment of her cognitive status was	F 246		

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F 246	Continued From page 13 documented as severely impaired; and required extensive assistance of 2+ persons for bed mobility, personal hygiene and bathing. The resident required total assistance of 2+ persons for transfers, and required extensive assistance of 1 person for dressing, eating and toilet use. Additionally, the resident had functional limitation in range of motion with impairment on one side for the upper extremity and impairment on both sides for the lower extremity. The resident's communication care plan, dated 11/23/14, documented an intervention to place the call bell within reach at all times. On 5/7/15 at 9:55 AM, Resident #8 was observed to be awake and was laying in bed on her left side. The call light cord was tied to the bed rail on the opposite side (right side), and was not accessible for the resident to use. CNA #16 stated the resident's call light should have been on the side she was laying on, meaning the resident's left side. On 5/7/15 at 10:10 AM, the NPE stated, "It [call light] should have been on the side she can reach." On 5/8/15 at 6:25 PM, the Administrator and DON were made aware of the accommodation of need concern. No additional information was provided by the facility.	F 246		
F 248 SS=E	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		7/23/15

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F 248	Continued From page 14 the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and record review, it was determined the facility failed to provide an ongoing program of activities designed to meet individual and resident needs. This was true for 9 of 9 sampled residents (#s 1-9), and any resident who wanted to participate in an activity. This failure had the potential to cause more than minimal psychosocial harm when residents were not engaged in meaningful leisure pursuits or interactions for long periods of time. Findings include: The facility had a census of 36 residents at the time of the survey. A white board located on the Zone 1 & 2 Hallway listed the daily activities. An activity calendar was observed to be posted in each resident room. Copies of the May 2015 Activity Calendar, 12" x 16", were available at the main nursing station, however, the calendar did not specify the location of the activities. Review of the activity calendar for 5/4/15 documented a Fitness Fun activity was scheduled for 10:15 AM. On 5/4/15 at 10:20 AM, one female resident was observed in the small dining room drinking coffee. No other residents were in the small dining room and no activity was observed. The Director of Recreation (DR) stated she was gathering residents for the fitness activity which would be an exercise video for seniors. She stated the activity would be in the small dining room which was where most activities took place. The Fitness Fun activity started at 10:45 AM in	F 248	F 248 Residents Identified Resident # 9 discharged from facility on 4/15/15. Resident # 3 discharged from facility on 6/7/15 Residents # 1,2, 4-8 were re-interviewed by center recreation director on or before 6/10/15 regarding activity preferences. Care plans were updated at time of review as indicated. Resident # 14 was re-interviewed by center recreation director on 6/9/15 regarding room decorations including photos, activity preferences, receiving books on tape, outdoor strolls and other outside activities. A care conference was also held with resident and his interested party on 6/4/15 with the center IDT which included activity plan of care. Care plan and Kardex was updated at time of care conference. Hoyer sling was observed not to be under the resident while in bed on 6/4/15 by DON or designee. Resident also had a head to toe skin assessment as well as respiratory assessment by licensed nurse on 6/10/15 to ensure skin intact and no signs of aspiration noted. Assessment findings were within normal limits for resident. A PHQ-9 was	

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F 248	Continued From page 15 the small dining room. In attendance were 4 female residents, however, only two residents were participating. One resident had her head bowed on her chest with her eyes closed. Another resident seated in her WC (wheelchair) with her back towards the TV screen had her eyes closed, and appeared to be sleeping. The afternoon activity for 5/4/15 was Mail Call at 1:00 PM and Bingo at 2:00 PM. The Bingo activity was observed to start at 2:00 PM with eight residents in attendance. On 5/5/15 at 9:30 AM, the daily news activity with 2 male residents was observed in the small dining room, and the DR was reading the paper to them. No other activity was listed on the white board for the remainder of the morning until 11:45 am, which documented a United Methodist luncheon. At 11:50 AM, the DR stated they had three residents who attended the luncheon. However, one of the residents was a member of the Nazarene church and, since he was not a Methodist, had been asked not to attend. The afternoon activity for 5/5/15 was Mail Call at 1:00 PM and movie with popcorn at 2:30 PM. At 3:00 PM, two residents with two family members were observed in the small dining room, however, the movie had not started. The DR stated the cable cord was not working and the maintenance director was trying to locate one. At 4:15 PM, four residents and two family members were observed in the small dining room. Two residents were sleeping and one of the sleeping residents was taken out of the dining room by the DR and returned to her room. The DR stated the movie started at 3:15 PM. On 5/6/15, the facility's Activity Calendar listed Catholic Communion, without a designated time,	F 248	completed by SSD to ensure no increased signs or symptoms of depression on 6/4/15. Referrals made to center psychologist and Geri psych MD as indicated by results of PHQ-9. Potential Residents Other residents residing in the facility were re-interviewed by the recreation director on or before 6/12/15 for activity preferences. Care plans were updated at time of interview by recreation director. Resident council was completed on or before 6/12/15 with recreation director, administrator and DON for choices of gender and religion specific activities and any other input made by residents. Systematic Changes Center staff re-educated on need to assist residents to and from activities by recreation director on or before 6/12/15. Recreation director was re-educated by center administrator and or designee on or before 6/12/15 to add location of activities to white board, activity start time, and real time activity log documentation. Recreation Director will add location of activities to white board for staff and resident knowledge. Additional activity department staff has been approved by regional vice president of operations.	

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F 248	Continued From page 16 a Bible study activity at 9:45 AM, and Pet Therapy at 10:00 AM. The afternoon activity listed Mail Call at 1:00 PM and Bingo at 2:00 PM. On 5/7/15, the facility's Activity Calendar listed a Bible study at 9:45 AM, manicures by staff at 10:00 AM, and music memories at 12:00 PM. At 11:00 AM, the DR was observed giving personal manicures in resident rooms, however, no other staff was observed to be giving manicures. The afternoon activity listed Mail Call at 1:00 PM, Courtyard Gardening at 2:00 PM, which was canceled due to rain, and a store at 3:30 PM, where residents could come and go to redeem their points won from playing games. On 5/8/15, the facility's Activity Calendar listed daily news at 9:30 AM, and Bingo at 10:00 AM. The afternoon activity listed Mail Call at 1:00 PM, and Mother's Day Tea at 2:00 PM. On 5/8/15 at 8:15 AM, the DR stated her job included admission, quarterly and significant change MDS assessments. She stated she interviewed residents about the activities they enjoyed, and attended Resident Council to find out their likes and dislikes, and where they wanted to eat out for monthly outings. She stated she liked to involve families whenever possible in her assessments. The DR stated she felt like she had about 50% participation in group activities and tried to include 1:1 participation for the rest of the residents. She stated she tried to announce activities during meal times and mostly gathered residents for the activities herself. She stated the CNA's do help at times, however, day shift is pretty busy. She stated swing shift was more helpful. When asked about substitutions, the DR stated there were no substitutions this week.	F 248	Alternate activities will be planned in advance in the event the schedule is changed. Recreation Director will announce via overhead page prior to the start of an activity to alert staff to assist residents as they wish for increased resident participation. Activities will be planned based upon resident interview and resident council discussion. Ongoing Monitoring Beginning the week of 6/15/15, recreation director will interview 5 residents weekly for 4 weeks and then monthly for 2 months to ensure activities offered are meaningful and per resident choices. Also beginning the week of 6/15/15, DON or designee will review 5 times per week activity logs to ensure they are current, overhead pages of activities are announced, staff assisting residents to activities, location of activity is listed on center whiteboard, an alternate activity is occurring if original was cancelled, and that activities are occurring on time per schedule weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed at center performance improvement committee meeting (PI) monthly for a minimum of 3 months or until compliance sustained. Recreation Director is responsible for compliance.	

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F 248	Continued From page 17 When asked about Courtyard Gardening which was scheduled on Thursday, the DR stated, "Oh yes, I forgot, it was canceled due to weather." She then stated, "It wasn't actually canceled, they watered inside." When questioned further, the DR admitted only one resident watered the inside plants. The DR was asked about the activity list for the survey week and resident participation. The DR explained that it was hard for her to get attendance for the Fitness Fun activity due to the RNA program and therapy because the residents were already exercising. She stated she just started to change things up and had tried a grocery bag exercise in April. When asked how Mail Call was an activity, the DR stated she took the resident's mail to their room, usually about six residents received mail, and she would read it to them if they wanted. When asked about having only two residents at the daily news activity, the DR stated, "They like to read the paper on their own, or like to read it in their rooms." The DR was asked how many residents attended the United Methodist Luncheon activity. She stated two residents usually attended, however, on 5/5 one resident was with the doctor so only one resident actually attended the luncheon. The DR was asked how she included residents in 1:1 activities, and stated, "I just visit with people. I will take coffee to some residents and ask if they need anything. I will pray with residents, if they want me to. The DR explained she also helped staff answer call lights and helped with resident needs. The DR was asked about evening activities and stated the facility provided music activities on	F 248		

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F 248	Continued From page 18 Sunday, Tuesday and Saturdays. She stated evening activities were a challenge because the residents wanted to go to bed. When asked how many residents attended the music activity, the DR stated she didn't know, but thought maybe 3 or 4 residents went. She stated the music activity on Sundays and Tuesdays was provided in the Retirement Area. She stated residents could watch TV, do a puzzle, or play games in the evenings. The DR was asked about the Bible study activities and stated one resident, which happened to be the same resident, attended the Bible study on Wednesday and Thursday this week. The DR stated other residents were involved in therapy or had something else going on. She stated there were 4 residents who attended the Catholic Communion activity. The DR was asked about the Thursday morning manicures by staff and stated she did three manicures. She stated the rest of the residents could either read the newspaper or watch TV. The DR stated she had been fixing TV cable boxes, usually 5 per day and had to unplug it or reprogram it, which took quite some time. She stated (cable provide name) was actually obsolete and residents could not watch TV in their rooms. She stated the rollover from cable to high definition had not been a smooth transition, and the facility could call a technician, but they charged the facility every time they came out. When asked to identify resident preference for activities, the DR stated the residents wanted music entertainment, Bingo three times per week, puppets, and 1 or 2 outings per month. When asked what activities were offered for gentlemen,	F 248		

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F 248	Continued From page 19 she stated she use to have a social time, just for men to talk, and she was thinking about starting that again. When asked what activities were offered to help stimulate resident's minds, she stated that music and Bingo really stimulated residents. The surveyor informed the DR of multiple observations of residents watching TV in the afternoons, and were not observed to be engaged in the movie and popcorn activity or the the gardening or game prize store. The DR stated the residents liked to lay down after lunch and watch TV. The surveyor asked if the low participation in activity programs and a lot of TV watching were indicative of boredom. The DR stated, "I guess so, yeah." The DR was asked if she had identified the underlying reason why residents refused an activity and what alternatives were offered. The DR stated the residents were too tired from therapy. The DR was asked how she monitored and evaluated resident responses to the activity program. She stated, "I observe what they are doing. I haven't been able to keep up with Activity Logs for the past couple of three months because I am so busy with MDS assessments, trying to keep everything running with the TV's, helping residents in their rooms, plus answering lots of call lights." The facility did not ensure residents were involved in an activity program which met their needs as evidenced by the low participation and involvement by residents. The facility did not monitor or evaluate resident responses to the	F 248		

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F 248	Continued From page 20 activity program and did not identify an underlying reason for refusals. The Director of Recreation was involved in fixing cable boxes, answering call lights and responding to resident physical needs instead of ensuring the success of the activity program. On 5/8/15 at 6:25 PM, the Administrator and DON was informed of the concern with the Activity Program. No further information was provided by the facility.	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 record review and resident and staff interviews, it was determined the facility failed to provide social services involvement related to personal interactions and socialization skills for Resident #10. The deficient practice had the potential for harm when the facility failed to document patterns of conflict related to difficult interpersonal relationships among staff members. Findings included: Resident #10 was originally admitted to the facility on 3/23/12 and readmitted on 4/1/13 with multiple diagnoses which included anxiety, rheumatoid lung, acute and chronic respiratory failure, and chronic airway obstruction.	F 250	F 250 Residents Identified Resident # 10 was assessed by social services designee¿s (SSD) and Licensed Social Worker (LSW) consultant on or before 6/5/15 for psychosocial harm related to allegation of staff misconduct. Resident denied allegation at time of interview and no negative findings were noted. Family and MD were notified of allegation by Director of Nursing (DON) on 5/11/15. No new orders at time of notification and no concerns stated by family.	7/23/15

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F 250	Continued From page 21 On 5/7/15 at 1:10 PM, Resident #10 teared up and stated she was told she could get CNA #16 fired and would have to move out of her room. On 5/8/15 at 12:40 PM, the SSD stated Resident #10 required a lot of attention and tried to manipulate staff. She stated CNA #16 and Resident #10 had an up and down relationship and this situation had repeated itself multiple times. The SSD stated she spoke with Resident #10 and told her, "As a last resort we might need to move her to a different room so she had different aides." Please refer to F 226 as it relates to the aforementioned incident. The resident's record contained no documentation of the circumstances surrounding the incident, or of the SSD's assessment and involvement of the incident. No documentation was provided the SSD had assessed there had been a pattern of repeated interpersonal relationships with staff. The DON was asked to provide a copy of the audits of the residents the LSW saw and the dates they were seen. On 5/8/15 at 3:10 PM the DON provided a copy of the Quarterly Consultation, reviewed by the contracted LSW, dated 3/19/15, and stated this was all she had. Record review of the Quarterly Consultation, dated 3/19/15, did not document the LSW had reviewed Resident #10's medical record. Record review of the resident's care plan did not include an intervention to deal with patterns of interpersonal relationships with staff. On 5/8/15 at 4:00 PM, the surveyor pointed out the importance of documenting these type of	F 250	Potential Residents Other interviewable residents residing in the center were interviewed by social services designee on or before 5/19/15 to ensure safety of resident with no potential allegations of abuse. Residents interviewed all stated they had no allegations of any type of abuse. No concerns have been made by families of residents that were unable to interview. A resident council meeting was held on or before 6/12/15 with SSD, administrator and DON to ensure they are comfortable to make allegations of staff misconduct without retaliation and are free of such allegations. Any complaints will be followed up as indicated by members of the interdisciplinary team. Resident #10¿s was assessed by the licensed counselor on 5/12/15. The IDT reviewed and updated the Resident¿s #10 plan of care on or before 6/12/15 to include psychosocial support for resident and instructions to staff in how to respond to resident allegations. The SSD was educated by the regional social services consultant on 6/5/15 on how to respond to resident grievances and abuse allegations including documentation requirements. Systematic Changes and Education	

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F 250	Continued From page 22 incidents, especially since the SSD had stated there was a pattern of ups and downs between Resident #10 and CNA #16. The SSD stated, "That was my slip up, and I should have, but I know my residents."	F 250	SSD was re-educated on or before 6/5/15 by LSW consultant regarding investigating allegations of potential abuse and what triggers include and to document findings, investigation, and conversations in the medical record. Center staff including, CNA #10, were re-educated by DON or designee on 6-4-15, on how to respond to resident with grievances or allegations of abuse. SSD will review allegations of potential abuse with IDT for investigation and self-reporting guidelines to ensure resident safety and document in resident record any follow up that was completed including but not limited potential psychosocial harm to resident. LSW will do follow behind assessments for residents with suspected abuse for potential psychosocial distress. Center management team re-educated by Regional Vice President of Operations on grievance and abuse policy on 6/5/15. Ongoing Monitoring Beginning the week of 6/15/15, DON or designee will complete 4 resident interviews weekly for 4 weeks and monthly for 2 months to ensure that resident grievances and allegations of abuse are followed up on completely and investigations are documented. Follow up and record reviews will be completed as indicated through interviews. Results of	

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F 250	Continued From page 23	F 250	audits will be discussed in center monthly interdisciplinary performance improvement committee meeting monthly for a minimum of 3 months or until compliance sustained. DON is responsible for compliance.	
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 observation, record review, and staff interview, it was determined the facility failed to ensure adequate preventative interventions were in place and implemented to ensure a resident with a history of heart failure, did not have an exacerbation leading to hospitalization. This was true for 1 of 6 (#2) residents sampled. This failed practice resulted in the potential for harm when Resident #2 was observed by the facility with increased confusion and decreased oxygen saturations, was sent to the emergency room and hospitalized for 6 days. Findings included: Resident #2 was initially admitted to the facility on 4/26/11, and re-admitted on 4/14/15, with multiple diagnoses, including acute and chronic heart failure, acute and chronic respiratory failure, acute pulmonary edema (excess amount of fluid	F 309	F 309 Resident Identified Resident #2 had a total assessment completed by center licensed nurse on 6/3/15 including but not limited to edema status, oxygen saturation, blood pressure and weight. MD notified by DON or designee with no new orders received. Care plan updated as indicated by assessment by DON or designee. Potential Residents Other residents residing in the facility with diagnosis of heart failure had a total assessment including but not limited to, edema status, oxygen saturation, blood	7/23/15

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F 309	Continued From page 24 in the body tissues) pneumonia, chronic kidney disease, had a cardiac pacemaker, and had Methicillin Resistant Staphylococcus Aures (MRSA) in sputum. The MDS quarterly review dated, 1/22/15, coded Resident #2 was cognitively intact. The MDS comprehensive review dated, 4/21/15, coded Resident #2 was moderately cognitively impaired. Resident #2's acute are hospital discharge summary, dated 4/20/15, documented: - Admitted from the facility on 4/10/15 and discharged on 4/14/15. - Arrived with shortness of breath, acute confusion, cough and elevated blood pressure. - Diagnosed with pulmonary edema evidenced by x-ray, acute respiratory failure with hypoxemia and hypercapnia (high amounts of carbon dioxide in the blood), and acute altered mental status. These diagnoses were documented to be a result from the patient's chronic heart failure. Additionally, the resident was documented with having early pneumonia, and MRSA. The social service assessment dated, 1/23/15, documented the resident was, "active in the facility activities and outings, propels self in the wheelchair, feeds self, picks out own clothing daily, very social..." The social service assessment dated, 4/29/15, documented the resident was, "not feeling up to par - still very weak." The current care plan documented: - The resident was at risk for cardiovascular complications related to pacemaker, cardiac arrhythmia, congestive heart failure, diastolic heart failure, hypertension and required	F 309	pressure and weight by DON or designee on or before 6/12/15 to ensure that interventions were in place to avoid an exacerbation that would lead to a hospitalization. MD and families notified as indicated at time of assessment. New orders were followed and implemented as indicated if received. Systematic Change and Education Licensed nursing staff were re-educated on or before 6/12/15 by center NPE regarding ongoing assessments of residents with chronic conditions such as but not limited to heart failure. Center staff educated by nurse practice educator on implementation of ¿Stop and Watch¿ a nationally recognized tool for reporting possible changes of condition. Center will implement tool on or before 6/12/15. Center interdisciplinary team will review tools during morning clinical meeting for any further follow up. Licensed staff re-educated by center NPE on or before 6/12/15 to complete change of condition assessment (COC) with noted changes. COC assessments will be reviewed during morning clinical meeting by DON or designee for any additional follow up needed. Ongoing Monitoring Beginning the week of 6/15/15, DON or designee will review 5 stop and watch tools weekly and then monthly for 2	

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F 309	Continued From page 25 supplemental O2 to keep sats (the amount of oxygen in the blood) above 90%. - The resident is at risk for complications related to requiring use of O2 to keep sats above 90% related to cardiac disease and history of pneumonia. All interventions were created and initiated on 10/31/14 and documented: - monitor and report O2 sats levels via pulse oximetry as ordered and PRN (as needed); - O2 as ordered; - observe respiratory status and assess for changes as well as changes in mental status; - spot check O2 sats; - assess and monitor vital signs as ordered and report abnormalities to physicians; - educate resident to recognize and report cardiac symptoms. The resident's daily medication administration records for 5/1/15 - 5/5/15 documented: - "Check O2 sats as needed for shortness of breath." The form was blank. - "Oxygen at 2L/min via nasal cannula continuously. Every shift - Start Date - 4/14/15 2200." Adjacent to the order, the resident's O2 sats were documented 12 out of 15 times and were within normal limits. - The record did not contain orders to check the resident's O2 sats daily. The resident's daily medication administration records for 3/1/15 to 4/30/15 documented, "Check O2 sats. as needed for shortness of breath." The form was blank. Progress notes documented the following: - From 2/19/15 to 3/16/15, for a total of 25 days, there were no skilled nursing progress note	F 309	months to ensure COC assessment is completed including MD notification for possible order changes. Results of audits will be presented to the center performance improvement committee meeting for a minimum of 3 months or until compliance sustained. DON is responsible for compliance.	

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F 309	Continued From page 26 entries. - From 3/17/15 to 4/9/15, for a total of 24 days, there were no skilled nursing progress notes documenting resident's edema status or oxygen sats. - On 4/9/15, at 9:10 AM, documented the resident was in her wheelchair, had a lot of confusion, O2 sats were 73% while on 1 liter of oxygen, and had to increase the oxygen to 2 Liters to get her O2 sats to 80%. The MD was called and the resident was sent to the emergency room. On 5/7/15, at 5:00 PM, RN # 15 stated on 4/9/15 at the time she was sent to the hospital, the resident was "slumped over in her chair, clearly in distress, was transferred to the emergency room with big changes and increased confusion." The resident was admitted to the hospital on 4/10/15. On 5/8/15, at 11:15 AM, RN #3 described signs and symptoms of worsening heart failure. The RN stated preventative interventions would include listening to lung sounds and checking edema. RN #3 stated it was not the facility's practice to monitor those things daily. RN #3 stated the facility monitored the resident for these indicators when she got back from the hospital, but did not continue because the resident had a history of the issues. RN #3 was not aware of the resident having worsening heart issues until she was transported to the emergency room on 4/9/15. On 5/7/15 at 6:05 PM, the Administrator and DNS were notified about the identified concern. On 5/11/15, the facility faxed additional information which did not resolve the concerns.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		7/23/15

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F 312	Continued From page 27 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, it was determined the facility failed to ensure residents received oral care or baths as needed and scheduled. This was true for 4 of 9 residents (#s 5, 6, 8, & 10) sampled for ADL assistance. This deficient practice had the potential for more than minimal harm if residents experienced rashes or skin issues due to not being bathed regularly and experienced infections or red, swollen and bleeding gums due to lack of oral hygiene. Findings included: 1. Resident #8 was admitted to the facility on 8/8/14 with diagnoses which included late effects of cerebrovascular disease (stroke), artificial opening of digestive tract, aphasia (condition which affects the ability to speak, write or understand language), and dysphagia (swallowing difficulty) due to cerebrovascular disease, and contracture of hand joint. The resident's most recent Quarterly MDS Assessment, dated 2/7/15, documented the resident was rarely/never understood and required staff assessment for mental status. Staff assessment documented the resident was cognitively severely impaired, and required extensive assistance of 2+ persons for bed mobility, personal hygiene and bathing. The	F 312	F 312 Residents Identified Residents # 5, 6, 8, 10, received oral care by CNA on or before 6/12/15 and were assessed by Director of Nursing (DON) on 5/22/15 for any adverse effects related to oral care. No adverse findings were noted at time of assessment. Resident # 10 was provided with a battery for electric toothbrush on or before 5/7/15 by DON. Care plans and Kardex were updated by DON on or before 6/12/15 for oral care schedule. Residents # 5 and #8 received a shower by CNA on or before 5/12/15. Both residents had skin assessments completed by licensed nurse on or before 5/15/15 to ensure no adverse effects related to inconsistent shower schedules with any new findings noted at time of assessment. Resident # 5 and #8's shower schedules, care plans and Kardex were updated by DON or designee on or before 6/12/15. On or before 5/7/15 resident # 8 had gown replaced that was free of any fraying	

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F 312	Continued From page 28 resident required total assistance of 2+ persons for transfers, and required extensive assistance of 1 person for dressing, eating and toilet use. Additionally, the resident had functional limitation in range of motion with one sided upper extremity impairment and bilateral lower extremity impairment. Resident #8's ADL Care Plan, initiated 11/21/14, documented the following interventions: *"Consistently bathe the resident scheduled for Monday and Thursday, initiated 11/23/14; *Requires extensive assistance with dressing, grooming, bed mobility, bathing and locomotion, initiated 11/21/14; *Oral care BID, resident has own teeth. If resident does take food orally, make sure you do oral care after meals to make sure she is not aspirating food stuck in cheek or behind gums, initiated 11/23/14; and, *Ensure and assist with grooming needs, brush hair, washing face and hands, and oral cares BID and after meals." On 5/7/15 at 9:55 AM, the resident was observed laying in bed in an old, threadbare gown. At 10:10 AM, the NPE was shown the gown and stated, "Yes, the gown is rather thin...I personally would have thrown it away." The NPE was asked to examine the resident's teeth and gums. The NPE stated the ADL record did not have a space for oral care documentation, and was lumped with personal hygiene. The NPE took a sponge toothette to open the resident's mouth and stated sometimes the resident won't let you get in her mouth and then we would reapproach. The resident's gums were observed to be red and swollen with multiple layers of tartar buildup. The surveyor expressed to the NPE that oral care	F 312	by licensed nurse. Residents having the potential to be effected Other residents residing in the facility were assessed by DON or designee for oral care needs on or before 6/12/15. Oral care was provided at time of assessment as indicated and care plans and Kardex updated as indicated for oral care schedule. A review of resident ADL records for those currently residing in the center was completed by the DON or designee on 6/9/15 to ensure consistent bathing schedules and documented refusals as indicated. Showers provided at the time of review as indicated. Care plans and Kardex have been updated to reflect schedule. An inventory of center gowns completed by central supply coordinator on or before 5/25/15 to ensure gowns was free of any fraying. Gowns replaced as indicated at time of inventory. Systematic Changes and Education Center nursing staff was re-educated by DON or designee on or before 6/12/15 regarding oral care schedules, bathing schedules, including the need for equipment such as batteries. Center laundry staff were re-educated by housekeeping supervisor on 6/7/15	

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F 312	Continued From page 29 didn't appear to have been done for quite some time. The NPE stated, "You cannot get it to look better because her mouth and gums will bleed." According to the American Dental Association (ADA), periodontal disease, or periodontitis, can occur when gingivitis continues to an advanced stage. Gingivitis (inflammation of the gums) and periodontitis make your gums sensitive and more prone to bleeding. Symptoms of gingivitis include: puffy gums; soreness in the mouth and around the gums; and, bleeding gums. Plaque refers to the debris and bacteria that sticks to your teeth. Brushing your teeth removes plaque. Lack of oral care will lead to red, swollen and bleeding gums. According to the ADA, "Research has shown that infection in the mouth may be associated with heart disease, stroke, diabetes, pneumonia and other health problems that are common in older adults." Record review of Resident #8's ADL Flow Sheet, documented the following: *March 2015 - The resident received a bath on Sunday, 3/15, and was not bathed until the next Monday, 3/23, which meant the resident was not bathed for a seven (7) day period. The resident should have been bathed on Monday, 3/16, and Thursday, 3/19. The resident did not receive consistent bathing as care planned on Mondays and Thursdays. In March the resident received a bath on Wednesday, 5/4, instead of Thursday, 5/5, and on Sunday, 5/15, instead of Monday, 5/16. *April 2015, documented the resident received a bath on Thursday, 4/9, which meant the resident was not bathed for a ten (10) day period. The resident should have been bathed on Thursday, 4/2, and on Monday, 4/9. Additionally, the	F 312	regarding checking center gowns for integrity prior to stocking linen closets. Housekeeping supervisor will complete monthly inventory of center gowns to ensure integrity of material and that they are free of any fraying prior to stocking linen closets. ADL records will be reviewed by the Director of Nursing or designee in the morning clinical meeting to ensure that baths/ showers are being completed per resident schedule/preference. Monitoring Beginning the week of 6/15/15, DON or designee will complete audits of 8 residents that require assistance with oral care and showers, weekly for 4 weeks, then monthly for 2 to ensure that oral care is being provided according to resident needs and schedule. Results of audits will be presented to the interdisciplinary team meeting for a minimum of 3 months or until compliance sustained. DON is responsible for compliance.	

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F 312	Continued From page 30 resident received a bath on Monday, 4/13, but was not bathed again until Monday, 4/20, which meant the resident was not bathed for a six (6) day period. On 5/7/15 at 11:30 AM, CNA #2 was asked if residents missed their showers, she stated, "I try to get to them. I have to make time. Yesterday was my day off and I came in to make showers up..." On 5/8/15 at 11:35 AM, the DON stated the facility did not have a bathing policy. She stated residents are bathed according to the zone schedule (area the resident resided on in the facility) or as care planned. The DON was shown Resident #8's ADL Flow Sheet for March, where the resident went without a bath for 7 days, the DON stated, "There is no documentation." When shown the ADL Flow Sheet for April she stated, "Well, they didn't document on the 2nd, 6th, or 16th." The DON was made aware of the concerns regarding missed baths, not following the bathing schedule and consistent baths on Monday and Thursdays as care planned, lack of oral care as care planned, and the thread bare gown observation. 2. Resident #10 was originally admitted to the facility on 3/23/12 and readmitted on 4/1/13 with multiple diagnoses which included rheumatoid lung, acute and chronic respiratory failure, and chronic airway obstruction. The resident's most recent Annual Assessment, dated 3/3/15, documented the resident was cognitively intact with a BIMS score of 15. The resident needed extensive assistance of one person for bed mobility, transfers, locomotion on	F 312		

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F 312	Continued From page 31 unit, dressing, toilet use and bathing. The resident needed supervision and set up for eating and personal hygiene. The resident's ADL Care Plan, initiated 9/9/14 and revised 3/13/15, documented the following 9/9/14 interventions: "Encourage resident participation while providing appropriate ADL care; Identify self and expected tasks prior to beginning care; Use simple concrete statements; Monitor for SOB [shortness of breath], fatigue and change of condition and adjust task accordingly; and, [Name of resident] requires one person assistance with transfers, dressing, grooming, toileting, bed mobility and bathing." On 5/7/15 at 1:10 PM, Resident #10 was interviewed by the surveyor and was observed to have red and swollen gums with plaque buildup when the resident smiled. When asked if staff helped her with oral care at night, Resident #10 stated, "They haven't been. I need a battery for my toothbrush, it's battery operated and I need a little help." When asked if staff had noticed she needed a battery, the resident stated, "They are pretty rushed, there isn't much time to get ready to go to bed." The resident was asked when the last time she brushed her teeth and she stated, "Probably a week ago." On 5/7/15 at 6:05 PM, the Administrator and DON were made aware of grooming concerns. No additional information was provided by the facility. 3. Resident #5 was originally admitted to the facility on 2/27/04 and readmitted on 3/6/11 with diagnoses which included dementia with behavioral disturbances, peripheral neuropathy, anxiety, depression, and cognitive communication	F 312		

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F 312	Continued From page 32 deficit. The resident's most recent quarterly MDS assessment, dated 3/6/15, documented the resident was not able to be interviewed for the BIMS score and was assessed by staff to be moderately cognitively impaired to make daily decisions. The resident needed extensive assistance of 2+ persons for transfers and the assistance of 1 person for bed mobility, dressing, eating, toilet use, personal hygiene and bathing. Resident #5's ADL Care Plan, initiated 9/16/14, documented an intervention, initiated 12/14/14, to shower the resident two times per week on scheduled days and to give a bed bath if the resident refused a shower. Record review of the resident's ADL Flow Sheets documented the following: *March 2015, documented the resident received only one bath and/or shower the week of 3/15/15; and, *April 2015, documented the resident did not receive a bath and/or shower the week of 4/26/15. On 5/8/15 at 12:00 PM, the DON was shown the resident's ADL Flow Sheets and stated the resident was scheduled shower days on Tuesdays and Fridays. The DON stated, "Looks like there was a ten (10) day period without a shower." 4. Resident #6 was admitted to the facility on 3/12/13 with diagnoses which included adult failure to thrive, dementia, spinal stenosis, and muscular wasting and disuse atrophy.	F 312		

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F 312	Continued From page 33 The resident's most recent significant change MDS assessment, dated 2/6/15, documented the resident was cognitively intact with a BIMS score of 13, and needed extensive assistance of one person for bed mobility, transfer, locomotion on unit, dressing, toilet use, personal hygiene and bathing. Resident #6's ADL Care Plan, initiated 9/29/14, documented the resident's preference of bathing one time per week and to shower the other time. Record review of the resident's ADL Flow sheets documented the following: *March 2015 - The resident received one bath on Thursday, 3/5; Thursday, 3/12; and, Monday, 3/16. *April 2015 - The resident received one bath on Monday, 4/20, and Thursday, 4/30, which meant the resident was not bathed for a total of nine (9) days and should have been bathed an additional 2 times. On 5/8/at 11:45 AM, the DON stated residents were bathed 2 times per week, unless they had a different preference. She stated residents who resided on Zones 1 & 2 were bathed on Mondays and Thursdays, and those who resided on Zones 3 & 4 were bathed on Tuesdays and Fridays. She stated if residents wanted more than 2 baths per week, then the facility would just fit them in. The DON read the resident's ADL care plan intervention and stated the resident's preference was one time per week. The actual intervention, initiated 9/29/14, documented, "[Name of resident] requires one person assistance with bathing. Prefers to have a bath one time per week. [sic] and shower the other time." The DON was shown the April ADL Flow	F 312		

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F 312	Continued From page 34 Sheet and stated, "There is a span of nine (9) days without documention." On 5/8/15 at 6:25 PM, the Administrator and DON were made aware of the aforementioned concerns. No additional information was provided by the facility.	F 312		
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 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, resident 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 1 residents (#3) reviewed who was at risk for and 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. Findings included: Resident #3 was admitted to the facility with multiple diagnoses, including protein calorie malnutrition, weight loss, delusional disorder, and chronic kidney disease stage III.	F 314	F 314 Resident Identified Resident # 3 discharged from the facility on 6/7/15. Potential Residents A skin sweep of other resident¿s residing in the facility was completed by members of the nurse management team on or before 6/12/15. A review of resident risk factors was also completed at time of sweep. Care plans and Kardex updated as indicated by DON or designee on or before 6/12/15. MD and families notified	7/23/15

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F 314	Continued From page 35 The resident's quarterly MDS assessment, dated 2/11/15, coded the resident was cognitively intact, did not reject cares, required extensive assist for bed mobility and transfers, was frequently incontinent, had weight loss, was at risk for pressure ulcers, and had skin tears. The current care plan documented the resident required extensive assist for bed mobility, two person assist for transfers, and assistance for repositioning. The resident was at risk for skin breakdown related to history of limited bed mobility, debility, frail elderly skin and history of skin tears (11/10/14). Interventions included evaluate for skin risk factors (11/10/14) and weekly skin assessments by licensed nurse (11/10/14). The facilities policy and procedures for; skin wound management, wound documentation guidelines, pressure ulcer prevention guidelines, intervention guidelines, and incontinence skin care, documented the following: - Monitor all co-morbid (contributing) conditions that may delay or prevent wound healing such as malnutrition, renal disease - For residents at risk for pressure ulcers, interventions include; perform daily observations of the skin, provide turning and repositioning for those who have impaired mobility. - For residents with identified wounds, monitor all dressings and /or wound sites daily - Daily monitoring documentation to include status of the dressing, surrounding tissue and any pain. The 24 hour change of status reporting form, dated 4/30/15, documented, a skin opening on	F 314	of any findings as indicated at time of reviews. Systematic Changes and Education Nursing staff re-educated on or before 6/12/15 regarding preventative measures including but not limited to risk identification and pressure relief to maintain skin integrity. Center nursing staff educated by NPE on or before 6/12/15 regarding implementation of ¿Stop and Watch¿ a nationally recognized tool to identify possible changes of condition. Center will implement tool on or before 6/18/15. Center interdisciplinary team will review tools during morning clinical meeting for any further follow up. Center CNAs received wound basic education by Regional Clinical Education Specialist on or before 6/12/15 to include but not limited to offloading, daily observations of skin, and reporting changes to licensed nurse. Ongoing Monitoring Beginning the week of 6/15/15 DON will review 5 residents weekly for 4 weeks and then monthly for 2 months to ensure preventative measures are in place and risk factors for skin breakdown have been identified. Results of these audits will be reviewed by the center interdisciplinary performance improvement committee for a minimum of 3 months or until	

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F 314	Continued From page 36 the resident's coccyx, Optifoam dressing applied. The skin integrity report, dated 4/30/15, documented the coccyx - top of natal cleft as the following: - not incontinence related - skin tear, partial thickness - no pain - "E-epithelial (ex..stg 2 [stage 2 wound]) - length, width, depth, was 2 x 1 x 0.1 - serosanguineous drainage [blood and liquid part of blood, red and yellow in color] - healthy surrounding tissue - no odor - care plan updated Note: The skin care plan did not have any interventions documented after 4/30/15. According to Perry Potter, Nursing Clinical Skills and Techniques 8th edition, "A partial thickness wound (loss of tissue limited to epidermis and possible partial loss of the dermis) heals by the process of regeneration," and identified underlying factors that prevent the ability of the cells to regenerate [return to normal] include inadequate nutrition and advanced age. (p921). Additionally, "Stage II wound, Partial-thickness Skin Loss or Blister. A partial loss of dermis presents as a shallow open ulcer with a red-pink wound bed without slough. This stage should not be used to describe skin tears...(p1179) On 5/8/15 at 11:15 AM, RN #3 stated, "I have had a ton of wound training. A skin tear is a partial thickness injury. If they don't go to the dermis it is partial thickness and to the dermis is a full thickness." The change in skin condition progress notes,	F 314	compliance sustained. DON is responsible for compliance.	

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F 314	Continued From page 37 documented the following: - 5/1/15, 5/2/15: no change - 5/3/15, 5/4/15: improved - 5/5/15: improved, no pain The skin integrity report, dated 5/6/15, documented the coccyx - top of natal cleft as the following: - not incontinence related - skin tear, partial thickness - yes pain - "E-epithelial (ex..stg 2 [stage 2 wound]) - length, width, depth, was 2 x 1 x 0.1 - serous drainage (thin clear watery drainage) - inflamed/indurated surrounding tissue - no odor - care plan updated Note: The skin care plan did not have any interventions documented after 5/6/15. On 5/8/15, at 12 PM, RN#3 provided an incident/accident report for the 4/30/15 skin incident. The report was last modified on 5/6/15 at 6:52 PM, and documented: - self inflicted injury - a red blanchable area on top of the residents natal cleft and upper buttocks - one area was a skin tear with open peeled off skin, - the resident scratched her backside - 2 hours later the scratches were not open and fading. The following observations were made during the survey process: - On 5/5/15, at 9:35 to10:05 AM, 11:29 AM to 1:00 PM, 2:15 PM to 2:50 PM, and at 5:55 PM, Resident #3 was sitting in her wheelchair.	F 314		

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F 314	Continued From page 38 - On 5/7/15, from 2:05 PM to 2:30 PM, the dressing to Resident #3's coccyx was removed and changed by RN #3. RN #3 stated that on 4/30/15, the resident scratched herself and other scratched areas had been present at the time along with a "yeasty smell," which was not identified in the 4/30/15 or 5/6/15, skin assessment. RN #3 identified the current wound was on the residents bony prominence, appeared to be a stage 1 wound and stated a wound consult may be needed. The wound bed was open, skin was missing, the wound bed and the immediate surrounding tissues was not blanchable, and the outermost layer was blanchable. RN #3 stated she measured it the day before and the wound was 2 x 1 x 0.1 (length x width x depth). RN #3 stated to the resident 3 times, "You still scratching your bottom?" Resident # 3 responded 3 times, "I never scratch my bottom," then commented, "I have long nails but I don't scratch my bottom." RN #3 stated to resident, "Remember, it was itchy." Resident #3 responded, "No it wasn't." RN #3 stated, Resident #3 refused to turn at times, and stated "I don't know why all the other scratches healed, I know it looks concerning, I think it progressed but I don't know why." On 5/7/15, RN #3 stated all of Resident #3's skin assessments and skin documentation had been provided to the survey team. The progress note dated 2/10/15, documented, "skin intact." The next documentation of the resident's skin was on 4/30/15. On 5/8/15 at 12:00 PM, RN #3 stated all the scratches that appeared on 4/30/15 had healed within 2 hours and stated the current wound was	F 314		

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F 314	Continued From page 39 on an area of pressure and an Optifoam had been placed because the resident was thin. The RN was unable to explain how the pressure area was unavoidable, and the absence of care plan interventions as the area was discovered and failed to resolve. On 5/8/15, at 6:15 PM, the DNS stated a blanchable wound is not considered pressure. However, did not verbally identify the unblanchable wound bed. The DNS requested that the surveyor view the wound again and stated she will ask the resident if that was OK. The DNS did not follow up with the surveyors. On 5/7/15 at 6:05 PM, the Administrator and DNS were notified about the identified concern. On 5/11/15, the facility faxed additional information which did not resolve the concerns.	F 314		
F 323 SS=E	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 observation, staff interview and record review, it was determined the facility failed to provide adequate supervision, and ensure the environment was free from accident hazards. This was true for 2 of 9 (#s 1 & 6) and 1 Random	F 323	F 323 Residents identified Residents # 1 and 6 had a new fall assessment completed by DON or	7/23/15

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F 323	Continued From page 40 Resident (#17) sampled for falls. This deficient practice had the potential for more than minimal harm when Resident #1 was left unsupervised and fell in the shower; Resident #6 fell out of bed when she tried to reach her bedside table, which was against the wall; and, Random Resident #17 did not have the Sit to Stand sling buckled at her waist and was assisted by an untrained housekeeping staff member. Findings included: 1. Random Resident #17 was most recently admitted to the facility on 3/22/11 with multiple diagnoses to include Congestive Heart Failure (CHF), pulmonary embolism and infarction, dementia, and abnormality of gait. The current Fall care plan, dated 10/15/14, documented, "Assist resident getting in and out of the bed with two person assist," however the current Activities of Daily Living (ADL) care plan, dated 10/14/14, documented, "Resident requires one and two person assistance with bed mobility, transfers, and toileting." The facility's Sit to Stand lift policy and procedure documented, "Position the sling around the patient's lower back; place the belt toward the patient with the labels at the top and facing away from the patient; position the patient's arms outside the sling; ensure the back of the sling covers the patient from just below the shoulder blades to the lower back; and fasten the safety belt around the waist and adjust to a snug but comfortable fit. Additionally, the use of Sit to Stand lift requires two staff members. Use of only one staff member requires discussion by the Interdisciplinary Team." The Manufacturer's specifications for the use of	F 323	designee on 6/5/15. No falls noted for residents #1 and 6 within the last 30 days. Resident #17 had a new lift assessment completed by DON or designee on or before 5/27/15. Resident was assessed by licensed nurse on 6/10/15 for any adverse effects related to transferring against care plan with no negative findings. Care plan and Kardex were updated at time of review as indicated. Other residents having the potential to be effected Residents residing in the facility that sustained a fall in the past 30 days had a new fall assessment completed by the DON or designee on or before 6/12/15 Care plans and Kardex were updated at time of review to reflect new interventions that include but are not limited to increased supervision as indicated. Residents residing in the facility had a lift assessment completed by licensed nurse on or before 6/12/15 to ensure current transfer status accurately reflects care plan. Care plans were updated at time of assessments by DON or designee as indicated. Systematic Changes and Education Licensed nurses were re-educated by DON or designee on or before 6/12/15 regarding need for new interventions after a fall including increased supervision as	

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F 323	Continued From page 41 the Sit to Stand lift documented, "The belt MUST be snug, but comfortable on the patient, otherwise the patient can slide out of the sling during transfer, possibly causing injury." On 5/5/15 at 11:55 AM, CNA #9 asked the house keeping (Hskp.) #12, "Can you come in and spot me while I get RR #17 up, the state surveyors are here." Hskp. #12 followed CNA #9 into the resident's room and shut the door. When the surveyor entered the resident's room, Hskp. #12 was washing her hands in the sink on far side of the room and CNA #9 was using the sit-to-stand by herself to raise RR #17 out of her recliner and into her wheelchair. The sling was secured under the resident's arm pits, however the waist belt was undone. CNA #9 was asked about the waist belt being unbuckled and she stated, it should have been buckled, " I just forgot to buckle it." On 5/5/15 at 12:40 PM, during an interview, Hskp. #12 stated she did not know how and did not receive training during orientation on how to perform a Sit to Stand transfer or how to "spot" the resident during the transfer. On 5/5/15 at 2:20 PM, the DNS informed the survey team she had been informed by staff that CNA #9 had asked housekeeping staff to assist with the transfer on RR #17. The DNS stated, "Only nursing staff can assist with mechanical lift transfers," and she was currently providing education to facility staff. On 5/6/15 at 4:50 PM, the Administrator was notified about the concern and no additional information was provided. 2. Resident #1 was admitted on 4/3/14 with	F 323	indicated for multiple falls to ensure resident safety. Licensed nurses were re-educated by DON or designee on or before 6/12/15 on lift assessment to assist with determining safe method of transfer for residents and need to communicate transfer status via care plan and Kardex upon completion of assessment. Residents sustaining falls will be reviewed by center IDT during morning clinical meeting for new interventions including but not limited to increased supervision as indicated. Residents will also be reviewed during center customer at risk meeting weekly times 4 weeks after a fall to ensure intervention is effective. Residents lift assessment will be reviewed by center IDT post admission and scheduled assessments during morning clinical meeting to ensure care plans accurately reflect current transfer status. Lift competencies for nursing assistant were completed by center nurse practice educator on or before 6/12/15 to ensure systematic change effective including but not limited to 2 trained staff members operating full mechanical lifts. Ongoing Monitoring Beginning the week of 6/15/15 DON or designee will review 5 lift assessments and 5 falls per week weekly for 4 weeks and then monthly for 2 months to ensure	

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F 323	Continued From page 42 diagnoses which included paralysis agitans, abnormality of gait, muscular wasting and disuse atrophy and lack of coordination. The resident's most recent quarterly MDS Assessment, dated 1/6/15, documented the resident was moderately cognitively impaired with a BIMS score of 12. The resident needed extensive assistance of one person to walk in the corridor, locomotion off the unit and bathing. Resident #1's Fall Care Plan, initiated 10/10/14, documented the resident was at risk for falls related to tremors, Parkinson's disease, history of falls and use of medications that could contribute to falls. The fall interventions, initiated 10/10/14, documented the following: "Utilize low bed; provide verbal cues for safety and sequencing when needed; Place call light within reach at all times; Maintain a clutter-free environment in the resident's room and consistent furniture arrangement; When resident is in bed, place all necessary personal items within reach; Monitor for and assist toileting needs; and, Bilateral transfer bars to bed for assist with in/out bed and bed mobility." Additionally, an intervention, dated 1/16/15, documented, "Administer medications as ordered." The resident's Fall Risk Evaluation, dated 1/19/15, documented the resident was at high risk for falls with a score of 13. Record review of the facility's Risk Management System, dated 3/12/15, documented Resident #1 fell, on 3/9/15 at 12:30 PM, without injury. The circumstances which described the event documented the bath aide had just given the resident a shower when she soiled her	F 323	that care plans are updated for falls and transfer status. Results of audits will be presented to the interdisciplinary team meeting for a minimum of 3 months or until compliance sustained. DON is responsible for compliance.	

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F 323	Continued From page 43 disposable brief. The bath aide went to retrieve additional supplies and left the resident alone in the shower. The resident fell when she reached for her shampoo which was sitting on a shelf and fell out of the shower chair. An Event Investigation Interview Record, dated and signed 3/12/15 by the bath aide, but not timed, documented she had given the resident her shower and the resident soiled her brief after the bath aide had put a clean one on her. The bath aide left the resident to retrieve additional briefs. She documented the resident reached for her deodorant, slipped forward and sat on the floor. When the bath aide returned, the resident insisted on getting up, and the bath aide pulled the call cord. She sat the resident on the toilet until nursing staff could assess. A Resident Alert, dated 3/12/15, but not timed, documented Resident #1 fell in the bathroom reaching for an item on the shelf while the bath aide was returning with supplies. The intervention, which was signed by the bath aide, documented, "Use call cord and have someone else retrieve supplies if necessary." The Resident #1's Fall Care Plan was updated with the following interventions: *Initiated 3/11/15 - "Reinforce importance of asking for assist when tremors more severe for toileting. If [name of resident] using toilet at time of shower, remind her to wait stay put if need to retrieve any supplies;" and, *Initiated 3/12/15 - "If additional supplies are needed when showering [name of resident] will use the Call Cord to ask for someone to bring supplies rather then [sic] leave resident alone."	F 323		

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F 323	Continued From page 44 The Investigation Record included a CNA Kardex, with a print date of 3/12/15, documented the following safety interventions: *"If additional supplies are needed when showering [name of resident], the aide will use the Call Cord to ask for someone else to bring supplies rather then [sic] leave resident alone; and, *Reinforce importance of asking for assist when tremors more severe for toileting. If [name of resident] using toilet at time of shower, remind her to wait stay put if need to retrieve any supplies." On 5/7/15 at 4:55 PM, the DON stated the bath aide went to get supplies after the resident soiled the new brief. When asked where the bath aide went, the DON stated she didn't know and could not answer that question. The DON stated the resident should have had supervision at all times when she was in the shower. She stated the bath aide should have remained with the resident and should have used the call light to get supplies. 3. Resident #6 was admitted to the facility on 3/12/13 with diagnoses which included adult failure to thrive, dementia, spinal stenosis, and muscular wasting and disuse atrophy. The resident's most recent Significant Change MDS Assessment, dated 2/6/15, documented the resident was cognitively intact with a BIMS score of 13. The resident needed extensive assistance of one person for bed mobility, transfer, locomotion on unit, dressing, toilet use, personal hygiene and bathing. Resident #6's Fall Care Plan, initiated 9/29/14, documented the resident was at risk for falls	F 323		

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F 323	Continued From page 45 related to impaired mobility, cognitive loss, hallucination/delusional activity, use of pain medications, decreased safety awareness, decreased balance and muscle weakness. The fall interventions, initiated 9/29/14, documented the following: "Assess for changes in medical status, pain status, mental status and report MD as indicated; Place glasses within reach and encourage use; Assist resident getting in and out of bed with one person; Assist resident with ambulation providing one person assistance using a FWW and use of gait belt; Provide verbal cues for safety and sequencing when needed; Place call light within reach at all times; Remind resident to use call light when attempting to ambulate or transfer; maintain a clutter-free environment in the resident's room and consistent furniture arrangement; When resident is in bed, place all necessary personal items within reach; and, Assist resident getting in [and] out of bed with the assist of one person during transfer." Record review of the facility's Risk Management System (RMS) report, dated 1/18/15, documented Resident #6 had an unwitnessed fall out of bed, without injury, on 1/18/15 at 3:00 PM. The circumstances which described the event documented the resident was calling out and was found sitting on her room floor facing her bed. Her feet were straight out and she was resting on her hands. The resident was lifted to her feet by two staff members and placed in her wheelchair. The report documented, "She [the resident] was trying to get to her (overbed) table which was away from her bed, up against the wall." The report documented the resident's wheelchair was out in the common area by the recliner and, "Usually staff leave her overbed table next to her bed and her wheelchair by her bed." Neuro	F 323		

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F 323	Continued From page 46 checks were started and were found to be within normal limits. The RMS report documented the root cause of the fall was that the resident was reaching for items on her bedside stand, which had not been replaced within the resident's reach when she was assisted to bed. The report documented the interventions added immediately after the fall were to have the bedside stand positioned within reach, and staff re-educated to assure bedside stand/items within reach when in bed. Note: The bedside table had been previously care planned under the 9/29/14 intervention, "When resident is in bed, place all necessary personal items within reach." The RMS report documented the corrective action, "Staff re-educated to assure bedside stand placed at bedside with personal items within reach when assisted to bed." A Resident Alert, dated 1/19/15, documented, "Interventions: Please be very careful to assure bedside stand and all nec[essary] equipment within reach when [name of resident] is in bed." However, the Resident Alert had 12 lines for employee signatures which were blank, and had not been signed by any employee. On 5/7/15 at 4:10 PM, the DON stated, "Staff should have kept the bedside table by the door to prevent the resident from falling." On 5/7/15 at 6:05 PM, the Administrator and DON were made aware of the aforementioned fall concerns. No further information was provided by the facility.	F 323		

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F 328	Continued From page 47	F 328		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident's oxygen concentrator was set at the ordered liter flow rate. This was true for 1 of 5 (#4) residents sampled for oxygen use. This deficient practice created the potential for harm should the resident have a drop in oxygen saturations resulting in anxiety, confusion and/or experience respiratory distress. Findings included: Perry & Potter's Clinical Nursing Skills & Techniques, 7th Edition, 2010, states on p. 629, "Treat oxygen therapy as a medication...As with any drug, continuously monitor the dosage or concentration of oxygen. Routinely check the health care provider's orders to verify that the patient is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."	F 328	F 328 Residents Identified Resident # 4 had a respiratory assessment completed by licensed nurse on or before 6/12/15 for any adverse effects related to oxygen not administered per MD orders. No negative findings were noted at time of assessment. Other Residents Having the Potential to be effected Other residents residing in the facility with oxygen orders were reviewed by the DON or designee on or before 6/12/15 to ensure oxygen was being delivered per MD orders. Corrections were made at time of review as indicated. Systematic Changes and Education	7/23/15

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F 328	Continued From page 48 Resident #4 was admitted to the facility on 10/24/14 with multiple diagnoses to include congestive heart failure, atrial fibrillation, anxiety, and history of venous thrombosis and embolism. The Physician Recapitulation Orders dated 5/6/2015 documented, Oxygen at 2 liters via nasal cannula continuously every shift. The current Respiratory care plan documented the following interventions: * HOB (head of bed) elevated for Resident #4's comfort, r/t SOB when laying flat; * Oxygen as ordered; and * Observe respiratory status and assess for changes as well as changes in mental status. On 5/5/15 from 9:45 AM to 9:55 AM, the resident was observed laying in her bed with the oxygen cannula in her nose and the oxygen concentrator button in the off position. On 5/5/15 at 9:55 AM, LN #5 was asked to check the resident's oxygen saturation. The resident's initial oxygen saturation was 84% and rose to 86% after the concentrator was turned on. When asked what the policy was for turning the oxygen concentrator on in the room, LN #5 stated the CNAs cannot turn the oxygen on it has to be done by a nurse. She stated, "The CNAs should have asked me to turn the oxygen on when they laid the resident down." On 5/7/15 from 10:00 AM to 10:35 AM, the resident was observed laying in her bed with the oxygen cannula in her nose and the concentrator was turned on, however it was set at 1.5 liters and not the prescribed dose of 2.0 liters.	F 328	Licensed nurses were re-educated by DON or designee on or before 6/12/15 regarding ensuring that the oxygen is set per MD orders. Education will also occur during new employee orientation for nursing staff by center nurse practice educator. CNAs will bring resident to the licensed nurse who will verify oxygen orders prior to turning portable concentrator on. Upon resident return to room, CNA will leave resident on portable tank and alert licensed nurse for need to change oxygen to electric concentrator. Licensed nurse and nursing assistant competencies for systematic change were completed by center NPE on or before 6/12/15. Ongoing Monitoring Beginning the week of 6/15/15 DON or designee will review 5 residents requiring oxygen therapy weekly for 4 weeks and then monthly for 2 months to ensure that care plans are updated for falls and transfer status. Results of audits will be presented to the interdisciplinary team meeting for a minimum of 3 months or until compliance sustained. DON is responsible for compliance.	

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F 328	Continued From page 49 On 5/7/15 at 10:35 AM, LN #11 was asked to check the setting on the concentrator and confirmed it was set at 1.5 liters and should be set at 2.0 liters. On 5/7/15 at 6:05 PM, the Administrator and DNS were notified about the above observations, and no additional information was provided.	F 328		
F 329 SS=D	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.	F 329		7/23/15

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F 329	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview, it was determined the facility failed to ensure a resident was free from unnecessary medications. This was true for 1 of 6 (#3) sampled residents. The deficient practice had the potential for harm from adverse side effects when anti-phychotic and anti-depressant medications were administered without clear indication for use or adequate monitoring. Findings included: Resident #3 was most recently re-admitted to the facility on 7/25/13, with multiple diagnoses including cognitive communication deficient, depressive disorder, delusional disorder, osteoarthritis, muscle wasting and abnormality of gait (walking). The resident's most recent quarterly MDS, dated 2/11/15, coded the resident was cognitively intact with a BIMS score of 13, had moderate to severe depression, had delusions, was absent of behavioral symptoms, and did not reject cares. The current care plan documented the resident had hallucinations and delusions at times and was at risk for complications related to the use of psychotropic drugs. Interventions included: - Complete behavior monitoring flow sheet; (11/7/14). - Discuss in monthly psychotropic medication meetings for possible medication adjustments; (11/7/14). - Obtain psych eval; (11/7/14). - Medicate resident as ordered by physician and monitor for side effects; (11/7/14). - Non-pharmacological interventions 1:1, remove resident from her room when she is seeing	F 329	F 329 Resident Identified Resident # 3 discharged from facility on 6/7/15 Potential Residents Residents residing in the facility receiving antipsychotic medications were reviewed by DON or designee on or before 6/12/15 to ensure dose reductions have been attempted and behavior flow sheets are reflective of current behaviors. New orders were implemented as indicated at time of review. Systematic Changes and Education Center staff re-educated on by center NPE on or before 6/12/15 regarding use of behavior flow sheets and to include quantitate data to reflect resident¿s current behaviors including non-pharmacological interventions. Residents behavior flow sheets will be reviewed weekly during center customer at risk meeting by DON or designee to ensure behaviors are identified on flow sheet and include non-pharmacological interventions. Resident behaviors and medications will also be reviewed monthly during the interdisciplinary psychotropic meeting with pharmacy consultant. Ongoing Monitoring	

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F 329	Continued From page 51 people in there, to ease her anxiety, call family to talk to with her. Offer toileting, attempt to re-direct; (12/2/14). Note: It is unable to be determined how offering toileting to the resident was an appropriate intervention when the resident stated she saw men in her room and saw a man demanding masturbation. Please see progress notes below. The Interdisciplinary progress notes and care review progress documented the following: - 10/8/14, 6:00 AM, hallucinations, seeing men in her room, a flood, bugs on the wall. "Unable to alter these hallucinations. States, 'you all just think I'm crazy'." - 10/14/14, medication change, started on Remeron. - From 10/18/14 to 10/23/14, review of 19 progress notes identified the resident had hallucinations on 5 occasions, did not have hallucinations on 5 occasions, and hallucinations were not addressed on 9 occasions. When documented, the hallucinations consisted of the resident seeing men in her room, seeing ants on the wall, seeing her deceased husband, and seeing 3 women, and one man in her room who was demanding masturbation. - 10/22/14, "...Had increase in antidepressant recently will notify MD of increased confusion/delusional activity." - 10/23/14, the medication, Remeron, was discontinued due to the resident having increased hallucinations, trying to leave the facility to go home. - From 10/24/14 to 10/29/14, review of 14 progress notes identified the resident had 1 occasion of hallucinations (not described), 1 occasion of seeing her deceased husband, one occasion of seeing her deceased cousin and 10	F 329	Beginning the week of 6/15/15, DON or designee will review 5 residents receiving antipsychotic medication weekly for 4 weeks and then monthly for 2 months to ensure behavior flow sheets are completed to reflect current behaviors. Results of audits will be discussed at center¿s interdisciplinary performance improvement committee meeting for a minimum of 3 months or until compliance sustained. DON is responsible for compliance.	

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F 329	Continued From page 52 occasions without hallucinations and or confusion. - 10/28/14, care review progress note, "Care review - res (resident) has had less delusions/hallucinations since the D/C (discontinuation) of Remeron." - 10/30/14, 11:00 AM an IDT note documented the resident had a fall, the chair alarm was heard from the hallway, the resident was found on the floor in the sitting position. The note also documented the resident was started on the medication, Risperdal, for increased hallucinations/delusions. Note: The 10/30/14 progress related to the fall did not identify the resident was having delusions. Physician orders dated 10/30/14, at 11:25 AM, documented, "Risperdal 0.25 mg (milligrams) PO (by mouth) q (every) am and q 2 pm for delusions secondary to general medical condition." Bullet this, and add MD prog notes at the introduction to the bullets, if you have not already done so. * 10/30/14, at 1:30 PM, IDT note, "Resident knew where she was, knew her name, DOB (date of birth), & (and) month." * 10/31/14, the IDT progress note related to the fall, documented, the resident transferred herself, was delusional and saw people in her room, was difficult to redirect, thinking she could stand by herself. Note: The facility could not explain why the 10/30/14 progress note for the resident's fall did not contain documentation of hallucinations. It was not was not clear from the IDT note on 10/31/14 how the facility determined hallucinations were the root cause of the reisdent's fall, nor how it could be determined that	F 329		

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F 329	Continued From page 53 there was no other underlying cause to the hallucinations which could be addressed without the use of an antipsychotic medicacation. - 12/2/14, the resident had decreased delusions and hallucinations since starting on the Risperdal. - 1/16/15, the resident had increased behaviors and delusional thinking and may need and increase in Risperdal 0.25 mg two times a day. The interdisciplinary psychotropic meeting notes, dated, 8/12/14, 9/8/14 and 10/13/14, were typed, copied and adhered to the paper. The formatting, spacing and wording is exactly the same each month, and a handwritten signature is below each note and documented: "(Resident #3) She was started on Sertraline 75 mg po [by mouth] daily for depression (-20-14, increased 7-29-14). She did show some improvement with her depression. Her family wants a psych because she is talking about joining her dead husband. No side effects have been noted. No medication changes are recommended at this time." The interdisciplinary psychotropic meeting notes, dated, 11/10/14, 12/8/14, 1/12/15 and 2/9/15 were typed, copied and adhered to the paper. The formatting, spacing and wording is exactly the same each month, and a handwritten signature is below each note and documented: "(Resident #3) She is on Risperdal 0.25 mg bid for delusions (started 10-30-14) and Sertraline 75 mg po daily for depression (5-20-14, increased 7-29-14). She did show some improvement with her depression but recently has shown delusions and hallucinations. Dr [name] recently saw her and added the Risperdal. No side effects have been noted. No medication changes are	F 329		

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F 329	Continued From page 54 recommended at this time." On 5/8/15, at 12:00 PM, RN #3 was asked to provide documentation on all target behaviors monitored related to the start of and continued use of Risperdal, including all non pharmacy interventions put in place before, during and after it was ordered. RN #3 was also asked if the resident had a care plan specifically for the Risperdal medication. On 5/8/15, after the above request, RN #3 provided the same care plan above however had omitted "Obtain psych eval as ordered," and in its place, dated 5/6/15, documented, "Patient utilizes psych consult for med (medication) management to assist with s/s [signs and symptoms] of hallucinations/delusions." RN#3 hand-wrote, "(Resident #3) r/t [related to] Risperdal use." When asked, the facility did not provide evidence of ongoing behavior tracking for hallucinations or delusions, evidence of non-pharmacological interventions attempted should these indicators occur, nor the results of the interventions. The psychotropic medication use evaluation form dated 4/13/15, documented, no changes in the residents behavior symptoms, had "N/A," (not applicable) in the section for non-pharmacological interventions attempted in the last 30 days, documented the pharmacy recommended GDR for Risperdal, and the medication Zoloft was had a recent dose change in the last 30 days on 2/26/15, and the "Gradual Dosage Reduction NOT Recommended," section was incomplete. On 5/7/15 at 6:05 PM, the Administrator and DNS were notified about the above observations.	F 329		

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F 329	Continued From page 55 On 5/12/15, documented the following: "On 4/14/15, she (Resident # 3) was reviewed by the IDT and a request for a GDR (gradual dose reduction) was sent and the MD declined stating that even with the current regimen, she was continuing to have active, disturbing, threatening hallucinations involving men in her room." However, this documentation did not resolve the concern as to how it could be determined, without ongoing monitoring of the resident's specific target behaviors, how the continued use of Risperdal was effective and or appropriate.	F 329		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		7/23/15

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F 353	Continued From page 56 This REQUIREMENT is not met as evidenced by: Based on observations; resident, staff, family, and group interview; medical record review, and a community reported complaint to the Bureau of Facility Standards; it determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of all residents. This affected 3 of 10 (#s 3, 4, & 5) sampled residents; 2 of 4 residents who attended the group interview; 2 of 8 (#s 14 & 16) Random Residents; and had the potential to affect all other residents who lived in the facility that required assistance. This failed practice created the potential for psychosocial harm and physical harm to the residents; if call lights were not answered in a timely manner; residents went without showers/baths; residents developed a skin issues; residents oxygen was not turned on; residents fell due to lack of supervision; and if residents did not receive oral care. Findings include: Observations: 1. On 5/4/15 after lunch Resident #4, a two person total assist via mechanical lift, requested to lay down. Staff A asked 5 staff to assist with the resident, and was told they were busy. Staff A alerted staff a surveyor was in the room, 3 staff immediately responded to help. Staff A said when the survey team arrived there was an overabundance of office staff available to assist the CNAs on the floor. Staff A stated the office staff did not routinely assist the CNAs with resident care. 2. On 5/5/15, from 11:55 AM to 1:01 PM the	F 353	F353 Residents Identified Resident # 3 discharged from facility on 6/7/15. Residents #s 4,5,14,16 were assessed for psychosocial harm by SSD on 6/5/15 related to inadequate staffing. No signs of distress were noted at time of assessment. Potential Residents Other residents residing in the facility have been observed by DON or designee on or before 6/12/15 for call lights answered in a timely manner, showers/baths being given as scheduled, skin integrity issues, oxygen delivered as ordered and oral care provided per plan of care. Systematic Changes The staffing schedule was revised by DON on 6/2/15 to better accommodate the needs of residents and to assist with staff efficiency. Center staff was educated by DON or designee on 6/4/15 as to the responsibility of all staff answering call lights, and the new process/schedule of baths/showers.	

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F 353	Continued From page 57 following was observed for Resident #3: * 12:05 PM, the resident was served lunch in the dining room and staff did not provide set-up help for the resident and/or ask the resident if she needed assistance. * From 12:05 PM to 12:10 PM the resident attempted to open the ranch dressing container several times by shaking it and was unsuccessful. The resident then attempted to alert RN #3, CNA #10 and the Activity Director she needed assistance by holding the container out infront of her as the staff walked passed her. * 12:15 PM, Resident #3 placed the unopened ranch dressing container on the right of her plate and continued to eat. From 12:05 PM to 12:52 PM, the staff were not observed to interact the resident. * At 12:52 PM, Resident #3 was the last resident in the dining room. CNA #10 identified the resident's ranch was unopened and said to the resident, "You couldn't get it open?" Resident #3 confirmed she could not get the container opened and requested to be taken back to her room. CNA #10 told the resident, "I am cleaning up, let me finish, how about give me a second and then I will take you back to your room and we can spend time together." The CNA left the resident in the dining room and proceeded to gather hall trays. * At 12:57 PM, Housekeeping #12 asked the resident, "Are you done?" at which time CNA #10 returned to the dining room and stated to the houskeeper, "I told her (Resident #3) to let me finish, just to give me a second." * At 1:01 PM, Resident #3 wheeled herself out of the dining room and down the hall towards her room. * At 2:40 PM, CNA #10 stated she did not get to spend time with the resident and was unable to follow through with the promised assistance	F 353	Ongoing Monitoring Beginning the week of 6-15-15, SSD or designee will complete 5 resident or family interviews to assess if they feel their needs are being met weekly for 4 weeks then monthly for 2 months. Staffing will discussed monthly at the resident council meeting to identify any concerns or issues. Results of interviews will be reported to the PI Committee for a minimum 3 months or until compliance sustained. DON will be responsible.	

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F 353	Continued From page 58 becuase she was needed to transfer patients and did not have the time. 3. On 5/6/15, the following observations were made from 7:09 - 7:30 AM, Resident #5 called out for help 19 times. Resident #5 was observed to be left in her wheelchair in the middle of her living room. The call light was not within the residents reach. Staff B was asked to assist the resident and stated Resident #5 was not supposed to be in the living room and should either be in the bed or in the dining room and a call light should have been within the residents reach. Staff B stated she did not know why the resident was left and stated the facility was short one CNA with three on the floor rather than four and did not know why the facility was short-staffed. 4. On 5/8/15, the following observations were made from 9:18 to 9:45 AM. At 9:18 AM, Resident # 16 asked the NPE for assistance to use the bathroom. The NPE looked down the halls, identified that no staff were in sight, opened the door of room 210, alerted the staff in the room of the residents need, closed the door of room 210 then stated to Resident # 16, "Your CNA is almost done, then she will come help you." Note: The door to room 210 remained closed until 9:40 AM. * At 9:19 AM, the NPE continued working at the nurses station. While Resident # 16 waited for assistance, the DNS, the Administrator, CNA #2, CNA #19, and RN #20 passed by the resident and the NPE. At no time did the NPE alert the other staff to the residents need. During that time, the resident had wheeled herself from one end of the nurses station to the other and looked at each	F 353		

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F 353	Continued From page 59 person that had passed and attempted to gain a staff members attention by lifting her arm and pointing at them. The resident's movements were slow and each time the staff passed by, the resident was either ignored or a staff member said hello and continued to pass by the resident. * At 9:30 AM, staff D stated to the surveyor, "There are only two of us here to help, one CNA is on a break." * At 9:37 AM, the resident asked the surveyor, "How do I get to the bathroom from here?" When CNA #19 passed by the resident for a 5th time and said hello while bending down to the residents wheelchair level, the resident asked, "Can you take me to the bathroom." * At 9:45 AM, the NPE was asked how the facility ensured a resident was taken to the bathroom when she was the only one who knew of the residents need and had only asked a CNA who was already busy. The NPE comfirmed that the DNS, The Administrator and all Nursing staff were cleared to transfer residents and stated she was unable to transfer secondary to back issues. Resident Interviews: On 5/7/15, at 11:55 AM, Resident #14 was interviewed. When asked if staff assisted him to get up when he requested, the resident replied, "How are they going to do that, it takes more than one." Resident #14 stated the facility was short-staffed lately and morning cares felt rushed with little personal interactions. The resident stated he felt like things were being, "done to him," rather than ,"with him," and in the mornings, staff did not always wake him up to brush his teeth resulting in his teeth being brushed 4-5 times a week. Resident #14 stated he waited for staff to ask him because he knew they were	F 353		

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F 353	Continued From page 60 always busy and did not want to bother them. The resident stated there had been more than one occassion where he called for assistance because he was incontinent and had waited up to a half hour for assistance, stated, "You can only do what you can do," and "they are busy and I hate to interupt or bother them." The resident stated, staff were quickly in and out of his room and they did not have time to spend with him. The resident stated he did not favor the "shifting crews," and stated, "This place is kind of like a home ya know and when you get to know someone pretty good, it changes and the staff are like family and then I deal with shifts in personalities and have to re-adjust." Staff Interviews: 1. On 5/6/15, Staff C stated there were 3 CNAs' on the floor but there was usually 4 and stated when there was only 3, the 35 residents are split in thirds. Staff C stated, about a month ago, there was an incident when only 2 CNAs' were on the floor and it was a very difficult time. Staff C stated there were 9 lift residents that required 2 person assist and often the staff had to make residents wait until another staff was available and stated, sometimes CNA's are toileting a resident who cannot be left alone when other staff are needing help. Documentation: 12 Call light audits, dated 3/23/15 from 10:35 AM, to 2:35 PM, identified 50% of the call lights were answered in 10 minutes or greater, of that 50%, 4 call lights were answered in 14 minutes or greater.	F 353		

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F 441	Continued From page 61	F 441		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		7/23/15

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F 441	Continued From page 62 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to use appropriate hand washing practices to reduce the spread of infections and prevent cross-contamination for 1 of 9 (#6) sampled residents and 1 random resident (#12). This failed practice created the potential risk for residents in the facility to spread infection from one resident to another. The facility's Hand Hygiene Policy and Procedure documented: *"1. Wash hands with soap and water in the following situations...Before and after direct patient care; *2. Decontaminate hands using an alcohol based hand rub or wash hands with soap and water in the following clinical situations...Before any direct contact with patient...After contact with patient's intact skin...After contact with inanimate objects in the immediate vicinity of the patient; *3. Follow proper technique for hand hygiene practices...3.1 To wash hands with soap and water: Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously for at least 15 to 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use towel to turn off facet." 1. Resident #6 was admitted to the facility on 3/12/13 with diagnoses which included adult failure to thrive, dementia, spinal stenosis, and muscular wasting and disuse atrophy. On 5/5/15 at 8:40 AM, CNA #17 was observed to	F 441	F 441 Resident Identified Resident # 6 and 12 were assessed by DON or designee on 6/4/15 for any signs and symptoms of potential cross contamination related to lack of hand washing during resident care. No adverse effects were noted at time of assessment. Potential Residents Staff competencies completed by NPE on or before 6/12/15 to ensure hand washing occurred per policy during resident care. Systematic Changes and Education Center staff, including identified CNAs, were re-educated by nurse practice educator on or before 6/12/15 on hand hygiene occurring per policy during resident care. Hand washing competencies were completed by members of the nursing department by the center nurse practice educator on or before 6/12/15. Ongoing Monitoring Beginning the week of 6/15/15, DON or designee will complete 7 staff hand washing competencies weekly for 4	

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F 441	Continued From page 63 answer the call light for Resident #6 who was in the bathroom. CNA #17 assisted the resident in her WC (wheelchair) to the sink, located in the common area of the resident's room, where the resident brushed her teeth and washed her face. CNA #17 left the resident's room but did not wash her hands or use hand sanitizer. She walked down the hall into the dining room, spoke to a housekeeper and was observed to enter another resident's room. On 5/5/15 at 8:50 AM, CNA #17 stated, "Oh sorry, she [Resident #6] was in front of the sink. I should have washed my hands...we are inserviced on hand washing every quarter." On 5/6/15 at 3:45 PM, the NPE stated, "She [CNA #17] should have used the hand sanitizer if she didn't have direct hand contact." 2. On 5/5/15 at 5:15 PM, CNA #18 was observed to assist in a hoyer transfer for Random Resident #12. After the resident was transferred from her bed to the WC, CNA #18 was observed to wash her hands, and dry them with paper towels. She then discarded the paper towels in a trash can and turned the sink knobs to the off position with her bare hands. On 5/6/15 at 3:30 PM, CNA #18 stated, "I didn't use paper towels on the handles, I apologize. I've been taught to wash my hands for 15 seconds, then use a paper towel to turn the water off." On 5/6/15 at 3:45 PM, the NPE stated, "She [CNA #18] should have used a dry paper towel to turn off the water. She knows to use a dry paper towel."	F 441	weeks and then monthly for 2 months. Results of these competencies will be discussed in the center¿s performance improvement committee meeting monthly for a minimum of 3 months or until compliance sustained. DON is responsible for compliance.	

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F 441	Continued From page 64 On 5/6/15 at 4:50 PM, the Administrator and DON were made aware of handwashing concerns. No further information was provided by the facility.	F 441		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, review of the facility's policies and procedures for pressure ulcers, oxygen, hand hygiene, and infection control, it was determined the Administrator, Director of Nursing, and the management team failed to administer resources which would effectively and efficiently prevent systematic problems. This was true for 9 of 9 sampled residents (#s 1-9) and had the potential to affect any resident who resided in the facility. This failure resulted in the Administrator, Director of Nursing and management team providing insufficient direction and control, necessary to ensure residents' Quality of Life, Quality of Care and Infection Control needs were met. The facility failed to provide sufficient implementation, monitoring, evaluation and continued oversight to maintain regulatory compliance in the following areas: A. Refer to F 248 - The facility failed to provide an ongoing program of activities designed to meet	F 490	F 490 Residents Identified Please refer to F 441, F 328, F 314, and F 248 for actions taken for identified residents. Potential Residents Residents residing in the facility had the potential to be affected under this citation. Please also see F 441, F 328, F 314, and F 248 for actions taken to identify specific residents. Systematic Changes and Education On 6/5/15 the Regional Vice President educated the Center's Performance Improvement (PI) Committee on running a comprehensive PI program including the	7/23/15

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F 490	Continued From page 65 the physical, mental and psychosocial well-being of each resident. The deficient practice had the potential to cause more than minimal harm if residents experienced boredom and/or mood changes related to a lack of meaningful stimulation. B. Refer to F 314 - The facility failed to ensure residents with pressure ulcers received thorough wound assessments and interventions, and failed to develop and implement systems for prevention of pressure ulcers. The facility misdiagnosed a pressure ulcer which developed over a bony prominence. C. Refer to F 328 - The facility failed to ensure residents received proper treatment and care for oxygen therapy. The deficient practice created the potential for harm should residents have a drop in oxygen saturations resulting in anxiety, confusion, and/or experience respiratory distress. D. Refer to F 441 - The facility failed to use appropriate handwashing practices and did not provide a safe and sanitary environment to prevent the development and transmission of disease and infection. The deficient practice created the potential risk for residents in the facility to spread infection from one resident to another. The Administrator, Director of Nursing, and management team were unable to show that the facility was able to provide resources effectively and efficiently to prevent systematic problems in Quality of Life, Quality of Care and Infection Control areas. On 5/8/15 at 4:30 PM, the Administrator was	F 490	reports, tools, location of policy and procedures and how to reference them, and metrics that are available to the Committee in real time. The training will also include conducting productive monthly PI meetings. The Center Performance Improvement (PI) Committee which includes administrator, DON and other management team members will bring key clinical process metrics, audit results, resident council reports and other information warranting the Committee¿s discussion/actions to the monthly PI meeting. The Pharmacy consultant and medical director will also be in attendance at least quarterly. Ongoing Monitoring During the week of 6/15/15, the administrator will chair the performance improvement committee meeting and review resources brought to meeting by committee members along with the compliance audits from this survey and resident council meeting minutes to ensure recommendations, audit results and metric trends are acted upon. Results of recommendations and audits will be discussed by team members to include but not limited to cause identification with systematic reviews for necessary changes. The PI meeting will occur monthly with regional support available and as needed. Administrator is	

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F 490	Continued From page 66 notified of the identified concern. No further information was provided by the facility.	F 490	responsible for compliance.	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, and review of the facility's compliance history, it was determined the facility's quality assessment and assurance (QAA) committee failed to take actions that identified and resolved	F 520	F 520 Residents Identified Please refer to F 441, F 328, F 314, and F 248 for actions taken for identified	7/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135102		05/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY RIDGE	2609 SUNNYBROOK DRIVE 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 520	Continued From page 67 systematic problems for 3 of 9 sampled residents (#s 3, 4, & 6), and 1 random resident (#12), with the potential to affect all residents in the facility. This failure resulted in the QAA committee providing insufficient direction and control, over the facility, necessary to ensure residents' quality of life, assessments, and quality of care needs were being met. Findings included: The QAA committee failed to provide sufficient monitoring and oversight, and the ability to sustain regulatory compliance, as evidenced by the recitation of the following citations for the current annual recertification survey, dated 5/8/15. A. Refer to F 248 as it related to the QAA committee's failure to ensure there were ongoing individualized activities to meet the interests and physical, mental, and psychosocial well- being of each resident. The facility was previously cited at F 248, with a scope and severity of D, during the annual recertification survey, dated 1/31/14. The facility was recited at F 248 for the current annual recertification survey, dated 5/8/15, at a scope and severity of E. B. Refer to F 314 as it related to the QAA committee's failure to ensure residents received thorough wound assessments and interventions, and failure to develop and implement systems for the prevention of pressure ulcers. The facility was previously cited at F 314, with a scope and severity of G, during the annual recertification survey, dated 1/31/14. The facility was recited at F 314 for the current annual recertification survey, dated 5/8/15, at a scope and severity of D. C. Refer to F 328 as it related to the QAA	F 520	residents. Potential Residents Residents residing in the facility had the potential to be affected under this citation. Please also see F 441, F 328, F 314, and F 248 for actions taken to identify specific residents. Systematic Changes and Education On 6/5/15 the Regional Vice President will educate the Center¿s Performance Improvement (PI) Committee on running a comprehensive PI program including the reports, tools and metrics that are available to the Committee in real time. The training will also include conducting productive monthly PI meetings. The Center Performance Improvement (PI) Committee which includes administrator, DON and other management team members will bring key clinical process metrics, audit results, resident council reports and other information warranting the Committee¿s discussion/actions to the monthly PI meeting. The Pharmacy consultant and medical director will also be in attendance at least quarterly. Ongoing Monitoring During the week of 6/15/15, the administrator will chair the performance improvement committee meeting and review resources brought to meeting by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 68 committee's failure to ensure residents received proper treatment and care for oxygen therapy. The facility was previously cited at F 328, with a scope and severity of D, during the annual recertification survey, dated 1/31/14. The facility was recited at F 328 for the current annual recertification survey, dated 5/8/15, at a scope and severity of D. D. Refer to F 441 as it related to the QAA committee's failure to use appropriate handwashing practices and did not proved a safe and sanitary environment to prevent the development and transmission of disease and infection. The facility was previously cited at F 441, with a scope and severity of F, during the annual recertification survey, dated 1/31/14. The facility was recited at F 441 for the current annual recertification survey, dated 5/8/15, at a scope and severity of E. On 5/8/15 at 2:30 PM, the Administrator was interviewed regarding the facility's QAA process and the concerns with the Activities Program observed during the survey. The administrator stated he addressed the activity concerns himself and felt the results were good. He determined the root cause was due to a lack of focus, and that activity participation sheet had not filled out. He stated audits were done for two quarters. The survey team identified the facility failed to ensure identified systemic changes continued after audits were completed. When asked about the QAA process and the concerns with pressure ulcers, the Administrator stated, "We just don't have pressure ulcers." When asked about the QAA process for oxygen therapy, the Administrator stated previously the root cause of the incorrect oxygen flow rate was related to unintentional	F 520	committee members along with the compliance audits from this survey and resident council meeting minutes to ensure recommendations, audit results and metric trends are acted upon. Results of recommendations and audits will be discussed by team members to include but not limited to cause identification with systematic reviews for necessary changes. The PI meeting will occur monthly with regional support available and as needed. Administrator is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135102		05/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 69 removal of the stickers and/or the stickers had not included revisions of the oxygen flow rates. The Administrator stated the previous plan of correction identified the facility would remove and no longer use the stickers. This required the Licensed Nurse to administer the oxygen at the physician ordered flow rate, however, the Administrator did not identify how communication would occur between the CNA and Licensed Nurse, to ensure room concentrators were turned on at the correct liter flow. When asked about the QAA process for handwashing, the Administrator stated there was retraining of correct handwashing technique, competencies were done and the NPE had done spot checks. The survey team identified the systemic change implemented by the facility was dependent on staff to remember training and did not include tools to help staff modify existing processes. The facility was unable to show the QAA process to be effective at sustaining compliance as evidenced by the repeated deficiencies in four areas of quality of care, quality of life and infection control categories.	F 520		

IDAHO DEPARTMENT OF
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TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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September 8, 2015

G. David Chinchurreta, Administrator
Sunny Ridge
2609 Sunnybrook Drive
Nampa, ID 83686-6332

Provider #: 135102

Dear Mr. Chinchurreta:

On **May 8, 2015**, an unannounced on-site complaint survey was conducted at Sunny Ridge. The complaint allegations, findings and conclusions are as follows:

Complaint #6859

ALLEGATION #1:

Residents are not showered or shaved and wear the same clothes for three to four days in a row.

Residents are not receiving oral care for three to four days in a row.

FINDINGS #1:

These allegations were substantiated and cited at F312.

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

ALLEGATION #2:

A resident attempted to attend a scheduled activity, "But it never happened. All they have is Bingo."

FINDINGS #2:

This deficient practice was substantiated and cited at F248.

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

ALLEGATION #3:

Staff have been heard in the hallways talking about other residents' medical conditions.

FINDINGS #3:

This deficient practice was substantiated and cited at F241.

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

ALLEGATION #4:

A Certified Nurse Aide is rough and grabs residents.

FINDINGS #4:

This deficient practice was substantiated and cited at F226.

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

ALLEGATION #5:

One day, the dumpster was overflowing with incontinent briefs and a recliner was left in the dumpster for "Two months."

FINDINGS #5:

During the survey, observations and resident and staff interviews were conducted. Additionally, Resident Council meeting minutes and grievances were reviewed.

The facility's Resident Council meeting minutes and grievances from November 2014 to May 2014 were reviewed. None of the records included concerns regarding over flowing dumpster and/or a recliner being left in the dumpster for an excessive period.

Observations of the dumpster were conducted from May 4, 2015 to May 7, 2015, throughout the survey. No concerns were identified related to over flowing and/or recliner in the dumpster. Four residents from the Resident Group interview, three residents, two resident advocates, the Maintenance Director and two housekeeping staff were interviewed and did not verbalize concerns related to an over flowing and/or recliner in the dumpster.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Social Services did not respond to reported concerns from residents ' advocates.

FINDINGS #6:

This deficient practice was substantiated and cited at F250.

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

ALLEGATION #7:

A sore developed on the "backside" of a resident after admission to the facility.

FINDINGS #7:

This deficient practice was substantiated and cited at F314.

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

Based on the findings of the investigation, deficiencies were cited and included on the Statement

of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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

Sincerely,

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

NS/dmj

IDAHO DEPARTMENT OF
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October 8, 2015

G David Chinchurreta, Administrator
Sunny Ridge
2609 Sunnybrook Drive,
Nampa, ID 83686-6332

Provider #: 135102

Dear Mr. Chinchurreta:

On **May 8, 2015**, an unannounced on-site complaint survey **OR** investigation of an entity-reported incident was conducted at Sunny Ridge. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint or Entity-Report Incident #ID00006870

ALLEGATION #1:

The complainant stated oral care was not performed at night, and residents were put to bed with remnants of dinner on their T-Shirts.

FINDINGS #1:

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure Survey conducted on May 4 to May 8, 2015.

***The following observations were made:

- Direct care staff and management staff interactions along with multiple other residents;
- Meal observations of identified residents and multiple other residents; and,
- Direct care staff during the provision of care to the identified residents, nine sampled residents and eight random residents.

The following documents were reviewed:
- The medical records for nine residents, including the identified residents;
- The facility's grievance files, incident and accident reports, and reports of allegations of abuse;
- Resident Council meeting minutes; and,
- Staffing hours records.

The following interviews were completed:
- A group of residents were interviewed and several individual residents were interviewed regarding quality of care and quality of life concerns;
- The Director of Nursing was interviewed regarding various quality of care and quality of life concerns;
- The unlicensed staff member responsible for social services was interviewed regarding quality of care concerns; and,
- The Administrator was interviewed regarding various quality of care and quality of life concerns.

Based on observation, record review and staff interviews, it was determined the allegation was substantiated and the facility was cited at F-312.

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

ALLEGATION #2:

The complainant stated that bed sheets had holes.

FINDINGS #2:

Based on observations, interviews with identified residents, and the reside group interview, this allegation could not be substantiated.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that trash was frequently on the ground around the dumpster, including incontinence briefs.

FINDINGS #3:

Based on observations throughout the survey week of May 4 - 8, 2015, and interviews with various staff members, this allegation could not be substantiated.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified CNA instructed tanother facdility staff member not to assist an identified resident at meals.

FINDINGS #4:

Based on observations, record review, and interviews with the identified CNA and the identified resident, this allegation could not be substantiated, but was substantiated for other residents during the survey process and cited at F-353.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated identified residents who required heavy care were told to stay in bed for breakfast.

FINDINGS #5:

Based on interviews with the identified residents, this allegation was not substantiated. However, based on observations during the survey week of May 4, 2015, this allegation was substantiated for other residents and the facility was cited at F-353.

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

ALLEGATION #6:

The complainant stated that activities for residents rarely occurred except for Bingo and special music programs.

FINDINGS #6:

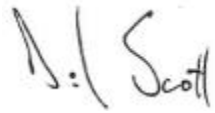
Based on observation, staff interviews, and record review, this allegation was substantiated and the facility was cited at F-248.

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

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

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

Sincerely,



DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt

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October 7, 2015

G David Chinchurreta, Administrator
Sunny Ridge
2609 Sunnybrook Drive,
Nampa, ID 83686-6332

Provider #: 135102

Dear Mr. Chinchurreta:

On **May 8, 2015**, an unannounced on-site complaint survey **OR** investigation of an entity-reported incident was conducted at Sunny Ridge. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint or Entity-Report Incident #ID00006965

Allegation:

An interested party made an inquiry at the facility about a specific resident, both in person and on the telephone. The facility gave no information about this resident, and the interested party was asked to leave the facility. The interested party reported the resident's Power of Attorney paperwork was forged.

Findings:

This allegation was investigated during a recertification survey between May 4, 2015 and May 8, 2015. The record of the identified resident was reviewed. The Ombudsman, the facility Administrator, and the Director of Nursing were interviewed. The identified resident was not at the facility at the time of the survey.

This allegation was known to, and investigated by, the facility, the Ombudsman and the local police department.

This complaint was unsubstantiated. There are no Federal regulatory requirements for the identified allegations.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt