



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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May 26, 2015

Bridger Fly, Administrator
Communicare, Inc #3 Pond
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #3 Pond, Provider #13G010

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #3 Pond, which was conducted on May 15, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Bridger Fly, Administrator
May 26, 2015
Page 2 of 2

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 8, 2015**, and keep a copy for your records.

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 the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by June 8, 2015. If a request for informal dispute resolution is received after June 8, 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 our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,



ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures

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

PRINTED: 05/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #3 POND			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 SOUTH POND BOISE, ID 83705		
(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	
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey conducted from 5/11/15 to 5/15/15. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disabilities Professional CDC - Centers for Disease Control and Prevention ER - Extended Release HPV - Human Papillomavirus IPP - Individualized Program Plan LPN - Licensed Practical Nurse NOS - Not Otherwise Specified NSAID - Nonsteroidal Anti-Inflammatory Drug OT - Occupational Therapy PRN - As needed QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	W 000			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124	W124 Corrective Actions: We have clarified the process in our current QIDP Oversight Manual and have included the page of instructions as Attachment A. The QIDP at this location was hired 11/14 and still is learning the very complex job of a QIDP. The QIDP Supervisor generally prepares the behavior	07/15/15	

RECEIVED
MAY 29 2015
FACILITY STANDARDS

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

TITLE

Administrator

(X6) DATE

5/29/15

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

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W 124	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient information was provided to guardians on which to base consent decisions for 1 of 4 individuals (Individual #2) whose consents were reviewed. This resulted in inaccurate, insufficient information being provided to an individual's guardian regarding restrictive interventions. The findings include:</p> <p>1. Individual #2's IPP, dated 10/1/14, documented a 56 year old male whose diagnoses included severe mental retardation and bipolar disorder.</p> <p>Individual #2's Psychoactive Medication Reduction Plan, dated 3/30/15, documented Individual #2 received Risperdal (an antipsychotic drug), Seroquel (an antipsychotic drug) and Depakote (an anticonvulsant drug) for depression and hypomania related to bipolar disorder symptoms and physical aggression.</p> <p>Individual #2's Behavior Management/Support Plan, dated 4/2015, documented he demonstrated symptoms of depression defined as "looks sad, is tearful."</p> <p>The plan documented Individual #2's hypomania symptoms included "a smirk and/or devious look on his face, verbalizes/vocalizes, paces and/or stomps his feet, pounds with his fist on a table, couch/window, engages in teasing/invades other's personal space, grabs/touches others, touches others (primarily females) in an inappropriate manner; [sic] and masturbates in inappropriate locations."</p>	W 124	<p>management/support plan and the medication reduction plan. The reasons for use of medications for various psychiatric conditions match. Instruction was given to the previous QIDP to make sure the information on informed consents matched these two documents but this did not happen. The QIDP Supervisor did not sufficiently train the she QIDP as to this issue of consistency needed between these documents and she used previous consents as her model.</p> <ol style="list-style-type: none"> 1) The QIDP Supervisor will review the attached document and other consent processing instructions with the QIDP. 2) The QIDP Supervisor and QIDP will work together to review all current consents and those which are not consistent will be reprocessed. <p>Identifying Others Potentially Affected: All individuals at this location are potentially affected.</p> <p>System Changes: Please refer to corrective actions.</p> <p>Monitoring: The QIDP and QIDP Supervisor will monitor each other's work related to the preparation of consents and consistency with other documents mentioned above.</p>	

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W 124	<p>Continued From page 2</p> <p>However, Individual #2's consents were reviewed and did not include comprehensive, accurate information, as follows:</p> <p>a. Individual #2's Psychoactive Medication Authorization and Informed Consent for Risperdal, dated 9/10/14, documented "Risperdal is an atypical antipsychotic mood stabilizer to treat hypomania symptoms of Bipolar Disorder, NOS as evidenced by assaults/impulsivity. They can improve the ability to be less agitated and to be calmer."</p> <p>b. Individual #2's Psychoactive Medication Authorization and Informed Consent for Seroquel, dated 12/24/14, documented the medication was "Prescribed for treatment of Bipolar Disorder, NOS, and sleep disturbance related to Bipolar Mania."</p> <p>c. Individual #2's Psychoactive Medication Authorization and Informed Consent for Depakote, dated 4/17/15, documented the medication was "Prescribed for treatment of Bipolar Disorder, NOS, and sleep disturbance related to Bipolar Mania."</p> <p>d. Individual #2's record contained a Behavior Management Plan/Support Authorization and Informed Consent, dated 9/10/14. During an interview on 5/15/15 from 9:58 - 11:54 a.m., the QIDP Supervisor stated the consent for the behavior plan included consent for the use of restraint with Individual #2 during medical appointments.</p> <p>The consent and the attached Behavior Management/Support Plan, dated 9/2014, were reviewed. Specific information related to the use</p>	W 124			

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W 124	Continued From page 3 of medical restraint could not be found. The plan documented for the use of restraint, staff were to refer to the separate medical restraint guidelines and/or the adult restraint board guidelines. When asked, during an interview on 5/15/15 from 9:58 - 11:54 a.m., the QIDP Supervisor stated she was unsure if the guidelines had been submitted with the consent for guardian review. The QIDP Supervisor stated Individual #2's medication reduction plan was accurate related to the purpose of Individual #2's medications. The QIDP Supervisor stated she had not worked with the new QIDP yet to ensure that the purpose of the medications matched on the consent and the reduction plan. The facility failed to ensure Individual #2's consents included comprehensive and accurate information to allow Individual #2's guardian to make informed decisions.	W 124		
W 315	483.450(e)(4)(i) DRUG USAGE Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure drugs used for control of inappropriate behavior were monitored closely for adverse side effects for 1 of 4 individuals (Individual #2) whose medical records were reviewed. This resulted in an individual receiving a behavior modifying drug without appropriate monitoring to determine if	W 315	W315 Corrective Actions: We will be taking the following actions to address this issue. 1) The RN Supervisor and LPN will review all current Nursing Summaries for accuracy related to adverse reactions and allergies and this information will be documented on the nursing summary. 2) During discussions with the psychiatric provider it will be the LPN's responsibility to review this information and present it to the	07/15/15

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W 315	<p>Continued From page 4 adverse effects were noted. The findings include:</p> <p>1. Individual #2's IPP, dated 10/1/14, documented a 56 year old male whose diagnoses included severe mental retardation and bipolar disorder.</p> <p>Individual #2's Physician's Order Sheet and Progress Note, dated 5/1/15, documented he received Depakote (an anticonvulsant drug) daily. Individual #2's Psychoactive Medication Reduction Plan, dated 3/30/15, documented Individual #2 received Depakote for depression and hypomania related to bipolar disorder symptoms and physical aggression.</p> <p>However, Individual #2's record contained a History and Physical Examination, dated 9/15/11, from his former placement. The examination documented under the "Allergies-Sensitivities" section, "Depakote - excessive lethargy (09/25/00, [physician name])."</p> <p>When asked, during an interview on 5/15/15 from 9:58 - 11:54 a.m., the QIDP Supervisor stated she was not present at the appointment where Depakote was prescribed. She stated she was unaware Individual #2 had adverse effects from Depakote in the past.</p> <p>The facility failed to ensure staff were aware of, and monitoring for, adverse side effects of Individual #2's behavior modifying drug.</p>	W 315	<p>psychiatric services provider for discussion.</p> <p>Identifying Others Potentially Affected: All individuals at this location are potentially affected.</p> <p>System Changes: Please refer to corrective actions.</p> <p>Monitoring: The RN and QIDP Supervisor both typically attend psychiatric clinics for individuals at this location. If the LPN does not remember to check the nursing summary for adverse reactions, the RN Supervisor will instruct him to do so. If neither the RN Supervisor nor the LPN remembers to check this information, the QIDP Supervisor will remind them to do so.</p>	
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p>	W 322		

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W 322	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in an individual not receiving an evaluation as recommended. The findings include:</p> <p>1. Individual #1's IPP, dated 10/15/14, documented a 68 year old male whose diagnoses included severe mental retardation.</p> <p>Individual #1's medical record included a Physician's Order Sheet and Progress Notes entry, dated 9/5/14, which documented "OT evaluation as recommended."</p> <p>Individual #1's record also included a fax cover sheet, dated 9/18/14, from the QIDP to the company which completed the facility's OT evaluations. The cover sheet documented "Here is doctor [sic] referral for [Individual #1] to have O.T. eval...Please contact [AQIDP name and phone number] to set up eval. time."</p> <p>However, the only OT evaluation that could be found in Individual #1's record was dated 7/15/10.</p> <p>During an interview on 5/15/15 from 9:58 - 11:54 a.m., the QIDP Supervisor stated the facility had recently changed QIDPs and follow-up for the recommendation was not completed.</p> <p>The facility failed to ensure Individual #1 was provided with an OT evaluation as recommended.</p>	W 322	<p><u>W322</u></p> <p>PLEASE NOTE: We have had a number of key personnel changes the past year. A new LPN was hired 11/03/14 and resigned 01/30/15. Her replacement was hired 02/08/15. A new QIDP was hired 11/10/14. Both the newest LPN and this QIDP are new to ICF/ID service delivery and neither had participated in a state survey. We had planned to do a Quality Assurance assessment of records 04/15 which hopefully would have identified this issue but there were a number of scheduling conflicts so this was to occur 05/15/15, the day of the survey exit. We understand that intentions are irrelevant to surveyors but we do have a records review system already developed.</p> <p>Corrective Actions: The QIDP Supervisor and RN Supervisor will meet with the LPN and QIDP to discuss how to deal with such recommendations. Additionally we will review all current medical and permanent records to see if there are any other evaluation/assessment issues that need to be addressed.</p> <p>Identifying Others Potentially Affected: All individuals at this location are potentially affected.</p> <p>System Changes: We are not making any systems change as we feel this is an implementation issue.</p> <p>07/15/15</p>

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W 324 W 324	<p>Continued From page 6</p> <p>483.460(a)(3)(ii) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure immunizations as recommended by the Public Health Service Advisory Committee were provided for 1 of 4 individuals (Individual #3) whose medical records were reviewed. This resulted in the potential for preventable illness to occur. The findings include:</p> <p>1. Individual #3's 10/22/14 IPP documented he was a 21 year old male whose diagnoses included mild intellectual disability.</p> <p>The CDC Pink Book, which contains the recommendations for vaccination needs and schedules, stated HPV can cause genital warts, laryngeal papillomas (tumors that form on the larynx or other parts of the respiratory tract, and cancer of the cervix, vulva, vagina, penis, and anus). The Pink Book stated "HPV is transmitted by direct contact, usually sexual, with an infected person. Transmission occurs most frequently with sexual intercourse but can occur following nonpenetrative sexual activity."</p> <p>The CDC recommends all females between age 9 and 26, and all males between 9 and 21, should</p>	W 324 W 324	<p>Monitoring: As previously stated the QIDP Supervisor, RN Supervisor, LPN and QIDP will review all current medical and permanent records to see if there are any other evaluation/assessment issues that need to be addressed. Additionally, we will schedule a formal QA review in six months (11/15) to again review all records. (Our QA review form is available to surveyors upon request.)</p> <p><u>W324</u></p> <p>PLEASE NOTE: We have had a number of key personnel changes the past year. A new LPN was hired 11/03/14 and resigned 01/30/15. Her replacement was hired 02/08/15. He is new to ICF/ID service delivery. We had planned to do a Quality Assurance assessment of records 04/15 which hopefully would have identified this issue but there were a number of scheduling conflicts so this was to occur 05/15/15, the day of the survey exit.</p> <p>Corrective Actions: A memo was sent out 7/13 to all LPN's about Zoster and HPV vaccinations. The LPN who was responsible for the home at this time did not document her actions related to this issue. The RN Supervisor, hired 10/21/13, is still learning the intricacies of her job. Monitoring expectations were reviewed with her initially but this will be done again jointly by the Administrator who is her</p>	07/15/15

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W 324	<p>Continued From page 7</p> <p>receive the HPV vaccination series, and males between 22 and 26 may receive the series unless contraindications exist.</p> <p>Individual #3's record was reviewed and did not include documentation he had received the HPV vaccination or that a discussion related to the need for the vaccination had been conducted with his physician.</p> <p>During an interview on 5/15/15 from 9:58 to 11:54 a.m., the LPN reviewed Individual #3's record and stated his record did not include documentation that Individual #3 received the HPV vaccination or the vaccination was discussed with his physician.</p> <p>The facility failed to ensure Individual #3 received the HPV vaccination as recommended by the Public Health Service Advisory Committee.</p> <p>483.460(a)(3)(iii) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure routine screening laboratory examinations were provided to 1 of 4 individuals (Individual #1) whose laboratory records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include:</p> <p>1. Individual #1's IPP, dated 10/15/14,</p>	W 324	<p>immediate supervisor and the QIDP Supervisor who helped to develop various monitoring systems.</p> <p>The need for this immunization has now been discussed with his guardian and she has chosen to decline its use so a medical declination will be processed by the QIDP with input from the LPN.</p> <p>Identifying Others Potentially Affected: There is only one other person in this age range living at this location. His guardian has declined this immunization for her son and a medical declination will be processed by the QIDP with input from the LPN.</p> <p>Monitoring: As previously stated the Administrator and the QIDP Supervisor will again inservice the RN Supervisor on monitoring systems and the Administrator, who is her immediate supervisor, will do a sampling of the implementation of these monitoring systems on a quarterly basis.</p> <p><u>W325</u></p> <p>PLEASE NOTE: We have had a number of key personnel changes the past year. A new LPN was hired 11/03/14 and resigned 01/30/15. Her replacement was hired 02/08/15. He is new to ICF/ID service delivery. We had planned to do a Quality Assurance assessment of records 04/15 which hopefully would have identified this issue but there were a</p>	07/15/15
W 325		W 325		

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W 325	<p>Continued From page 8</p> <p>documented a 68 year old male whose diagnoses included severe mental retardation.</p> <p>The CDC website stated the U.S. Preventive Services Task Force recommended "colorectal cancer screening for men and women aged 50-75 using high-sensitivity fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy." The website documented fecal occult blood testing should occur annually.</p> <p>Individual #1's medical record was reviewed and documented he received a colonoscopy in 2012. However, documentation of colon screening, specifically annual fecal occult blood testing, since the colonoscopy could not be found.</p> <p>During an interview on 5/15/15 from 9:58 - 11:54 a.m., the RN stated she could not find evidence that annual occult blood tests had been completed for Individual #1.</p> <p>The facility failed to ensure Individual #1 received annual occult blood testing.</p>	W 325	<p>number of scheduling conflicts so this was to occur 05/15/15, the day of the survey exit.</p> <p>Corrective Actions: The need for the fecal occult blood testing on an annual basis for individuals 50 years and over has been done sporadically and a system needs to be implemented. This procedure will be added to our annual physician's history and physical form and will either be done by the primary physician or delegated to an LPN. <i>These will be done with primary Physician</i></p> <p>Identifying Others Potentially Affected: Anyone 50 years of age or older is potentially affected. <i>06/05/15 WJ Seibert 06/02/15</i></p> <p>Monitoring: The RN Supervisor will insure this form is updated and implemented. She will check Annual History and Physical forms for inclusion of this information during regular Nursing Summary Reviews.</p>	
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate nursing services were provided for 3 of 5 individuals (Individuals #1, #4 and #5) whose physician's orders were reviewed. This resulted in a lack of clear physician orders being available to staff. The findings include:</p>	W 331	<p>The Administrator and the QIDP Supervisor will again inservice the RN Supervisor on monitoring systems and the Administrator, who is her immediate supervisor, will do a sampling of the implementation of these monitoring systems on a quarterly basis.</p> <p><u>W331</u></p> <p>Corrective Actions: This issue has been further evaluated by our RN Supervisor. The</p>	07/15/15

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

PRINTED: 05/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #3 POND		STREET ADDRESS, CITY, STATE, ZIP CODE 2650 SOUTH POND BOISE, ID 83705		
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W 331	<p>Continued From page 9</p> <p>1. Individual #1 - #5's physician's orders were reviewed. The Physician's Order Sheet and Progress Note forms included PRN medications which were duplicative and did not consistently include specific individualized orders, as follows:</p> <p>a. The PRN section of Individual #1's Physician's Order Sheet and Progress Note, dated 5/1/15, stated he was to receive Tylenol (an analgesic drug) 650 mg for pain every 4 hours. The section stated Individual #1 could also receive Ibuprofen (an NSAID) 600 mg for pain every 8 hours. The orders did not include specific information regarding how to determine which medication to use and when.</p> <p>b. The PRN section of Individual #4's Physician's Order Sheet and Progress Note, dated 5/1/15, stated he was to receive Tylenol 650 mg for pain every 4 hours. The section stated Individual #4 could also receive Ibuprofen 600 mg for pain every 8 hours. The orders did not include specific information regarding how to determine which medication to use and when.</p> <p>c. The PRN section of Individual #5's Physician's Order Sheet and Progress Note, dated 5/1/15, stated he was to receive Tylenol 650 mg for pain every 4 hours. The section stated Individual #5 could also receive Ibuprofen 600 mg for pain every 8 hours. The section included a third order which documented Individual #5 could receive Norco (an analgesic drug) 5 mg/325 mg as needed for pain. The orders did not include specific information regarding how to determine which medication to use and when.</p> <p>Additionally, the PRN section of Individual #5's</p>	W 331	<p>observations by the survey team were accurate and we have determined that further instruction and inservice training is needed related to this issue. An additional section will be added to our RN Oversight & Nursing Services Manual titled "Consistency of Records" (Attachment B). This document outlines expectations of nursing staff related to the issue of both making sure Physician's Orders are accurate resulting in accurate MARs and Nursing Summaries and clarification of how PRN orders are to be written. The RN Supervisor will inservice the LPN on these expectations and together they will review all current Physician's Orders then request that the physician clarify orders related to the dosages of PRN medications.</p> <p>Identifying Others Potentially Affected: All other individuals living at this location are potentially affected by this issue.</p> <p>System Changes: A copy of the addition to the RN Oversight & Nursing Services Manual titled "Consistency of Records" is attached.</p> <p>Monitoring: The RN Supervisor will insure that all orders for PRN medications are clarified as to dosage range and time span. She will check "Physician's Orders" during regular Nursing Summary Reviews.</p>	

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W 331	<p>Continued From page 10</p> <p>Physician's Order Sheet and Progress Note documented he was to receive Claritin (an antihistamine drug) 10 mg once daily as needed for cough and runny nose. A second order documented Individual #5 was to receive Mucinex ER (an expectorant drug) every 12 hours for runny nose. The orders did not include specific information regarding how to determine which medication to use and when.</p> <p>During an interview on 5/15/15 from 9:58 - 11:54 a.m., the QIDP Supervisor stated the orders needed clarified.</p> <p>The facility failed to provide sufficient nursing oversight necessary to ensure individuals' medication orders were clarified.</p>	W 331	<p>Additionally the Administrator and the QIDP Supervisor will again inservice the RN Supervisor on monitoring systems and the Administrator, who is her immediate supervisor, will do a sampling of the implementation of these monitoring systems on a quarterly basis.</p>
W 334	<p>483.460(c)(3)(i) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be by a direct physical examination.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure quarterly health status reviews were conducted by direct physical examination for 1 of 4 individuals (Individual #4) whose records were reviewed. This resulted in the potential for changes in health status to remain undetected and untreated without an actual physical examination. The findings include:</p> <p>1. Individual #4's 10/8/14 IPP stated he was a 62</p>	W 334	<p><u>W334</u></p> <p>07/15/15</p> <p>Corrective Actions: This issue occurred during the final quarter of work by a previous LPN who assured the RN Supervisor that this type of routine activity had been done. A correction to the lack of a document during this time period cannot be made. We will however, make sure that the current LPN is well aware of this expectation and that the RN Supervisor reviews records to make sure quarterly physical assessments are done in a timely manner.</p> <p>The RN Supervisor, hired 10/21/13, is still learning the intricacies of her job. Monitoring expectations were reviewed with her initially but this will be done again jointly by the Administrator who is her immediate</p>

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W 334	<p>Continued From page 11</p> <p>year old male whose diagnoses included severe mental retardation.</p> <p>Individual #4's record was reviewed and documented nursing summaries including direct physical examinations were completed on 2/27/15, 11/15/14 and 5/16/14. However, the record did not include a direct physical examination for the 3rd quarter (July, August, September) 2014.</p> <p>During an interview on 5/15/15 from 9:58 to 11:54 a.m., the facility nurse reviewed Individual #4's record and stated he was seen by a doctor on 8/1/14 however the doctor's progress note did not document that a physical examination was completed.</p> <p>The facility failed to ensure nursing quarterly exams were completed by direct physical examination for Individual #4.</p>	W 334	<p>supervisor and the QIDP Supervisor who helped to develop various monitoring systems.</p> <p>Identifying Others Potentially Affected: All individuals at this location are potentially affected if these types of assessments are not completed in a timely manner.</p> <p>System Changes: Please refer to corrective actions.</p> <p>Monitoring: The RN Supervisor will check for the completion of quarterly physical examinations during regular Nursing Summary Reviews.</p> <p>Additionally the Administrator and the QIDP Supervisor will again inservice the RN Supervisor on monitoring systems and the Administrator, who is her immediate supervisor, will do a sampling of the implementation of these monitoring systems on a quarterly basis.</p>	

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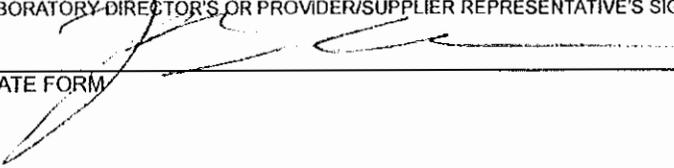
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 5/11/15 to 5/15/15. The surveyors conducting your survey were: Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disabilities Professional	M 000		
MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164	MM164 Please refer to W124	07/15/15
MM412	16.03.11.120.04(m) Furniture and Equipment All furniture and equipment must be maintained in a sanitary manner, kept in good repair, and must be so located to permit convenient use by residents. This Rule is not met as evidenced by:	MM412	MM412 This dresser will be replaced by 07/15/15 and AQIDP will continue to do monthly maintenance checks and will check all dressers in her 06/15 maintenance check. <i>SW Seider</i>	07/15/15

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FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE
Administrator

(X6) DATE
06/02/15
5/29/15

Bureau of Facility Standards

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MM412	Continued From page 1 Based on observation and staff interview, it was determined facility failed to ensure all furniture was kept in good repair for 1 of 7 individuals (Individual #6) residing in the facility. This resulted in Individual #6's chest of drawers being kept in a manner that did not permit ease of use. The findings include: 1. The AQIDP accompanied the surveyor during an environmental review on 5/14/15 from 2:30 to 2:57 p.m. During that time, the third drawer of Individual #6's five-drawer chest of drawers would not open. The AQIDP said Individual #6 had not told her the third drawer of the chest of drawers would not open. The AQIDP attempted but was unable to open the drawer. The facility failed to ensure repairs were maintained for Individual #6's chest of drawers.	MM412		
MM548	16.03.11.210.02(g) Immunization Record of immunizations; and This Rule is not met as evidenced by: Refer to W324.	MM548	<u>MM548</u> Please refer to W324	07/15/15
MM573	16.03.11.210.05(e) Health Care Complaints Notation record of the individual resident's health care complaints and problems together with evaluation and action followed. This Rule is not met as evidenced by: Refer to W315.	MM573	<u>MM573</u> Please refer to W315	07/15/15
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are	MM735	<u>MM735</u> Please refer to W322	07/15/15

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MM735	Continued From page 2 brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
MM737	16.03.11.270.02(a)(i) Medical Services Provided Directly Directly, through personal contact between physicians and residents; and This Rule is not met as evidenced by: Refer to W334.	MM737	<u>MM737</u> Please refer to W334	07/15/15
MM750	16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations Routine screening laboratory examinations, as determined necessary by the physician, and special studies when the index of suspicion is high. This Rule is not met as evidenced by: Refer to W325.	MM750	<u>MM750</u> Please refer to W325	07/15/15
MM762	16.03.11.270.03(b) Route of Contact Providing a route of contact with a resident's responsible physician to licensed personnel in the event of an unanticipated health related condition and to coordinate follow-up of care. This Rule is not met as evidenced by: Refer to W331.	MM762	<u>MM762</u> Please refer to W331	07/15/15