



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

CERTIFIED MAIL: 7000 1670 0011 3315 1569

June 15, 2015

Bridger Fly, Administrator
Communicare, Inc #7 Cougar
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #7 Cougar, Provider #13G072

Dear Mr. Fly:

Based on the Medicaid/Licensure survey completed at Communicare, Inc #7 Cougar on June 2, 2015, we have determined that Communicare, Inc #7 Cougar is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) Conditions of Participation of **Governing Body and Management (42 CFR 483.410)**, **Client Protections (42 CFR 483.420)**, **Active Treatment Services (42 CFR 483.440)** and **Health Care Services (42 CFR 483.460)**. To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these Conditions to be unmet, substantially limit the capacity of Communicare, Inc #7 Cougar to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

It is important that your Credible Allegation/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
6. Include dates when corrective action(s) will be completed.

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

Such corrections must be achieved and compliance verified by this office, before July 17, 2015. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than July 6, 2015.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **June 25, 2015.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Communicare, Inc #7 Cougar ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective June 2, 2015, through September 30, 2015. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **July 10, 2015**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Debra Ransom, R.N., RHIT
Licensing and Certification Administration, DHW
PO Box 83720
Boise, ID 83720-0009
Phone: (208)334-6626
Fax: (208)364-1888

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

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.

Bridger Fly
June 15, 2015
Page 4 of 4

This request must be received by June 25, 2015. If a request for informal dispute resolution is received after June 25, 2015 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

CommuniCare, Inc.
40 West Franklin, Ste F
Meridian, Idaho 83642

July 1, 2015

Michael Case, Health Facility Surveyor
Nicole Wisenor, Co-Supervisor
Non-Long Term Care
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise ID 83720-0009

RECEIVED
JUL - 1 2015
FACILITY STANDARDS

RE: CommuniCare, Inc. #7, Provider #13G072

Dear Survey Team:

Based on our conversation today with surveyors Michael Case and Ashley Hensheid, we are making the following adjustments to the plan of correction submitted for CCI #7 on 06/24/15.

W100

Please refer to W195 (instead of W165)

W149

Corrective Actions Addition

8. At a staff meeting at CCI #7 on 07/01/15 the RN Supervisor discussed and distributed a memo (Attachment O) regarding staff reporting medical issues that they did not feel were being resolved effectively.

W246

Monitoring Addition

During scheduled Trending & Tracking reviews, and as a part the monitoring process for time spent in the bedroom during the treatment of a medical condition, the RN Supervisor and QIDP Supervisor will review the alternate daily schedule of any individual whose schedule has been changed to meet their medical needs. This review will focus on how much time is spent out of the bedroom and notes will be added to the QIDP's Trending and Tracking summary notes related to any corrective actions needed which might include moving a bed into locations other than the bedroom or obtaining an additional bed to be used in another part of the home. Implementation of these actions will be reviewed at the subsequent Trending and Tracking meeting with further instructions provided as needed.

W326

Corrective Actions Clarification

Replace the statement "This was corrected as of 06/19/15" with "The Vitamin D level was obtained 06/19/15."

W331

Corrective Actions Addition

We have updated the "Job Responsibility Guidelines" to better address the issue of medication documentation on physician's orders and medication administration records for both the RN Supervisor (Attachment P) and LPNs (Attachment Q). Changes are in bold.

Monitoring Addition

We have updated the RN Nursing Services Review form (Attachment R) to make sure medication orders and medication documentation are completed according to RN Supervisor and LPN guidelines.

3. Please refer to W334

4. Please refer to W338

W334

Corrective Actions Addition

We have updated the "Job Responsibility Guidelines" to better address the issue of physical completed by a physician annually and a nurse quarterly for both the RN Supervisor (Attachment P) and LPNs (Attachment Q). Changes are in bold.

Monitoring Addition

We have updated the RN Nursing Services Review form (Attachment R) to make sure completion of physician and nursing physical are done according to RN Supervisor and LPN guidelines.

W338

Corrective Actions Addition

We have updated the "Job Responsibility Guidelines" to better address the issue of identifying the need for outside medical services for the RN Supervisor (Attachment P). Changes are in bold.

Monitoring Addition

We have updated the RN Nursing Services Review form (Attachment R) to make sure medical records are reviewed on a routine basis to determine if outside medical services are indicated.

Sincerely,



Bridger Fly, Administrator
CommuniCare, Inc.

Attachment O: Instructions to Staff re: Reporting Unaddressed Medical Issues
Attachment P: CCI RN Job Responsibility Guidelines/Revised
Attachment Q: CCI LPN Job Responsibility Guidelines/Revised
Attachment R: RN Nursing Services Review Form/Revised

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

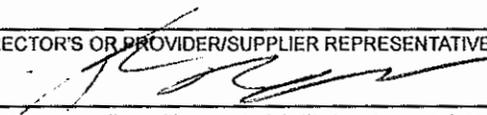
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey conducted from 4/20/15 to 4/22/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Ashley Henscheid, QIDP Common abbreviations used in this report are: ADL - Activities of Daily Living AQIDP - Assistant Qualified Intellectual Disabilities Professional BID - Twice daily CFA - Comprehensive Functional Assessment CIB - Carnation Instant Breakfast CLS - Cold-Like Symptoms DCS - Direct Care Staff ILW - Instructional Lead Worker IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record MOL - Medical Observation Log NS - Normal Saline NSAID - Non-Steroidal Anti-Inflammatory Drug OCD - Obsessive Compulsive Disorder PRN - As needed PT - Physical Therapist Q - Every QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse RTC - Return To Clinic w/c - Wheelchair	W 000			
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS	W 100	<u>W 100</u> Condition: Governing Body Please refer to 165	07/06/15	

RECEIVED

JUN 25 2015

FACILITY STANDARDS

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



TITLE

Administrator

(X6) DATE

6/24/15

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.

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 100	Continued From page 1 "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined each recipient for whom payment was requested was not receiving active treatment as specified in 483.440. The findings include: 1. Refer to W195 Condition of Participation: Active Treatment Services not met and related standard level deficiencies.	W 100			
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by:	W 102	<u>W102</u> Please refer to W104	07/08/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 102	Continued From page 2 Based on observation, policy review, record review, and staff interview, it was determined the facility's Governing Body failed to take actions that identified and resolved systematic problems. This failure resulted in inadequate protections, active treatment and health care services being provided to individuals. The findings include:	W 102			
W 104	1. Refer to W104 as it relates to the facility's failure to ensure the Governing Body provided sufficient operating direction over the facility. 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, policy review, record review and staff interview, it was determined the facility's Governing Body failed to provide sufficient monitoring and oversight that identified and resolved systematic problems. This failure directly impacted 4 of 4 individuals (Individuals #1 - #4) whose records were reviewed and had the potential to impact 8 of 8 individuals (#1 - #8) residing in the facility. This failure resulted in the Governing Body providing insufficient direction and control over the facility necessary to ensure individuals' needs were met. The findings include: 1. Refer to W111 as it relates to the Governing Body's failure to ensure a record keeping system that contained complete information was maintained.	W 104	<u>W104</u> 1. Please refer to W111 2. Please refer to W114 3. Please refer to W122 4. Please refer to W159 5. Please refer to W195 6. Please refer to W318	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 104	<p>Continued From page 3</p> <p>2. Refer to W114 as it relates to the Governing Body's failure to ensure all entries made in individuals' records were signed and dated.</p> <p>3. Refer to W122 Condition of Participation: Client Protections and associated standard level deficiencies as they relate to the failure of the Governing Body to provide sufficient monitoring and oversight to ensure policies were adequately implemented and monitored necessary to ensure individuals were not subjected to on-going medical neglect.</p> <p>4. Refer to W159 as it relates to the Governing Body's failure to ensure the QIDP provided sufficient monitoring and oversight for all individuals residing in the facility.</p> <p>5. Refer to W195 Condition of Participation: Active Treatment Services and associated standard level deficiencies as they relate to the Governing Body's failure to ensure the facility provided each individual with continuous active treatment designed to meet their individualized needs.</p> <p>6. Refer to W318 Condition of Participation: Health Care Services and associated standard level deficiencies as they relate to the Governing Body's failure to ensure the facility provided individuals with preventive and general medical care necessary to meet their individualized needs.</p> <p>The cumulative effect of these systemic deficient practices significantly impeded the facility's ability to meet the individuals' health, safety, and active treatment needs.</p>	W 104		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 111 W 111	Continued From page 4 483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained complete information for 2 of 4 individuals (Individuals #1 and #2) whose medical records were reviewed. This resulted in a lack of documentation to ensure appropriate medical care was provided. The findings include: 1. Individual #2's IPP, dated 5/14/14, documented a 71 year old female whose diagnoses included severe mental retardation. The PRN section of Individual #2's Physician's Order Sheet and Progress Note, signed by the physician on 5/1/15, stated she was to receive acetaminophen (an analgesic drug) 650 mg for pain or an elevated temperature every 4 hours. The section stated Individual #2 could also receive Ibuprofen (an NSAID) 600 mg for pain every 6 hours. Individual #2's MOL and MAR, both for 5/2015, were reviewed. The MOL and MAR did not include comprehensive information related to PRN medication administration, as follows: a. A MOL entry, dated 5/7/15 and timed 9:30 a.m., documented Individual #2 "is coughing + has a nasal [sic] discharge which is	W 111 W 111	<u>W111</u> <u>Record Keeping System</u> <u>Corrective Action:</u> 1. The issues identified in this citation relate to documenting the reason for and use of PRN medications for headache, pain, and cold symptoms. We have evaluated our current system and have determined that some structural changes are needed in the physician's order form and in how PRN medications are authorized. We have reviewed each physician order form and have now identified under which situations PRN medications can be given by Medication Assistants without additional authorization (i.e., Ibuprophen for complaints or observations of pain; Acetaminophen for temperature above 100.5 degrees; cold medicine for nasal drainage, observations of a stuffy nose, complains of or observations of a sore throat, coughing; medication for constipation, etc.). We have also identified when a nurse needs to authorize the use of a PRN (i.e., if an individual has both a prescription for an allergy medication and a cold medication, if an individual has multiple choices for treatment of constipation, etc.)	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 111	<p>Continued From page 5 yellowish/greenish in color. [Individual #2] recieved [sic] 2 - 325 mg tabs of acetaminophen + 1 tab of Sudogest [a decongestant drug] for CLS @ 7:20 a.m. this morning."</p> <p>The MOL and corresponding MAR entry did not include information related to the reasoning for administering acetaminophen for cold symptoms.</p> <p>b. A MOL, entry dated 5/7/15 and timed 9:15 p.m., documented Individual #2 "recieved [sic] ibuprofen 600 mg 1 tab at 432 pm [sic] & Sudogest 30 mg 1 tab at 430 pm [sic]."</p> <p>The MOL did not include information related to the reason the PRNs were administered. Additionally, a corresponding MAR entry could not be found.</p> <p>c. A MOL entry, dated 5/8/15 and timed 7:30 a.m., documented Individual #2 "was given Sudafed + ibuprofen for her cough + sniffles."</p> <p>The MOL and corresponding MAR entry did not include information related to the reasoning for administering ibuprofen for cold symptoms.</p> <p>d. A MOL entry, dated 5/13/15 and timed 12:01 p.m., documented Individual #2 "was given Sudogest 30 mg 1 tab at 7:17 am and also was given Acetaminophen 325 mg 2 tabs."</p> <p>The MOL and corresponding MAR entry did not include information related to the reason for administering the PRNs.</p> <p>e. A MOL entry, dated 5/14/15 and timed 7:45 a.m., documented Individual #2 "recieved [sic] 2 tabs of Acetaminophen 325 mg + 1 tab of</p>	W 111	<p>All Physicians' Orders for this location have been reprocessed and the primary physician will sign these orders before July 2, 2015. A sample is attached (Attachment A).</p> <p>We have updated instructions in the "Assistance with Oral Medication Module" related to the use and documentation of PRN medications. This update is Attachment B.</p> <p>2. Please refer to W114.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>System Changes:</u> Please refer to corrective Actions.</p> <p><u>Monitoring:</u> The RN Supervisor attends physician's clinics for individuals at this location and will review all Physicians' Orders to assure they are prepared according to these revised expectations prior to the LPNs recap meeting with the primary physician.</p>	
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 111	<p>Continued From page 6</p> <p>Sudogest 30 mg for CLS. [Individual #2] coughing frequently this am + has a nasal [sic] discharge. PRN's [sic] given @ 7:24 am."</p> <p>The MOL and corresponding MAR entry did not include information related to the reason for administering acetaminophen for cold symptoms.</p> <p>f. A MOL entry, dated 5/15/15 and timed 8:18 a.m., documented Individual #2 "coughing + has some clear nasal drainage. [Individual #2] received [sic] 2 - 325 mg tabs of Acetaminophen + 1 - 30 mg tab of Sudogest for CLS."</p> <p>The MOL and corresponding MAR entry did not include information related to the reason for administering acetaminophen for cold symptoms.</p> <p>During an interview on 5/15/15 from 9:05 a.m. - 12:20 p.m., the RN stated acetaminophen should not be administered unless Individual #2 exhibited pain or a temperature. The RN stated staff were supposed to include comprehensive information related to PRN administration in the MOL and she did not see any additional details to the identified administrations in the record.</p> <p>The facility failed to keep a complete record of Individual #2's PRN medication use.</p> <p>2. Refer to W114 as it relates to the facility's failure to ensure all entries in individuals' records were signed and dated.</p>	W 111		
W 114	<p>483.410(c)(4) CLIENT RECORDS</p> <p>Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.</p>	W 114	<p><u>W114</u></p> <p><u>Entries into records must be legible, dated, and signed.</u></p>	07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 114	<p>Continued From page 7</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 that all entries in the individuals' records were signed and dated for 1 of 4 individuals (Individual #1) whose records were reviewed. This resulted in a lack of information related to who completed the entries. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis.</p> <p>Individual #1's record was reviewed and included handwritten entries, as follows:</p> <p>a. Individual #1's MAR, dated April 2015, included the following handwritten entry: "Change dressing on tail Bone (sacrum) 3x wk. and PRN. 1) Use MicroKlenz with 4x4 gauze 2) Fill open wound with A+CalciCare silver dressing. 3) Use skin prep around area to hold dressing. (Not on open area) 4) Cover with Allevyn Adhesive dressing. *Document PRN changes in med obs."</p> <p>However, the entry did not include the initials or signature of the author, or the date the entry was made.</p> <p>b. Individual #1's MAR, dated May 2015, included the following handwritten entry: "Dressing change: on tail Bone (sacrum) 3x wk. Mon/Wed/Friday and PRN. 1) Use MicroKlenz with 4x4 gauze 2) Place CalciCare silver dressing on open wound. 3) Use skin prep around area to hold dressing in place. (Not on sore) 4) Cover</p>	W 114	<p><u>Corrective Action:</u> The LPN who made these entries is no longer employed with our company. A section titled "Nursing Documentation Expectations" has been added to the "RN Oversight & Nursing Services" Manual and the section titled "Medical Records" has been modified. These documents are included as Attachment C and D. The RN Supervisor will inservice the LPN who is now providing nursing services at this location and any nurses hired in the future on these expectations.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>System Changes:</u> Please refer to corrective Actions.</p> <p><u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. The RN will be reviewing medical records and service delivery using these systems on a monthly basis. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.</p>	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 114	<p>Continued From page 8 with Allewyn Adhesive dressing. *Document PRN changes in med. obs. please."</p> <p>However, the entry did not include the initials or signature of the author, or the date the entry was made.</p> <p>c. Individual #1's Non-Prescription Topicals & Treatments, dated January 2015, included, under both the a.m. and p.m. sections, the following handwritten entry: "Working Hand Cream to both sides of Butt + pressure area [left] side BID and PRN."</p> <p>However, the entry did not include the initials or signature of the author, or the date the entry was made.</p> <p>d. Individual #1's Non-Prescription Topicals & Treatments, dated February 2015, included, under the a.m. section, the following handwritten entries: "Use A Cover with (NS) moist 2x2 + Dry 4x4," "Keep him off his Back," and "Bacitracin Oint. to tail Bone BID."</p> <p>However, the entries did not include the initials or signature of the author, or the date the entries were made.</p> <p>Additionally, under the p.m. section the Topicals & Treatments sheet included the following handwritten entries: "Bacitracin Oint. to tail Bone," "cover [with] Moist (NS) 2x2, cover with Dry 4x4," and "Keep off his Back in Bed."</p> <p>However, the entries did not include the initials or signature of the author, or the date the entries were made.</p>	W 114			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 114	Continued From page 9 e. Individual #1's Non-Prescription Topicals & Treatments, dated March 2015, included, under both the a.m. and p.m. sections, included the following handwritten entry: "Working hands cream to both sides of bult and pressure area left side BID and PRN." The word "left" had been crossed out and the word "right" was handwritten in. The word "right" also had a strike through and the word "left" was handwritten back in. However, the handwritten changes did not include the initials or signature of the author, or the date the changes were made. f. Individual #1's Non-Prescription Topicals & Treatments, dated April 2015, included, under both the a.m. and p.m. sections, the following handwritten entry: "Carnation Breakfast (Vanilla only)." However, the entries did not include the initials or signature of the author, or the date the entries were made. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated she had made the entries on the MAR and the LPN had made the other entries. The RN stated all entries should be signed or initialed and dated. The facility failed to ensure all entries in individuals' records were signed and dated.	W 114		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.	W 122	<u>W122</u> Condition: Client Protections Please refer to W149	07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 122	Continued From page 10 This CONDITION is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to implement and monitor comprehensive systems to ensure individuals were free from medical neglect. This resulted in the facility's inability to ensure individuals were safe and that their health care needs were met. The findings include: 1. Refer to W149 as it relates to the facility's failure to ensure written policies and procedures that prohibited neglect were adequately implemented and monitored.	W 122		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment, were sufficiently implemented and monitored. This failure directly impacted 1 of 4 individuals (Individual #1) whose records were reviewed and had the potential to impact all individuals (Individuals #1 - #8) residing in the facility. This result in an individual's medical needs being neglected. The findings include: 1. The facility's abuse policy, dated 6/1/12, stated it was the responsibility of all employees to ensure individuals "will be protected from actual and/or potential abuse and/or neglect."	W 149	W149 <u>Develop/implement written policies and procedit that prohibit mistreatment/neglect/abuse</u> Please Note: The QIDP reports that he and the LPN employed during this time period were both looking at skin issues developed by Individual #1. The LPN implied that both the primary physician and the RN Supervisor were aware of the various skin issues as they developed and the QIDP took her at her word. The RN Supervisor reports that what she was being told by the LPN was different than what was actually occurring. The issue of possible medical neglect did not occur to either of these management staff. We agree that there was a breakdown in our normal oversight systems at this location and are in the process of correcting this issue.	07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 149	<p>Continued From page 11</p> <p>The policy's definition of neglect included "lack of timely assessment of individuals after injury" and "failure to adequately monitor and intervene for serious medical/surgical conditions."</p> <p>The Procedures section of the policy stated "trained management staff are most likely to identify a potentially neglectful situation through direct observation, review of written incident reports, review of medical/contact logs, review of data [sic] collection system, and by staff or family report." The Procedures also included "Suspected neglect identified by nursing staff or potentially involving nursing staff is to be reported to the RN Supervisor who will then report the situation to the Administrator/Designee."</p> <p>The policy was not sufficiently implemented to ensure individuals were not subjected to neglect, as follows:</p> <p>Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record, from 10/1/14 - 5/20/15, documented on-going skin breakdown and pressure-related wounds. However, the record did not include documentation that appropriate reporting, assessment and care had been provided to address Individual #1's skin integrity or wound issues consistently or in a timely manner, as follows:</p> <p>On 10/1/14 at 9:30 p.m., DCS documented in the</p>	W 149	<p><u>Corrective Actions</u></p> <ol style="list-style-type: none"> 1. The LPN who was working at this is no longer employed. An experienced CCI LPN will be providing nursing oversight. 2. The Administrator and QIDP Supervisor met with the RN Supervisor 06/17/15 and discussed the proper implementation of oversight systems. 3. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C. 4. An in-depth quality assurance review of all medical records will be completed by 06/30/15 so that any other medical issues which were not identified during this survey can be corrected. 5. The previous staff training module "Client Rights" has been expanded and is now "Client Rights and Responsibilities & Client Protections". This has been distributed to management staff at this location who will complete this module by 07/01/15. This module has moved to the #1 position for staff training within our organization. Instructional staff at CCI #7 will be given this module 07/01/15 and will be expected to complete it by 08/01/15. 6. Our staff observation module has been updated with an expanded section on "Paper-based" reviews with specifies that QIDPs and Nurses are 		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 149	<p>Continued From page 12</p> <p>MOL that Individual #1 "seems to have a rash."</p> <p>On 10/8/14 at 8:30 p.m., DCS documented in the MOL that Individual #1 "was getting peri care and his backside appears to be raw [and] redness all the way down."</p> <p>However, there was no documentation showing nursing staff had been notified, had addressed the concerns, or that the concerns had been resolved.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated nursing notification and follow-up should be documented in the MOL.</p> <p>Between 11/21/14 and 11/25/14, Individual #1's MOL documented he developed an open wound the size of a quarter on his buttocks. However, the documentation did not indicate the location of the open wound, and previous documentation indicated areas of concern on both the left and the right side. It was not clear if one or more wounds and/or areas of concern were present. Additionally, there was no documentation nursing staff had been notified regarding the areas of concern or the open wound.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the AQIDP and QIDP both stated there were areas of concern on both the left and right sides of Individual #1's buttocks. The AQIDP stated DCS would have left notes for the nurse, but should have documented calls to the nurse in the MOL.</p> <p>On 11/28/14, the LPN made an untimed entry in the MOL providing instruction to use Barrier Cream (a skin protectant) on the open wound.</p>	W 149	<p>to take a longitudinal view of entries in Medical Observation and Ancillary staff logs and management staff at this location, including the LPN, are to complete this module by 07/01/15.</p> <p>7. Starting 06/22/15 the QIDP Supervisor and RN Supervisor will attend scheduled Trending/ Tracking meetings at this location to provide administrative oversight.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>System Changes:</u> Please refer to corrective Actions.</p> <p><u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. She will be reviewing medical records and service delivery using these systems on a monthly basis. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C. Additionally the QIDP Supervisor and RN Supervisor will attend scheduled Trending/Tracking meetings.</p>		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 149	<p>Continued From page 13</p> <p>However, there was no indication the LPN had gathered information related to size or description of the wound, or had contacted the RN. Additionally, there was no indication the lack of reporting by DCS to nursing staff regarding the development of the wound had been investigated or addressed.</p> <p>On 12/12/14 and 12/13/14, the DCS documented in the MOL that the wound had odor and drainage. However, there was no documentation nursing staff had been notified of the changes to the wound.</p> <p>Additionally, on 1/24/15 at 2:21 p.m., DCS documented in the MOL that Individual #1 had a bruise "at the top of his bottom in the creased area." However, there was no documentation to indicate the bruise (unexplained bruising) was reported or investigated.</p> <p>From 11/21/14 - 3/24/15, Individual #1's record documented multiple wounds in various stages of development and healing. Additionally, the record documented various treatment modalities, including Barrier Cream to the open wounds, Bacitracin ointment (an antibiotic drug), Working Hands Cream (an over-the-counter hand cream designed for dry, cracked hands and feet), Tegaderm (a transparent wound dressing), and wet-to-dry dressings (application of saline soaked gauze covered with dry gauze).</p> <p>However, all of the treatment was directed by the LPN and completed without physician's orders. There was no documentation to support the RN or Individual #1's physician had been notified of the wounds prior to 3/25/15.</p>	W 149		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 149	<p>Continued From page 14</p> <p>On 3/25/15 the LPN received an order from Individual #1's physician to refer him to a wound clinic. Individual #1 was seen at the wound clinic on 3/31/15 where aggressive treatment and strict offloading (only allowed into his wheelchair for 3 one-hour periods each day and positioned side-to-side in bed the rest of the time) was initiated.</p> <p>During an interview on 5/28/15 from 2:16 - 2:29 p.m., DCS D stated she did not understand the treatments being used for Individual #1's wounds. DCS D stated the treatments did not appear to be helping and the wounds were getting worse. DCS D did not report the concerns.</p> <p>An interview was conducted, on 6/2/15 from 9:05 a.m. - 12:20 p.m., with the QIDP, AQIDP, QIDP Supervisor and RN. When asked about the wounds, the AQIDP and QIDP both stated they questioned why the wounds were not healing, but did not report the concerns as potential medical neglect. The QIDP stated medical neglect did not ever cross his mind. The QIDP Supervisor stated if it was not known where a bruise or mark came from, staff should have completed an incident report which would trigger an investigation. The QIDP Supervisor stated no concerns had been reported for investigation related to Individual #1's on-going wounds.</p> <p>The RN stated she had not been in the facility for several months prior to her review of the record, documented 4/17/15. The RN stated she was receiving verbal reports from the LPN, but had been told Individual #1 had diaper rash due to an attends issue. The RN stated she was not aware of the extent of the wounds until after Individual #1 was referred to the wound clinic.</p>	W 149			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 149	Continued From page 15 Individual #1 developed multiple on-going pressure-related wounds to his buttocks and tailbone. However, for almost 6 months all treatment was being directed by the facility's LPN. Changes to the wounds, or development of new wounds, was not reported to nursing staff in a timely manner, but no investigation into the delayed reporting was completed. Additionally, at least one DCS, the AQIDP, and the QIDP expressed concerns that treatment to the wounds was ineffective, but no reports to either the RN or Administrative staff were made to address the concerns. The facility failed to ensure issues related to Individual #1's pressure wound issues were documented, reported, and investigated for potential neglect.	W 149			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight of individuals' needs. This directly impacted 2 of 4 individuals (Individuals #1 and #2) reviewed, and had the potential to impact all individuals (Individuals #1 - #8) residing in the facility. This resulted in a lack of QIDP monitoring and oversight necessary to ensure individuals' needs were comprehensively addressed. The findings	W 159	<u>W159</u> <u>QIDP Monitoring</u> PLEASE NOTE: Under the monitoring of this QIDP over the past ten years there have been six zero deficiency surveys. We view the issues which developed at this location to be primarily related to the performance of one LPN and our lack of systems oversight. 1. Please refer to W196 2. Please refer to W240 3. Please refer to W243 4. Please refer to W244 5. Please refer to W245 6. Please refer to W246	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 159	<p>Continued From page 16 include:</p> <ol style="list-style-type: none"> 1. Refer to W196 as it relates to the facility's failure to ensure the QIDP ensured an individual received a continuous active treatment program. 2. Refer to W240 as it relates to the facility's failure to ensure the QIDP ensured an individual's IPP described relevant interventions needed to support independence. 3. Refer to W243 as it relates to the facility's failure to ensure the QIDP ensured an individual's IPP described the reason for supports needed to achieve body positioning. 4. Refer to W244 as it relates to the facility's failure to ensure the QIDP ensured an individual's IPP described how supports to achieve body positioning were to be used. 5. Refer to W245 as it relates to the facility's failure to ensure the QIDP ensured an individual's IPP included a schedule for the use of supports needed to achieve body positioning. 6. Refer to W246 as it relates to the facility's failure to ensure the QIDP ensured an individual with multiple disabling conditions spent a major portion of the day out of bed. 7. Refer to W249 as it relates to the facility's failure to ensure the QIDP ensured an individual's training plans were implemented appropriately. 8. Refer to W250 as it relates to the facility's failure to ensure the QIDP ensured an individual's active treatment schedule was sufficiently developed to direct staff. 	W 159	<ol style="list-style-type: none"> 7. Please refer to W249 8. Please refer to W250 9. Please refer to W253 10. Please refer to W259 11. Please refer to W260 12. Please refer to W436 	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 159	Continued From page 17 9. Refer to W253 as it relates to the facility's failure to ensure the QIDP ensured significant events related to an individual's program plan and assessments were documented. 10. Refer to W259 as it relates to the facility's failure to ensure the QIDP ensured an individual's CFA was updated as needed. 11. Refer to W260 as it relates to the facility's failure to ensure the QIDP ensured an individual's IPP was updated as needed. 12. Refer to W436 as it relates to the facility's failure to ensure the QIDP ensured an individual's adaptive equipment was appropriately maintained and repaired to meet his needs. The cumulative effect of these failures resulted a lack of advocacy and appropriate treatment being provided to an individual in relation to his pressure-related wounds.	W 159			
W 165	483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Professional program staff must work directly with clients. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure professional program staff worked directly with individuals for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in a lack of involvement by the LPN related to an individual's pressure wounds. The	W 165	<u>W165</u> <u>Professional Program Staff working Directly with Clients</u> <u>Corrective Actions:</u> PLEASE NOTE: This LPN is no longer employed with CCI. The QIDP reports that he and this LPN were both looking at skin issues developed by Individual #1 but clearly this screening was not documented sufficiently. There were instructions in the "RN Oversight & and Nursing	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 165	<p>Continued From page 18 findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record documented on-going skin breakdown and pressure-related wounds on his right and left buttocks and tailbone. However, the record did not include documentation that the LPN worked directly with Individual #1 to address his skin issues, as follows:</p> <p>- 10/1/14 at 9:30 p.m., DCS documented in the MOL that Individual #1 "seems to have a rash."</p> <p>- 10/8/14 at 8:30 p.m., DCS documented in the MOL that Individual #1 "was getting peri care and his backside appears to be raw [and] redness all the way down."</p> <p>There was no documentation the LPN had addressed Individual #1's skin issues.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated any nursing follow-up should be documented in the MOL.</p> <p>- 11/13/14 at 1:50 p.m., the AQIDP documented in the MOL that Individual #1 began wearing attends at night.</p> <p>- 11/21/14 at 8:45 a.m., DCS documented in the that MOL "black attends cover has left deep set red marks on left hip [and] thigh from elastic</p>	W 165	<p>Services" manual related to documentation responsibilities. See Attachment D. When this LPN was hired we were contracting for RN Oversight Services and therefore most of the training received was from other LPNs. It is our belief that the RN Supervisor, when hired 10/13 was under the impression that this LPN had been adequately trained.</p> <p>The RN who had been hired immediately before the current RN had done some training with her but in hindsight we realize that her training for RN Oversight responsibilities in an ICF/ID service delivery system was not sufficient.</p> <p>1. The Administrator and QIDP Supervisor met with the RN Supervisor 06/17/15 and discussed the proper implementation of oversight systems.</p> <p>2. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.</p> <p>3. Our staff observation module has been updated with an expanded section on "Paper-based" reviews with specifies that QIDPs and Nurses are to take a longitudinal view of entries in Medical Observation and Ancillary staff logs and management staff at this location, including the LPN, are to complete this module by 07/01/15.</p> <p>4. A section titled "Nursing Documentation Expectations" has</p>		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 165	<p>Continued From page 19</p> <p>bands. not [sic] so bad on right but visible."</p> <p>- 11/21/14 at 3:30 p.m., the AQIDP documented in the MOL that Individual #1 "has small round dip (in color) red mark on his left bottom down by leg area."</p> <p>- 11/22/14 at 11:30 a.m., DCS documented in the MOL that Individual #1 "has two small round dark red marks on his right side by his bottom on the hind part of his thigh close under his buttocks. he [sic] hasn't complained of any discomfort due it [sic] them. noticed [sic] when getting him dressed after shower."</p> <p>- 11/24/14 at 9:45 p.m., DCS documented in the MOL that Individual #1 "has a sore on his right buttox [sic] about 1" wide."</p> <p>- 11/25/14 at 8:20 a.m., DCS documented in the MOL that Individual #1 "has an open sore the size of a quarter. Barrier creme [sic] was applied."</p> <p>- 11/28/14, no time documented, the LPN documented in the MOL "Please continue to use the barrier cream on open area on [Individual #1's] Bottom. Keep area clean and dry. Lay [Individual #1] on his side in bed, with attends open in back to let air into his buttocks - Have him lie down twice a day if possible and PRN."</p> <p>Between 11/21/14 and 11/25/14, Individual #1 developed an open wound the size of a quarter. However, there was no documentation the LPN had addressed the issue prior to 11/28/14. At that time, the documentation showed the LPN provided directions to staff, but did not indicate the LPN worked directly with Individual #1 in relation to the wound (i.e., to gather assessment</p>	W 165	<p>been added to the "RN Oversight & Nursing Services" Manual and the section titled "Medical Records" has been modified. These documents are included as Attachment D and E. The RN Supervisor will inservice the LPN who is now providing nursing services at this location by 07/02/15 and any nurses hired in the future on these expectations.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>System Changes:</u> Please refer to corrective Actions.</p> <p><u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. She will be reviewing medical records and service delivery using these systems on a monthly basis. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.</p>	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 165	<p>Continued From page 20</p> <p>information to provide to the RN such as measurements and description of the wound, to develop schedules related to offloading and positioning, to provide education to Individual #1 or DCS, etc.).</p> <p>From 11/28/14 - 12/31/14, 4 entries in Individual #1's MOL had been completed by the LPN, as follows:</p> <ul style="list-style-type: none"> - 12/9/14 at 3:45 p.m., the LPN documented in the MOL "Peri area and buttocks checked. Area on [right] inner buttock is now open, draining light pink drainage, the area is about a dime size pressure area, Stage II. Cleansed and dried well. Tegaderm drsg [dressing] applied. Staff please clean peri area carefully so as to not dislodge the Tegaderm. Leave on during shower. Tape drsg in place if needed. May replace tegaderm if it comes off with ½ piece. Change tegaderm every 4-7 days. (Tegaderm is a clear plastic dressing pad, it is in his Basket at bedside [sic]." - 12/15/14 at 1:00 p.m., the LPN documented in the MOL "Please remove Tegaderm. Wash with soap [and] water. Dry well, then use Bacitracin, then a small amount of Barrier Cream, cover with dry 4x4 and change as needed. Use Bacitracin antibiotic oint. twice daily. And document." - 12/17/14 at 8:30 a.m., the LPN documented in the MOL "Pressure area [right] inner Buttock is healing - half the size it was last week. Scant amt. light pink drainage noted. Please continue to use above instructions until healed." - 12/31/14 at 7:00 a.m., the LPN documented "Discontinue using Bactracin [sic] now. Use only Barrier cream. Please let [Individual #1] lie down 	W 165		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 165	<p>Continued From page 21 as much as possible to get off his Bottom."</p> <p>Of the 4 entries, only the 12/9/14 and 12/17/14 entries indicated the LPN had worked directly with Individual #1 during the month of December 2014.</p> <p>From 1/1/15 - 1/31/15, 9 entries in Individual #1's MOL had been completed by the LPN, as follows:</p> <ul style="list-style-type: none"> - 1/5/15 at 1:35 p.m., the LPN documented in the MOL "Use Bactracin [sic] on pressure area on [Individual #1's] bottom only if it is 'open.' Continue to use Barrier Cream." - 1/7/15 at 9:00 a.m., the LPN documented in the MOL "Please do not use tape or Bactracin [sic] on [Individual #1's] Bottom - cover with loose gauze only and barrier cream." - 1/9/15 at 9:30 a.m., the LPN documented in the MOL "New Memory foam pad placed on wheelchair seat yesterday, hopefully to held [sic] prevent skin breakdown on Buttocks. harness [sic] straps unaffected. [Individual #1] states it feels 'really good.' Will continue to monitor." - 1/12/15 at 11:00 a.m., the LPN documented in the MOL "Continue to use Barrier Cream on Buttocks. Let [Individual #1] lie down as much as possible. Keep attends changed (Dry and Clean)." - 1/13/15 at 8:50 a.m., the LPN documented in the MOL "Pressure area on [left] buttock remains stage II. Continue to use, a good amt., of Barrier cream, do NOT cover with gauze or washcloths. Please continue to Keep [sic] attends clean/dry. Lie down after." 	W 165		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 165	<p>Continued From page 22</p> <p>- 1/13/15 at 9:00 a.m., the LPN documented in the MOL "Please keep water proof pads under [Individual #1] as flat and smooth as possible."</p> <p>- 1/14/15 at 10:00 a.m., the LPN documented in the MOL "Please start using "Working Hands" cream on [Individual #1's] Bottom - as instructed on ADLS sheet."</p> <p>- 1/26/15 at 1:00 p.m., the LPN documented "Please use 'pull-ups' during the day only. Leave [Individual #1's] bottom open to the air while he is in bed. Also turn him on his side and use pillows to prop him up, do this as often as possible. Be very gentle when cleaning [Individual #1's] bottom. Use a good amount of 'Working Hands' cream on pressure areas. may [sic] change to Barrier Cream if area is worse."</p> <p>- 1/28/15 at 2:00 p.m., the LPN documented in the MOL "Pressure improving, Approx dime size Stage II intact, [no] drainage. Continue good genital [sic] peri care - use 'Working hands' cream on area - please keep him off Bottom [sic] as much as possible. There appears to be an abrasion or scratch at bottom of tailbone. Use 'working hands' cream on it as well."</p> <p>Of the 9 entries, only 3 of the entries (1/9/15 related to placing a cushion in Individual #1's wheelchair, and 1/9/15 and 1/28/15 related to wound size) indicated the LPN had worked directly with Individual #1 during January 2015.</p> <p>From 2/1/15 - 2/28/15, 4 entries in Individual #1's MOL had been completed by the LPN, as follows:</p> <p>- 2/6/15 at 11:00 a.m., the LPN documented in</p>	W 165		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 165	<p>Continued From page 23</p> <p>the MOL "Continue to use 'Working Hands' cream on any reddened or sore areas on [Individual #1's] bottom."</p> <p>- 2/17/15 at 9:00 a.m., the LPN documented in the MOL Individual #1 "has a stage II pressure sore on his coccyx (tailbone), Approx. the size of nickel. Sm. hemotoma [sic] on edge. Wash carefully and gently [sic]. Use Bacitracin ointment twice a day and cover with moist 2x2 pads and cover with 4x4 pad. Do Not use Working hands or Barrier cream on tailBone [sic] at this time. Monitor. At this time no foul order [sic] noted. Sm. amt clear white drainage noted."</p> <p>- 2/17/15 at 2:30 p.m., the LPN documented in the MOL "Please use Bacitracin Oint. on tail Bone twice a day, cover with moist 2x2 (NS) Normal Saline and cover with dry 4x4. Keep him off his back while in bed. Position with fold towel [sic] under hip - turn from side to side. Old pressure on [left] buttock, healing, no redness, closed. Continue use of Working hands on both side [sic] of buttocks. Do Not use Working hands or Barrier cream on tailbone at this time. Document what you see."</p> <p>- 2/23/15 at 1:30 p.m., the LPN documented in the MOL "Please continue treatment of [Individual #1's] coccyx ([left] ischial) with Bacitracin oint. And Normal Saline (wet to dry) dressing. Please use Rolled towel under his hips to turn him off his bottom."</p> <p>Of the 4 entries, only the 2/17/15 entry indicated the LPN had worked directly with Individual #1 in February 2015.</p> <p>From 3/1/15 - 3/31/15, 6 entries in Individual #1's</p>	W 165			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 165	<p>Continued From page 24 MOL had been completed by the LPN, as follows:</p> <ul style="list-style-type: none"> - 3/12/15 at 9:00 a.m., the LPN documented in the MOL "Skin check done. [left] tail healing, Drying, peeling some. No drainage noted. Continue NS dressing and Bactricin [sic] oint. [Right] Buttock clear, [left] Buttock has an old pressure area that has an open edge. Please use Working hands on that area. [Illegible] Buttock." - 3/24/15 at 10:00 p.m., the LPN documented in the MOL "[Left] pressure sore tailbone (ischial area) healed. New Stage II pressure area on coccyx (center tailbone) now open. Lg. amt. working hands with N.S. gauze placed on area. Will call [physician's name] tomorrow. Continue saline dressing for now." - 3/25/15 at 10:00 a.m., the LPN documented in the MOL "Order received from [physician's name] for [Individual #1] to go to [hospital name] wound clinic. Order faxed." - 3/26/15 at 9:20 a.m., the LPN documented in the MOL "Duoderm dressing placed on coccyx. to [sic] be changed every 5-7 days by Nursing. May shower/get wet. Do Not Remove! If dressing becomes soiled please call nurse." - 3/31/15 at 2:00 p.m., the LPN documented in the MOL "Seen today at [name of hospital] Wound Clinic for pressure area on coccyx. Stage II wound cleaned by P.A. [Physician's Assistant] Culture done. Dressing applied by R.N. P.A. wants [Individual #1] to stay home from work for 1 week in bed, turn side to side every 2 hrs. Up in w/c [wheelchair] for only 3 times a day for one hour at [sic] time for meds and meals. [Name of 	W 165		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 165	<p>Continued From page 25</p> <p>PA) PA [sic] will call with Cx [culture] results if pos[itive]. [Name of PT] PT Accessed [sic] w/c cushion and will call [wheelchair company] regarding cushion."</p> <p>- 3/31/15 at 3:00 p.m., the LPN documented in the MOL Individual #1 "is to be kept home for the next week until next wound clinic Appt., in bed on his sides, turning (Q) every 2 hrs. He may be up 3 times a day for 1 hr each for meals [and] meds. He may not have showers, give Bed Bath keep dressing Dry. Please give [Individual #1] his meds as soon as he finishes his meals and then back to Bed. Dressing to be changed 4x weekly. Instructions to follow."</p> <p>The documentation indicated the LPN had worked with Individual #1 to perform skin checks on 3/12/15 and 3/24/15. After that time, treatment was sought for Individual #1 at a Wound Clinic.</p> <p>Although Individual #1's record documented significant skin integrity issues and pressure wounds from 10/1/14 - 3/24/15, the LPN was documented to have worked with Individual #1 on only 8 occasions.</p> <p>During an interview on 5/28/15 from 2:04 - 2:15 p.m., DCS A stated she had seen the LPN at the facility during the day shift, but could not state how frequently.</p> <p>During an interview on 5/28/15 from 2:42 - 2:50 p.m., DCS F stated she had only seen the LPN once or twice at the facility.</p> <p>During an interview on 5/29/15 from 9:43 - 9:57 a.m., DCS B stated the LPN was present maybe</p>	W 165		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 165	<p>Continued From page 26</p> <p>once a week. DCS B stated the LPN would read staff documentation and if concerns were noted, the LPN asked staff what they thought, but did not look at the individuals for herself.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated the LPN was expected to be at the facility daily on normal working days (Monday - Friday). The RN stated the LPN should have been looking at the wounds and not relying only on DCS descriptions.</p> <p>From 10/1/14 - 3/24/15, the record documented the LPN only worked directly with Individual #1 on 8 occasions out of the 175 days in the time period. The remaining 23 entries from the LPN documented instructions to DCS. The documentation did not indicate the LPN had worked directly with Individual #1 to provide or develop treatment that would facilitate the healing of his skin integrity and pressure wound issues.</p> <p>On 3/25/15, a referral to a wound clinic was received. Individual #1 began receiving treatment oversight by the wound clinic on 3/31/15, and the wound was documented as "pinpoint" size on 5/18/15.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated she was not aware of any additional documentation that would indicate the LPN had worked directly with Individual #1.</p> <p>The facility failed to ensure the LPN worked directly with Individual #1 to address his pressure wound needs.</p>	W 165			
W 169	483.430(b)(4) PROFESSIONAL PROGRAM SERVICES	W 169	<p><u>W169</u></p> <p><u>Professional Program Staff Development</u></p>		07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 169	<p>Continued From page 27</p> <p>Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure professional staff sought and received training in other disciplines as needed to meet the needs of 1 of 1 individuals (Individual #1) whose wound care records were reviewed. This resulted in a lack of knowledge necessary to effectively address the individual's needs related to pressure wounds. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>From 10/1/14 - 3/24/15, Individual #1's medical record documented on-going skin breakdown and pressure-related wounds, including multiple open areas to both his left and right buttocks and tailbone areas. The documentation indicated treatment, including various forms of dressing changes and topical ointments, was being completed by DCS as instructed by the LPN with no input or direction from the RN or Individual #1's physician. On 3/25/15, the physician referred Individual #1 to a wound clinic with a Stage 2 sacral pressure ulcer.</p>	W 169	<p><u>Corrective Actions:</u> We have reviewed the "Preventing Skin Injuries" material shared by the surveyors and have also ordered the book "Clinical Guide to Skin and Wound Care" which should arrive by 06/29/15. We already have a system for certifying staff in a variety of medical procedures. We will develop staff training material from these two documents and an accompanying certification record and nursing staff will certify staff at this location on this issue by July 1, 2015.</p> <p><u>Identifying Others Potentially Affected:</u> Any individual at this location can develop a medical issue specifically related to them and therefore all are potentially affected.</p> <p><u>System Changes:</u> Please refer to corrective Actions. In addition, when emerging medical issues are identified, these will be discussed at Trending & Tracking meetings and the RN Supervisor will determine what staff training materials and certifications are needed, will develop these, and nursing staff will train instructional staff.</p> <p><u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. She will be reviewing medical records and service delivery using these systems on a monthly basis. The Administrator will meet with the RN monthly for the next three months or longer until he is</p>	
-------	---	-------	---	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 169	<p>Continued From page 28</p> <p>A review of Individual #1's record documented the QIDP and AQIDP reviewed the documentation in the MOL regarding the development, progression and treatment of the wounds. However, Individual #1's IPP, CFA, Active Treatment Schedule and training programs had not been adjusted to meeting his changing needs related to pressure relief and wound healing.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP stated he only worked part-time, but reviewed the MOL each time he was at the facility. The QIDP and the AQIDP, who was present during the interview, both stated Individual #1 had multiple wounds from 10/1/14 until he was referred to the Wound Clinic on 3/25/15. The QIDP stated he assumed the LPN was coordinating with the needed professionals in order to treat the wounds. The QIDP stated he looked at the wounds each time he was at the facility and thought they were healing, but stated he had no specialized training and had no experience dealing with wounds. The QIDP stated he saw no reason to question what was taking place.</p> <p>The RN, who was also present during the interview, stated she was only receiving verbal reports from the LPN and understood the issue to be diaper rash related to an attends issue. The RN stated she assumed the LPN was well trained. The RN also stated the LPN was the one training staff, and direct care staff may have been training other direct care staff, but no other training on care of the wound was sought until the Wound Clinic referral.</p> <p>The facility failed to ensure DCS, the QIDP and the AQIDP sought and received training from</p>	W 169	<p>assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.</p>	
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 169	Continued From page 29 relevant professional staff related to the care and treatment needs for Individual #1's pressure wounds.	W 169			
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met.	W 195	<u>W195</u> Please refer to W196		07/06/15
W 196	This CONDITION is not met as evidenced by: Based on observations, record review and staff interviews, it was determined the facility failed to ensure active treatment services were provided to each individual participating in the facility's program. This resulted in a lack of necessary services and supports being provided to an individual in order to adequately address his individualized needs. The findings include: 1. Refer to W196 as it relates to the facility's failure to ensure each individual was provided with continuous and consistent active treatment services in accordance with identified needs. 483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status.	W 196	<u>W196 Condition:</u> Active Treatment 1. Please refer to W240 2. Please refer to W249 3. Please refer to W250 4. Please refer to W253 5. Please refer to W259 6. Please refer to W260		07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 196	Continued From page 30 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals were provided with continuous and consistent active treatment services in accordance with their individualized needs for 1 of 4 individuals (Individual #1) whose active treatment programs were reviewed. That failure resulted in an individual not receiving services and supports necessary to meet his needs. The findings include: 1. Refer to W240 as it relates to the facility's failure to ensure an individual's IPP described relevant interventions needed to support independence. 2. Refer to W249 as it relates to the facility's failure to ensure an individual's training programs were implemented appropriately. 3. Refer to W250 as it relates to the facility's failure to ensure an individual's active treatment schedule was sufficiently developed to direct staff. 4. Refer to W253 as it relates to the facility's failure to ensure significant events related to an individual's program plan and assessments were documented. 5. Refer to W259 as it relates to the facility's failure to ensure an individual's CFA was updated as needed. 6. Refer to W260 as it relates to the facility's failure to ensure an individual's IPP was updated as needed.	W 196			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the individual program plan described relevant interventions to support independence for 1 of 4 individuals (Individual #1) whose IPPs were reviewed. This resulted in insufficient information being available to staff related to an individual's positioning needs. The findings include:</p> <p>1. Refer to W243 as it relates to the facility's failure to ensure an individual's IPP described the reason for supports needed to achieve body positioning.</p> <p>2. Refer to W244 as it relates to the facility's failure to ensure an individual's IPP described how supports to achieve body positioning were to be used.</p> <p>3. Refer to W245 as it relates to the facility's failure to ensure an individual's IPP included a schedule for the use of supports needed to achieve body positioning.</p>	W 240	<p><u>W240</u></p> <p><u>IPP Describes Relevant Interventions</u></p> <p>1. Please refer to W243 2. Please refer to W244 3. Please refer to W245</p>	07/06/15	
W 243	<p>483.440(c)(6)(iv) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the reason for each support.</p> <p>This STANDARD is not met as evidenced by:</p>	W 243	<p><u>W243</u></p> <p><u>IPP Describe Mechanical Supports</u></p> <p><u>Corrective Actions:</u> The IPP dated 05/27/15 (Attachment F) was updated as of 06/24/15 and describes these supports more completely. A</p>	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 243	<p>Continued From page 32</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure the IPP specified the reason for each mechanical support for 1 of 2 individuals (Individual #1) reviewed who used mechanical supports. This resulted in a lack of information being available for staff to ensure their proper use. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record, from 10/1/14 - 5/20/15, documented on-going pressure-related wounds to his buttocks.</p> <p>The LPN documented in the MOL, on 2/17/15 at 2:30 p.m., "Keep him off his back while in bed. Position with fold [sic] towel under hip - turn from side to side."</p> <p>A second entry by the LPN in the MOL, dated 2/23/15 at 1:30 p.m., stated "Please use Rolled towel under his hips to turn him off his bottom."</p> <p>However, Individual #1's IPP did not contain the reason for the rolled towels.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP stated positioning devices or procedures had not been incorporated into Individual #1's IPP.</p> <p>The facility failed to ensure Individual #1's IPP contained the reason for the rolled towel.</p>	W 243	<p>mechanical supports protocol has been developed (Attachment G) which is considered to be a supplement to the IPP for Individual #1 and for all other individuals using mechanical supports at this location. Staff will be inserviced as to use and contents of this protocol 07/01/15 and it will be adjusted as needs change.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>Systems Changes:</u> Refer to Corrective Actions.</p> <p><u>Monitoring:</u> The QIDP Supervisor and RN Supervisor attended the Trending/Tracking meeting 06/22/15 and will attend scheduled Trending/Tracking meetings on a regular basis to provide administrative oversight related to IPP documentation.</p>	
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 244	<p>483.440(c)(6)(iv) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the situations in which each is to be applied.</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 the IPP specified the situation in which each mechanical support was to be applied for 1 of 2 individuals (Individual #1) reviewed who used mechanical supports. This resulted in a lack of information being available for staff to ensure their proper use. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record, from 10/1/14 - 5/20/15, documented on-going pressure-related wounds to his buttocks.</p> <p>The LPN documented in the MOL, on 2/17/15 at 2:30 p.m., "Keep him off his back while in bed. Position with fold [sic] towel under hip - turn from side to side."</p> <p>A second entry by the LPN in the MOL, dated 2/23/15 at 1:30 p.m., stated "Please use Rolled towel under his hips to turn him off his bottom."</p> <p>However, Individual #1's IPP did not specify the</p>	W 244	<p><u>W244</u></p> <p><u>Identify Mechanical Supports</u></p> <p><u>Corrective Actions:</u> A mechanical supports protocol has been developed (Attachment F) for Individual #1 and for all other individuals using mechanical supports at this location. This will be updated as changes are needed by management staff and reviewed and signed by the RN Supervisor.</p> <p><u>Identifying Others Potentially Affected:</u> Anyone using mechanical supports is potentially affected.</p> <p><u>Systems Changes:</u> Refer to Corrective Actions.</p> <p><u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. She will be reviewing medical records and service delivery using these systems on a monthly basis and reviewing these types of protocols will be included in this process. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.</p>	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 244	Continued From page 34 situation in which the rolled towel was to be applied. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP stated positing devices or procedures had not been incorporated into Individual #1's IPP. The facility failed to ensure Individual #1's IPP specified the situation in which the rolled towel was to be applied.	W 244			
W 245	483.440(c)(6)(iv) INDIVIDUAL PROGRAM PLAN The individual program plan must identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify a schedule for the use of each support. This STANDARD is not met as evidenced by: Based on record review and staff interview. it was determined the facility failed to ensure the IPP specified a schedule for the use of each mechanical support for 1 of 2 individuals (Individual #1) reviewed who used mechanical supports. This resulted in a lack of information being available for staff to ensure their proper use. The findings include: 1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.	W 245	<u>W245</u> <u>Schedule Use of Mechanical Supports</u> <u>Corrective Actions:</u> A mechanical supports protocol will be developed (Attachment G) for Individual #1 and for all other individuals using mechanical supports at this location which identifies the schedule of use by 07/01/15 and staff will be inservices as to its content and use on that date. This protocol will be updated as changes are needed by management staff and reviewed and signed by the RN Supervisor. <u>Identifying Others Potentially Affected:</u> Anyone using mechanical supports is potentially affected. <u>Systems Changes:</u> Refer to Corrective Actions. <u>Monitoring:</u> The QIDP Supervisor and RN Supervisor attended the Trending/ Tracking meeting 06/22/15 and will	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 245	Continued From page 35 Individual #1's medical record, from 10/1/14 - 5/20/15 documented on-going pressure-related wounds to his buttocks. The LPN documented in the MOL, on 2/17/15 at 2:30 p.m., "Keep him off his back while in bed. Position with fold [sic] towel under hip - turn from side to side." A second entry by the LPN in the MOL, dated 2/23/15 at 1:30 p.m., stated "Please use Rolled towel under his hips to turn him off his bottom." However, Individual #1's IPP did not contain a schedule for the use of the rolled towels. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIPD stated positioning devices or procedures had not been incorporated into Individual #1's IPP. The facility failed to ensure Individual #1's IPP contained a schedule for the use of the rolled towel.	W 245	attend scheduled Trending/Tracking meetings on a regular basis to provide administrative oversight related to the use of mechanical supports.		
W 246	483.404(c)(6)(v) INDIVIDUAL PROGRAM PLAN The individual program plan must provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure individuals with multiple disabling	W 246	<u>W246</u> <u>Multiple Disabling Conditions</u> <u>Corrective Actions:</u> Some alternatives for Individual #1 being out of his bedroom had been tried but were not documented. The QIDP has produced an "Intervention History" (Attachment H) to document these efforts and will add to this as other methods are attempted.	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 246	<p>Continued From page 36</p> <p>conditions spent a major portion of each waking day out of bed and outside the bedroom area for 1 of 2 individuals (Individual #1) reviewed, who were non-ambulatory. This resulted in an individual being isolated in his room for long periods of time. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>During an environmental review, on 5/26/15 from 2:55 - 3:25 p.m., the furniture in the living room on the west side of the facility, shared by Individual #1 and 3's housemates, was observed. The furniture consisted of two recliners and one upholstered chair.</p> <p>The AQIDP, who was present during the review, stated one of the recliners belonged to Individual #6 and one belonged to the facility, but was used primarily by Individual #7. The AQIDP stated the upholstered chair belonged to Individual #4. When asked about Individual #1, the AQIDP stated he only sat in his power wheelchair when he was not in bed.</p> <p>Individual #1's medical record, from 10/1/14 - 5/20/15, documented on-going pressure-related wounds to his buttocks. The record documented Individual #1 required increased time out of his chair to relieve pressure to his buttocks, as follows:</p> <p>- 11/28/14, no time documented, the LPN documented in the MOL "Lay [Individual #1] on</p>	W 246	<p>PLEASE NOTE that due to comfort issues, Individual #1 prefers to spend most of his time when out of his customized wheelchair in his bed watching television, listening to his radio, making phone calls, using a walkie-talkie to communicate with staff on duty, or napping and can make his preferences known.</p> <p><u>Identifying Others Potentially Affected:</u> Anyone using mechanical supports is potentially affected.</p> <p><u>Systems Changes:</u> Refer to Corrective Actions.</p> <p><u>Monitoring:</u> The QIDP Supervisor and RN Supervisor attended the Trending/Tracking meeting 06/22/15 and will attend scheduled Trending/Tracking meetings on a regular basis to provide administrative oversight related to the documentation and use of mechanical supports.</p>		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 246	Continued From page 37 his side in bed, with attends open in back to let air into his buttocks - Have him lie down twice a day if possible and PRN." - 12/31/14 at 7:00 a.m., the LPN documented "Please let [Individual #1] lie down as much as possible to get off his Bottom." - 1/12/15 at 11:00 a.m., the LPN documented in the MOL "Let [Individual #1] lie down as much as possible." - 1/28/15 at 2:00 p.m., the LPN documented in the MOL "please keep him off Bottom [sic] as much as possible." - 2/16/15 at 5:00 p.m., DCS documented in the MOL Individual #1's "Bed Sore appears to be infected. Nurse [LPN's name] left instructions on care for [Individual #1]...He is to be laying in bed 2X's a day without his pants [and] underwear too." - 3/31/15 at 2:00 p.m., the LPN documented in the MOL "Seen today at [name of hospital] Wound Clinic for pressure area on coccyx. Stage II wound...P.A. wants [Individual #1] to stay home from work for 1 week in bed, turn side to side every 2 hrs. Up in w/c for only 3 times a day for one hour at [sic] time for meds and meals." - 3/31/15 at 3:00 p.m., the LPN documented in the MOL Individual #1 "is to be kept home for the next week until next wound clinic Appt., in bed on his sides, turning (Q) every 2 hrs. He may be up 3 times a day for 1 hr each for meals [and] meds. He may not have showers, give Bed Bath keep dressing Dry. Please give [Individual #1] his meds as soon as he finishes his meals and then	W 246			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 246	Continued From page 38 back to Bed [sic]. An undated and unsigned entry by the LPN in the MOL stated "Continue to turn every 2 hrs from side to side. May be up 3 hrs daily for meals, snacks and meds." - 4/3/15, time not indicated, the LPN documented in the MOL "[Individual #1] remains in bed [due to] pressure area." - 4/6/15 at 1:53 p.m., the AQIDP documented in the MOL "After lunch had [Individual #1] lay down in recliner to see if it can work." - 4/8/15 at 11:55 a.m., the LPN documented in the MOL "Continue to rest in bed, change position often." - 4/10/15 at 1:15 p.m., the LPN documented in the MOL "Continue bed rest, up for meals and meds." A wound clinic note, dated 4/20/15, stated "strict offloading, turning, repositioning and up in wheelchair 3 hours each day for meals." - 4/20/15 at 11:45 a.m., the LPN documented in the MOL "remaining on bedrest." - 4/20/15 at 12:40 p.m., DCS documented in the MOL "returned home from Wound Clinic in Meridian. Dr. suggested that [Individual #1] should sit upright rather than recline in his chair at 45 [degrees] as this may put pressure on his coccyx [and] pressure sore." - 4/24/15 at 11:00 a.m. and 4/27/15 at 9:00 a.m., the LPN documented in the MOL "continue Bed	W 246		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 246	<p>Continued From page 39 [sic] rest."</p> <p>A wound clinic note, dated 5/5/15, stated Individual #1 could be up in his wheelchair "<3 hrs" (less than 3 hours) a day turning and repositioning.</p> <p>- 5/5/15 at 11:00 a.m. and 5/12/15 at 8:15 a.m., the LPN documented in the MOL "Continue bed rest."</p> <p>A wound clinic note, dated 5/18/15, stated Individual #1 should be up in his wheelchair only 3 hours a day with meals, and should be turned and repositioned every hour. The note stated Individual #1 could visit his work setting once a week for 2 hours, and careful inspection of his skin should be completed when he returned to the facility.</p> <p>With the exception of the trial in the recliner, documented in the MOL on 4/16/15, there were no documented attempts to provide alternative options for Individual #1 to be outside of his bedroom at times he was out of his power wheelchair.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the AQIDP stated the recliner was uncomfortable for Individual #1. The AQIDP and the QIDP, who was present during the interview, could not provide any additional evidence of efforts made to allow Individual #1 time outside of his bedroom when he needed to be out of his power wheelchair.</p> <p>The facility failed to ensure Individual #1 was able to spend a major portion of his waking day out of bed and outside his bedroom area.</p>	W 246			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals received training and services consistent with their program plans for 1 of 4 individuals (Individuals #1 - #4) whose programs were reviewed. This resulted in an individual not receiving training in accordance with their identified needs. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record, from 10/1/14 - 5/20/15, documented on-going pressure-related wounds to his buttocks. Additionally, the record documented an increased need for time out of his wheelchair to relieve pressure on his buttocks. On 3/31/15, Individual #1 was ordered to remain on bed rest, only being up in his wheelchair 3 times a day for 1 hour at a time for meals and medications.</p>	W 249	<p><u>W249</u></p> <p><u>Continuous Active Treatment Program</u></p> <p><u>Corrective Action:</u> The statement that we "Did not document changes in his training programs to accommodate" the issues described is accurate. We have updated our IPP Training Module with a section that specifies to the QIDP what documentary adjustments are to be made when there is a significant and/or extended change in status. Please see Attachment I. The QIDP Supervisor inserviced the QIDP regarding this change on 06/22/15.</p> <p><u>Identifying Others Potentially Affected:</u> Any individual at this location can develop a medical or other issue specifically related to them and therefore all are potentially affected.</p> <p><u>System Changes:</u> Please refer to corrective Actions. In addition, when emerging issues are identified, these will be discussed at Trending & Tracking meetings and the QIDP Supervisor and/or RN Supervisor will give clarifying instructions as needed.</p> <p><u>Monitoring:</u> The QIDP Supervisor and RN Supervisor will attend scheduled Trending/Tracking meetings and will provide direction as needed for ensuring adequate documentation related to this issue.</p>	07/06/15
-------	--	-------	--	----------

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 249	<p>Continued From page 41</p> <p>However, Individual #1's record did not document a change to his training programs to accommodate his increased downtime. This resulted in lack of implementation of training programs. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - A Shower program, dated 6/14, stated Individual #1 was to wash the upper right side of his chest while sitting in a shower chair. <p>However, the LPN documented in the MOL, on 3/31/15, Individual #1 was to have bed baths only.</p> <ul style="list-style-type: none"> - A Range of Motion Exercise program, dated 6/14, stated staff were to assist Individual #1 to lay on his back on his bed to complete the exercises. <p>However, the LPN documented in the MOL, on 2/17/15, Individual #1 was not to be placed on his back.</p> <ul style="list-style-type: none"> - A Deodorant program, dated 6/14, stated he was to obtain his deodorant from his grooming kit in his closet and apply it to his left arm. <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the AQIDP and QIDP both stated no changes had been made to Individual #1's training plans to accommodate his change of condition.</p> <p>During a follow-up telephone interview, on 6/10/15 from 10:00 - 10:05 a.m., the AQIDP stated staff would implement Individual #1's training programs during the 3 one-hour blocks of time he was up for meals and medications. The AQIDP stated some programs, like Nutrition,</p>	W 249		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 249	Continued From page 42 Communication, and Calm Breathing (an alternative behavior program) could be implemented while in bed but only took a few moments to complete. The AQIDP stated other programs were just not implemented at all. When asked what Individual #1 did when down on bed rest for all but 3 hours a day, the AQIDP stated he would watch TV or talk on the phone. The AQIDP stated no changes had been made to implement continuous active treatment while Individual #1 was on bed rest. The facility failed to ensure a continuous active treatment program was implemented for Individual #1.	W 249		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to develop active treatment schedules which were consistent and reflective of individualized needs for 1 of 4 individuals (Individual #1) whose active treatment schedules were reviewed. This resulted in the lack of supports and services being provided to an individual necessary to meet his needs. The findings include: 1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included	W 250	<u>W250</u> <u>ATS</u> <u>Corrective Action:</u> The issue of pressure sore for Individual #1 has been an on-going issue. Many efforts have been made to prevent these but do to this individual's multiple disabling conditions; he will continue to be susceptible. He is now receiving services from a Wound Clinic and we are implementing their instructions. As we have determined that there will probably be times when he can participate in his normal schedule and times that increased bed rest or time out of his wheelchair is necessary for any wound to heal we have developed an "Alternative" active treatment schedule (Attachments J.1., J.2).	07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 250	<p>Continued From page 43</p> <p>profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record, from 10/1/14 - 5/20/15, documented on-going pressure-related wounds to his buttocks. However, his record did not include documentation that his Active Treatment Schedule had been adjusted to assist him in relieving pressure, as follows:</p> <p>A Physical Therapy Evaluation, dated 9/9/14, stated "He needs to be removed from his wheelchair and placed on his bed or on a mat at intervals during the day."</p> <p>On 11/28/14 (untimed), the LPN documented in the MOL "Lay [Individual #1] on his side in bed, with attends open in back to let air into his buttocks - Have him lie down twice a day if possible and PRN."</p> <p>On 12/31/14 at 7:00 a.m., the LPN documented in the MOL "Please let [Individual #1] lie down as much as possible to get off his Bottom [sic]."</p> <p>On 1/13/15 at 8:50 a.m., the LPN documented in the MOL "Please continue to Keep [sic] attends clean/dry. Lie down after."</p> <p>On 1/26/15 at 1:00 p.m., the LPN documented in the MOL "Leave [Individual #1's] bottom open to the air while he is in bed. Also turn him on his side and use pillows to prop him up, do this as often as possible."</p> <p>On 1/28/15 at 2:00 p.m., the LPN documented in the MOL "please keep him off Bottom [sic] as</p>	W 250	<p>The QIDP supervisor will continue to work with the AQIDP and ILW at this location on developing alternatives as they are needed. The trigger for the alternate schedule will be a recommendation from the Wound Clinic which will result in an IDT which will activate the implementation of an alternate schedule. When the wound has healed sufficiently, another IDT will be held which will trigger the re-implementation of this individual's regular schedule. As previously stated, these instructions to QIDPs are documented on Attachment I.</p> <p><u>Identifying Others Potentially Affected:</u> Any individual at this location can develop a medical or other issue specifically related to them and therefore all are potentially affected.</p> <p><u>System Changes:</u> Please refer to corrective Actions. In addition, when emerging issues are identified, these will be discussed at Trending & Tracking meetings and the QIDP Supervisor and/or RN Supervisor will give clarifying instructions as needed.</p> <p><u>Monitoring:</u> The QIDP Supervisor and RN Supervisor will attend scheduled Trending/Tracking meetings and will provide direction as needed to ensure action has been taken as needed and that there is adequate documentation related to this issue.</p>	
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 250	<p>Continued From page 44 much as possible."</p> <p>However, Individual #1's Active Treatment Schedule did not include documentation the recommendations for downtime to relieve pressure had been incorporated into his schedule.</p> <p>Individual #1's Active Treatment Schedule for Monday - Friday, dated 2/4/15, included time out of his wheelchair, as follows:</p> <ul style="list-style-type: none"> - 6:00 a.m.: Individual #1 was awakened and allowed 5 minutes to use a urinal. He was then transferred to a shower chair with a hooyer lift. The schedule did not indicate when Individual #1 was transferred to his wheelchair. - 8:15 a.m.: Individual #1 was to be transferred to a toileting chair with the hooyer lift if he needed to have a bowel movement. - 9:30 a.m. - 3:00 p.m., Individual #1 was at his day treatment program. - 3:15 p.m.: Individual #1 was to participate in the use of the hooyer. - 3:30 p.m.: Individual #1 was to be placed in bed. - 4:30 p.m.: Individual #1 was to choose a leisure activity. The schedule did not indicate if the leisure activity was to be done in bed or in his wheelchair. The schedule did not indicate when staff were to transfer Individual #1 back to his chair. - 4:45 p.m.: Individual #1 was to participate in a snack in the kitchen. 	W 250		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 250	<p>Continued From page 45</p> <p>- 8:45 p.m.: Individual #1 was to be transferred to a toileting chair if he needed to have a bowel movement.</p> <p>- 9:00 p.m.: Individual #1 was placed in bed.</p> <p>From 6:00 a.m. - 9:00 p.m., Individual #1's weekday schedule included one period of downtime for pressure relief for a maximum 1 hour and 15 minutes (from 3:30 - 4:45 p.m.).</p> <p>Individual #1's Active Treatment Schedule for weekends and holidays, dated 2/4/15, included time out of his wheelchair, as follows:</p> <p>- 7:00 a.m.: Individual #1 was awakened and utilized a urinal or was transferred to a toileting chair with a hooyer lift.</p> <p>- 7:15 a.m.: Individual #1 was transferred to his electric wheelchair with a hooyer lift.</p> <p>- 9:15 - 10:00 a.m.: Individual #1 completed showering and grooming tasks in a shower chair. He was then transferred back to his wheelchair.</p> <p>- 1:30 p.m.: Individual #1 was to be transferred to his bed for downtime "if he chooses to lay down."</p> <p>- 2:00 p.m.: Individual #1 was to be transferred back to his wheelchair.</p> <p>- 4:00 p.m.: Individual #1 was to be transferred to his bed for downtime.</p> <p>- 4:30 p.m.: Individual #1 was to be transferred back to his wheelchair to prepare for snack.</p>	W 250			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 250	<p>Continued From page 46</p> <p>- 8:45 p.m.: Individual #1 was to be transferred to a toileting chair if he needed to have a bowel movement, or to his bed.</p> <p>- 9:00 p.m.: Individual #1 was in bed for the night.</p> <p>From 7:00 a.m. - 9:00 p.m., Individual #1's weekend and holiday Active Treatment Schedule allowed for a 1/2 hour of downtime (4:00 - 4:30 p.m.). An optional 1/2 hour of downtime (1:30 - 2:00 p.m.) was available if Individual #1 chose to lie down.</p> <p>Individual #1's 2/4/15 Active Treatment Schedules were not reflective of the documented downtime needs for pressure relief.</p> <p>Individual #1's record included continued recommendations for increased downtime, as follows:</p> <p>On 2/16/15 at 5:00 p.m., DCS documented in the MOL "[Individual #1's] Bed Sore appears to be infected. Nurse [LPN's name] left instructions on care for [Individual #1]...He is to be laying in bed 2X's a day without his pants [and] underwear too."</p> <p>On 3/31/15 at 2:00 p.m., the LPN documented in the MOL "Seen today at [hospital name] Wound Clinic for pressure area on coccyx. Stage II wound...P.A. wants [Individual #1] to stay home from work for 1 week in bed, turn side to side every 2 hrs. Up in w/c for only 3 times a day for one hour at time for meds and meals."</p> <p>On 3/31/15 at 3:00 p.m., the LPN documented in the MOL "[Individual #1] is to be kept home for the next week until next wound clinic Appt., in bed</p>	W 250			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 250	<p>Continued From page 47</p> <p>on his sides, turning (Q) every 2 hrs. He may be up 3 times a day for 1 hr each for meals [and] meds. He may not have showers, give Bed Bath keep dressing Dry. Please give [Individual #1] his meds as soon as he finishes his meals and then back to Bed [sic]."</p> <p>An undated and untimed entry by the LPN in the MOL stated, "Bed Baths only, Continue to turn every 2 hrs from side to side. May be up 3 hrs daily for meals, snacks and meds."</p> <p>On 4/3/15, no time indicated, the LPN documented in the MOL "[Individual #1] remains in bed [due to] pressure area."</p> <p>A wound clinic note, dated 4/6/15, stated "strict offloading, reposition [every] 15 minutes, wheelchair cushion modifications, up in wheelchair daily for meds."</p> <p>On 4/6/15 at 4:00 p.m., the LPN documented in the MOL "Seen today at the Wound Clinic...Turn q 1-2 hrs. No more than 2 hrs."</p> <p>On 4/10/15 at 1:15 p.m., the LPN documented in the MOL "Continue bed rest, up for meals and meds."</p> <p>A wound clinic note, dated 4/20/15, stated "strict offloading, turning, repositioning and up in wheelchair 3 hours each day for meals."</p> <p>On 4/20/15 at 11:45 a.m., the LPN documented in the MOL "Seen at Wound Clinic today...RTC 2 wks remaining on bedrest. May be out of bed for an additional 15 mins a day."</p> <p>On 4/24/15 at 11:00 a.m. and 4/27/15 at 9:00</p>	W 250		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 250	Continued From page 48 a.m., the LPN documented in the MOL "continue Bed rest." A wound clinic note, dated 5/5/15, stated Individual #1 could be up in his wheelchair "<3 hrs" (less than 3 hours) per day. On 5/5/15 at 11:00 a.m. and 5/12/15 at 8:15 a.m., the LPN documented in the MOL "Continue bed rest." On 5/20/15 at 10:32 a.m., the RN documented in the MOL "[Individual #1] can go to work two times per week for 2-3 hours a day. Will check and evaluate sore three time per week (Mon., Wed., Fri.)." However, there were no changes made to the 2/4/15 Active Treatment Schedules to reflect Individual #1's increased need for downtime or limitations to the time he was allowed to be up in his wheelchair. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the AQIDP and QIDP both stated Individual #1's Active Treatment Schedules had not been revised since 2/4/15. The AQIDP and QIDP both stated the schedules were not reflective of Individual #1's needs. The facility failed to ensure Individual #1's Active Treatment Schedules were developed to prevent pressure wounds, and updated to address his pressure relief needs.	W 250		
W 253	483.440(e)(2) PROGRAM DOCUMENTATION The facility must document significant events that are related to the client's individual program plan	W 253	<u>W253</u> <u>Documentation of Significant Events</u>	07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 253	<p>Continued From page 49 and assessments.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure significant events were documented for 1 of 4 individuals (Individual #1) whose records were reviewed. This resulted in a lack of sufficient documentation related to an individual's wound care needs. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record, from 10/1/14 - 5/20/15, documented on-going pressure-related wounds to his buttocks. However, his record did not include documentation that his CFA, IPP and program plans were updated to meet his changing needs. Examples included, but were not limited to, the following:</p> <p>a. The LPN documented in the MOL, on 12/31/14 at 7:00 a.m., "Please let [Individual #1] lie down as much as possible to get off his Bottom [sic]."</p> <p>There was no additional information related to amount of time Individual #1 needed to lie down, or how increased time lying down would impact his active treatment program.</p> <p>b. The LPN documented in the MOL, on 11/28/14 (untimed), "Lay [Individual #1] on his side in bed, with attends open in back to let air into his</p>	W 253	<p><u>Corrective Action:</u></p> <p>1. A section titled "Nursing Documentation Expectations" has been added to the "RN Oversight & Nursing Services" Manual and the section titled "Medical Records" has been modified. These documents are included as Attachment D and E. The RN Supervisor will inservice the LPN who is now providing nursing services at this location and any nurses hired in the future on these expectations.</p> <p>2. We have updated our IPP Training Module with a section that specifies to the QIDP what documentary adjustments are to be made when there is a significant and/or extended change in status. Please see Attachment I. The QIDP Supervisor inservice the QIDP regarding this change on 06/22/15.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. She will be reviewing medical records and service delivery using these systems on a monthly basis. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.</p>	
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 253	<p>Continued From page 50</p> <p>buttocks - Have him lie down twice a day if possible and PRN."</p> <p>There was no documentation indicating how laying down twice a day impacted Individual #1's active treatment needs.</p> <p>c. A DCS documented in the MOL, on 2/16/15 at 5:00 p.m., "[Individual #1's] Bed Sore appears to be infected. Nurse [LPN's name] left instructions on care for [Individual #1]. Do not use cream on his sore. Use Bactracin [sic] [and] antibiotic ointment. He is to be laying in bed 2X's a day without his pants [and] underwear too."</p> <p>There was no documentation indicating how long Individual #1 was to be lying in bed, or how the time in bed impacted his active treatment needs.</p> <p>d. The LPN documented in the MOL, on 2/17/15 at 2:30 p.m., "Keep him off his back while in bed. Position with fold [sic] towel under hip - turn from side to side." A subsequent entry, dated 2/23/15 at 1:30 p.m., stated "Please use Rolled towel under his hips to turn him off his bottom."</p> <p>There was no documentation indicating how being positioned off his back or turned off his bottom impacted his active treatment needs.</p> <p>e. The LPN documented in the MOL, on 3/31/15 at 2:00 p.m., "Seen today at [hospital name] Wound Clinic for pressure area on coccyx. Stage II wound cleaned by P.A. Culture done. Dressing applied by R.N. P.A. wants [Individual #1] to stay home from work for 1 week in bed, turn side to side every 2 hrs. Up in w/c for only 3 times a day for one hour at [sic] time for meds and meals. [PA's name] PA will call with Cx [culture] results if</p>	W 253		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 253	Continued From page 51 pos[itive]. [PT's name] PT Accessed [sic] w/c cushion and will call [medical equipment company] regarding cushion." There was no documentation indicating how Individual #1's increased downtime and positioning needs impacted his active treatment needs. Individual #1's record documented continued and increasing issues related to pressure wounds. However, his record did not include documentation of team discussion or updates to his CFA, IPP and programs, regarding the significant impact the pressure wounds had on Individual #1's active treatment program. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP stated he, the AQIDP and the LPN discussed the lack of healing of the wound in March, at which time the LPN sought input from the physician. However, the impacts to Individual #1's active treatment program were not documented or addressed. The facility failed to ensure the impacts of Individual #1's pressure wounds on his active treatment program were documented.	W 253			
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it	W 259	<u>W259</u> <u>CFA Updated</u> <u>Corrective Action:</u> Please refer to the IPP dated 05/27/15 and revised 06/24/15 for annual updates. This QIDP has produced successful IPP documents for many years and	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 259	<p>Continued From page 52</p> <p>was determined the facility failed to ensure assessments were accurate and comprehensive for 1 of 4 individuals (Individual #1) whose assessments and IPPs were reviewed. This resulted in a lack of assessment information on which to base program decisions. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record, from 10/1/14 - 5/20/15, documented on-going pressure-related wounds to his buttocks. However, his record did not include documentation that his CFA was updated to meet his changing needs. Examples included, but were not limited to, the following:</p> <p>a. Individual #1's CFA, dated 5/28/14, included a Toileting Status section which stated he did not use incontinence briefs. The narrative section stated Individual #1 "has shown the ability to be continent of both bladder and bowel. [Individual #1] does experience periodic day and night time incontinence, but the frequency of occurrence is low."</p> <p>Individual #1's MOL documented, on 11/13/14, Poise Pads (incontinence pads) were implemented and attends (incontinence briefs) were to be worn at night.</p> <p>However, there was no documentation the CFA had been updated to reflect the need for, or use of, incontinence products.</p>	W 259	<p>we believe that the complexity of Individual #1 medical status and the lack of administrative oversight contributed to the issues noted.</p> <p>Updating of IPP's was further discussed with the QIDP on 06/17/15 with instructions given to either adjust the CFA section of the IPP summer or make a referral notation directing the reader to supplemental documentation.</p> <p><u>Identifying Others Potentially Affected:</u> We do not feel others were affected.</p> <p><u>Monitoring:</u> The QIDP Supervisor and RN Supervisor will attend scheduled Trending/Tracking meetings and will review IDT and IPP documentation related to status change.</p>	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 259	Continued From page 53 b. Individual #1's MOL included documentation from the LPN regarding positioning and down time that included, but was not limited to, the following: - 11/28/14, no time - "Lay [Individual #1] on his side in bed, with attends open in back to let air into his buttocks - Have him lie down twice a day if possible and PRN." - 12/31/14 at 7:00 a.m. - "Please let [Individual #1] lie down as much as possible to get off his Bottom [sic]." - 1/28/15 at 2:00 p.m., "please keep him off Bottom [sic] as much as possible." - 2/17/15 at 2:30 p.m. - "Keep him off his back while in bed. Position with fold [sic] towel under hip - turn from side to side." - 2/23/15 at 1:30 p.m. - "Please use Rolled [sic] towel under his hips to turn him off his bottom." - 3/31/15 at 2:00 p.m. - "Seen today at [hospital name] Wound Clinic for pressure area on coccyx. Stage II wound...[Physician's Assistant] wants [Individual #1] to stay home from work for 1 week in bed, turn side to side every 2 hrs. Up in w/c for only 3 times a day for one hour at time for meds and meals..." - 4/6/15 at 4:00 p.m. - "Seen today at the Wound Clinic. Turn q 1-2 hrs. No more than 2 hrs." However, Individual #1's CFA did not include information related to the pressure wounds, need for time out of his wheelchair, placement of	W 259			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 259	Continued From page 54 towels or other items for positioning in bed or extensive bed rest.	W 259		
W 260	<p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP stated no changes to Individual #1's CFA had been made.</p> <p>The facility failed to ensure Individual #1's CFA was updated as his status and needs changed.</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE</p> <p>At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</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 IPPs were revised to accurately reflect and respond to individuals' current needs and functional changes for 1 of 4 individuals (Individual #1) whose records and IPPs were reviewed. That failure resulted in an individual's IPP not reflecting his current status/needs. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record, from 10/1/14 - 5/20/15, documented on-going pressure-related wounds to his buttocks. However, his record did not include documentation that his IPP was</p>	W 260	<p><u>W260</u></p> <p><u>CFA Revised</u></p> <p><u>Corrective Action:</u> We have updated our IPP Training Module with a section that specifies to the QIDP what documentary adjustments, including updates to the CFA, are to be made when there is a significant and/or extended change in status. Please see Attachment I. The QIDP Supervisor inserviced the QIDP regarding this change on 06/22/15.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>Monitoring:</u> The QIDP Supervisor and RN Supervisor will attend scheduled Trending/Tracking meetings and will review IDT documentation related to status change.</p>	07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 260	<p>Continued From page 55</p> <p>updated to meet his changing needs. Examples included, but were not limited to, the following:</p> <p>a. Individual #1's MOL documented, on 11/13/14, Poise Pads (incontinence pads) were implemented and attends (incontinence briefs) were to be worn at night.</p> <p>However, the Strengths List section of the IPP stated Individual #1 was "Able to tell when needs to toilet." The IPP did not include an objective for toileting or include the use of Poise Pads or attends.</p> <p>b. Individual #1's IPP included a service objective to participate in range of motion exercises 8 times per month. The Intervention Plan for Range of Motion Exercises, dated 6/14, stated Individual #1 "should be assisted to lay on his back on his bed or on an exercise mat on the floor."</p> <p>An entry by the LPN in Individual #1's MOL, dated 2/17/15 at 2:30 p.m., stated "Keep him off his back while in bed. Position with fold [sic] towel under hip - turn from side to side." A second entry, dated 2/23/15 at 1:30 p.m., stated "Please use Rolled towel under his hips to turn him off his bottom."</p> <p>There was no information in the IPP explaining how staff were to complete the Range of Motion exercises and keep Individual #1 off of his back (e.g., modifications to the program, placing the program on hold, etc.). Additionally, the IPP was not updated to reflect the need for towels or other positioning devices while in bed.</p> <p>c. Individual #1's IPP including a bathing objective which stated he would wash his upper torso. The</p>	W 260		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 260	<p>Continued From page 56</p> <p>Intervention Plan for Shower, dated 6/14, stated "Staff will help [Individual #1] transfer to the shower, using the hooyer, and ensure needed bathing items are in restroom."</p> <p>An entry by the LPN in Individual #1's MOL, dated 3/31/15 at 3:00 p.m., stated "[Individual #1]...may not have showers, give Bed Bath keep dressing Dry." Another entry, dated 4/1/15 at 2:30 p.m., stated "Continue Bed Bath." A third entry, no date or time indicated, stated "Bed Baths only."</p> <p>The IPP did not include updated information related to Individual #1's need for bed baths, or how the changed need would impact his current training program.</p> <p>d. The LPN documented in the MOL that Individual #1 required increased down time. Entries included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 11/28/14, no time - "Lay [Individual #1] on his side in bed, with attends open in back to let air into his buttocks - Have him lie down twice a day if possible and PRN." - 12/31/14 at 7:00 a.m. - "Please let [Individual #1] lie down as much as possible to get off his Bottom [sic]." - 1/28/15 at 2:00 p.m., "please keep him off Bottom [sic] as much as possible." - 3/31/15 at 2:00 p.m. - "Seen today at [hospital name] Wound Clinic for pressure area on coccyx. Stage II wound...[Physician's Assistant] wants [Individual #1] to stay home from work for 1 week in bed, turn side to side every 2 hrs. Up in w/c for 	W 260		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 260	Continued From page 57 only 3 times a day for one hour at time for meds and meals..." - 4/6/15 at 4:00 p.m. - "Seen today at the Wound Clinic. Turn q 1-2 hrs. No more than 2 hrs." However, Individual #1's IPP did not include information related to increased downtime, or the impact increased downtime would have on his active treatment program. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP stated no changes to Individual #1's IPP had been made.	W 260			
W 318	The facility failed to ensure Individual #1's IPP was updated as his status and needs changed. 483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.	W 318	<u>W318 Condition: Health Care Services</u> Please refer to W322	07/06/15	
W 322	This CONDITION is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure necessary health care assessments, monitoring and timely follow-up occurred. This resulted in delayed identification, treatment, and follow-up necessary to meet the individuals' health care needs. The findings include: 1. Refer to W322 as it relates to the facility's failure to ensure individuals received general and preventative care in accordance with their needs. 483.460(a)(3) PHYSICIAN SERVICES	W 322	<u>W322</u> <u>General and Preventative Care</u>	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 322	<p>Continued From page 58</p> <p>The facility must provide or obtain preventive and general medical care.</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 4 of 4 individuals (Individuals #1 - #4) whose medical records were reviewed. This resulted in individuals not receiving health care services in accordance with their needs. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record documented on-going skin breakdown and pressure-related wounds. However, the record did not include documentation that general and preventative care had been provided to address Individual #1's skin integrity or wound issues consistently or in a timely manner, as follows:</p> <p>- 10/1/14 at 9:30 p.m., DCS documented in the MOL that Individual #1 "seems to have a rash."</p> <p>There was no additional documentation related to the location or description of the rash, or indication nursing staff had been notified and addressed the concern.</p> <p>- 10/8/14 at 8:30 p.m., DCS documented in the</p>	W 322	<p><u>Corrective Actions</u></p> <p>1. A. The LPN who was working at this is no longer employed. An experienced CCI LPN will be providing nursing oversight.</p> <p>1. B. The Administrator and QIDP Supervisor met with the RN Supervisor 06/17/15 and discussed the proper implementation of oversight systems.</p> <p>1. C. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.</p> <p>1. D. An in-depth quality assurance review of all medical records will be completed by 06/30/15 so that any other medical issues which were not identified during this survey can be corrected.</p> <p>1. E. Our staff observation module has been updated with an expanded section on "Paper-based" reviews with specifies that QIDPs and Nurses are to take a longitudinal view of entries in Medical Observation and Ancillary staff logs and management staff at this location, including the LPN, are to complete this module by 06/26/15.</p> <p>1. F. On 06/22/15 the QIDP Supervisor and RN Supervisor attended scheduled Trending/Tracking meetings at this location to provide additional oversight and this practice will continue on a regular basis.</p>		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 59</p> <p>MOL that Individual #1 "was getting peri care and his backside appears to be raw [and] redness all the way down."</p> <p>There was no additional documentation related to the actual location or description of the skin concerns, or documentation nursing staff had been notified and had addressed the concerns.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated nursing notification and follow-up should be documented in the MOL.</p> <p>- 11/13/14 at 1:50 p.m., the AQIDP documented in the MOL that Individual #1 began wearing attends at night.</p> <p>- 11/21/14 at 8:45 a.m., DCS documented in the MOL "black attends cover has left deep set red marks on left hip [and] thigh from elastic bands. not [sic] so bad on right but visible."</p> <p>- 11/21/14 at 3:30 p.m., the AQIDP documented in the MOL that Individual #1 "has small round dip (in color) red mark on his left bottom down by leg area."</p> <p>- 11/22/14 at 11:30 a.m., DCS documented in the MOL that Individual #1 "has two small round dark red marks on his right side by his bottom on the hind part of his thigh close under his buttocks. he [sic] hasn't complained of any discomfort due it [sic] them. noticed [sic] when getting him dressed after shower."</p> <p>- 11/24/14 at 9:45 p.m., DCS documented in the MOL that Individual #1 "has a sore on his right buttox [sic] about 1" wide."</p>	W 322	<p>1. G. We have reviewed the "Preventing Skin Injuries" material shared by the surveys and have also ordered the book "Clinical Guide to Skin and Wound Care" which should arrive next week. We already have a system for certifying staff in a variety of medical procedures. We will develop staff training material from these two documents and an accompanying certification record and nursing staff will certify staff at this location on this issue by July 1, 2015.</p> <p>1. H. A section titled "Nursing Documentation Expectations" has been added to the "RN Oversight & Nursing Services" Manual and the section titled "Medical Records" has been modified. These documents are included as Attachments D and E. The RN Supervisor will inservice the LPN who is now providing nursing services at this location and any nurses hired in the future on these expectations.</p> <p>2. Please refer to W323</p> <p>3. Please refer to W345</p> <p>4. Please refer to W352</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. She will</p>	
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 60</p> <p>- 11/25/14 at 8:20 a.m., DCS documented in the MOL Individual #1 "has an open sore the size of a quarter. Barrier creme [sic] was applied."</p> <p>Between 11/21/14 and 11/25/14, Individual #1 developed an open wound the size of a quarter. However, the 11/25/14 documentation did not indicate the location of the open wound, and previous documentation indicated areas of concern on both the left and the right side. It was not clear if one or more wounds and/or areas of concern were present. Additionally, there was no documentation nursing staff had been notified regarding the areas of concern or the open wound.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the AQIDP and QIDP both stated there were areas of concern on both the left and right sides of Individual #1's buttocks as a result of the attends cover. The AQIDP stated DCS would have left notes for the nurse, but should have documented calls to the nurse in the MOL.</p> <p>- 11/28/14, no time documented, the LPN documented in the MOL "Please continue to use the barrier cream on open area on [Individual #1's] Bottom [sic]. Keep area clean and dry. Lay [Individual #1] on his side in bed, with attends open in back to let air into his buttocks - Have him lie down twice a day if possible and PRN."</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated Barrier Cream (a moisture barrier) was not designed to treat open wounds.</p> <p>- 12/2/14 at 8:30 p.m., DCS documented in the MOL "Put on his butt bacitracin [sic] and</p>	W 322	<p>be reviewing medical records and service delivery using these systems on a monthly basis.</p> <p>The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C. Additionally the QIDP Supervisor and RN Supervisor will attend scheduled Trending/Tracking meetings.</p>	
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 61 MexSana power [sic]. Continue to monitor."</p> <p>- 12/5/14 at 10:55 a.m., DCS documented in the MOL "Applied Bactriactin [sic] [and] Mexana Powder to the open sore on [Individual #1's] lower buttock; looks better today."</p> <p>The record contained no other documentation regarding the wound and treatment from 11/28/14 - 12/5/14. Additionally, Individual #1's Physician's Order Sheet and Progress Note, signed by the physician on 11/7/14, did not include orders for Bacitracin (a topical antibiotic ointment) or Mexsana (a medicated starch-based skin protectant powder).</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated Individual #1 did not have physician's orders for the treatments that had been provided.</p> <p>- 12/9/14 at 3:45 p.m., the LPN documented in the MOL "Peri area and buttocks checked. Area on [right] inner buttock is now open, draining light pink drainage, the area is about a dime size pressure area, Stage II. Cleansed and dried well. Tegaderm drsg [dressing] applied. Staff please clean peri area carefully so as to not dislodge the Tegaderm. Leave on during shower. Tape drsg in place if needed. May replace tegaderm if it comes off with 1/2 piece. Change tegaderm every 4-7 days. (Tegaderm is a clear plastic dressing pad, it is in his Basket at bedside [sic]."</p> <p>A Quarterly Nursing Physical, dated 12/9/14 and signed by the LPN, stated "Dime size pressure area Left inner buttock. See Med Obs Log."</p> <p>The location of the wound was inconsistently</p>	W 322		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	Continued From page 62 documented. Additionally, Individual #1's record did not include an order for the use of Tegaderm. - 12/12/14 at 11:00 a.m., DCS documented in the MOL that Individual #1's "Tegaderm dressing applied (replaced) to open wound on [right] inner buttock. Had a foul smell to this area; thoughly [sic] washed area w/soap [and] water [and] dried. Wound appears closed over w/no notable redness observed. [Individual #1] stated the area 'does not hurt' when I applied T. dressing over wound. Will continue to monitor." - 12/13/14 at 10:35 a.m., DCS documented in the MOL that Individual #1's "Tezaderm [sic] dressing was replaced on open wound on [right] inner buttocks. Had a yellow colored discharge and a foul smell to that area; washed area with soap [and] water and dried area before applying [sic] Tezaderm [sic] dressing. [Individual #1] didn't complain of any pain or discomfort. Will continue to monitor." There was no documentation nursing staff were notified of the drainage or odor noted on 12/12/14 or 12/13/14. - 12/15/14 at 1:00 p.m., the LPN documented in the MOL "Please remove Tegaderm. Wash with soap [and] water. Dry well, then use Bacitracin, then a small amount of Barrier Cream, cover with dry 4x4 and change as needed. Use Bacitracin antibiotic oint. twice daily. And document [sic]." - 12/17/14 at 6:45 a.m., DCS documented in the MOL "Washed area with soap [and] water as directed dried well [and] applied Bacitracin then small amount of Barrier Cream and covered with a 4x4 gauze. No Drainage or odor [at] this time."	W 322		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 322	<p>Continued From page 63</p> <ul style="list-style-type: none"> - 12/17/14 at 8:30 a.m., the LPN documented in the MOL "Pressure area [right] inner Buttock is healing - half the size it was last week. Scant amt. light pink drainage noted. Please continue to use above instructions until healed." - 12/18/14 at 9:05 p.m., DCS documented in the MOL "Washed area with soap [and] water; dried [sic] area completely and applied Bactracin [sic] then a small amount of Barrier Cream and covered w/a 4x4 gauze." - 12/20/14 at 2:55 p.m., DCS documented in the MOL "Washed pressure area with soap [and] water, dried [sic] applied Bactracin [sic] then small amt of Barrier cream and covered with a 4x4 gauze." - 12/22/14 at 1:45 p.m., DCS documented in the MOL "(Late entry for 12/19/14) [Individual #1's] bottom cleaned with soap [and] water, applied Bactricen [sic] [and] gauze. Skin looks intact no fowl [sic] smell or discharge." - 12/22/14 at 1:47 p.m., DCS documented in the MOL Individual #1's "bottom cleaned w/soap [and] water, applied Bactricin [sic] [and] gauze. Skin looks good, says bottom doesn't 'hurt.'" - 12/22/14 at 8:45 p.m., DCS documented in the MOL "Late Entry for 12-21-14 put protective cream on [Individual #1's] Right behind." - 12/23/14 at 8:15 p.m., DCS staff documented in the MOL "washed area with warm water [and] soap dried completely and applied Bactracin [sic] and 4x4 gauze." 	W 322		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 64</p> <p>- 12/24/14 at 6:50 a.m., DCS documented in the MOL "washed with soap and warm water. Applied Bacitracin [sic] [and] small amount of barrier cream. Covered w/gauze."</p> <p>- 12/27/14 at 10:35 a.m., DCS documented in the MOL "after [Individual #1's] shower staff dried his Right [sic] bottom area and applied bacitracin [sic]; small amount of barrier cream and two 4x4 pieces of gauze prior to putting on his attends."</p> <p>- 12/28/14 at 9:10 p.m., DCS documented in the MOL Individual #1 "got bacitracin [sic] and protective Barrier cream on his right bottom I asked I [sic] he wanted tape [Individual #1] stated no but I also put gauze."</p> <p>- 12/29/14 at 1:14 p.m., DCS staff documented in the MOL, "Washed his sore on [right] lower buttock during shower this am. Applied Bacitracin [sic] [and] Barrier Cream on sore, covered with gauze [and] tape to sore [sic]. Looks the same as previous days with no significant changes noted."</p> <p>- 12/31/14 at 7:00 a.m., the LPN documented "Discontinue using Bacitracin [sic] now. Use only Barrier cream. Please let [Individual #1] lie down as much as possible to get off his Bottom [sic]."</p> <p>Individual #1's record did not include an order for the use of Bacitracin ointment, Barrier Cream, Tegaderm or gauze dressings. Additionally, from 12/15/14 - 12/31/14, the record did not document consistent treatment of the wound through dressing changes, or any information regarding offloading by spending time out of his wheelchair and position changes.</p>	W 322		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 322	<p>Continued From page 65</p> <p>- 1/3/15 at 11:45 a.m., DCS documented in the MOL "Applied Bacracin [sic] [and] Barrier Cream to [Individual #1's] bottom and covered with gauze."</p> <p>- 1/5/15 at 1:35 p.m., the LPN documented in the MOL "Use Bacracin [sic] on pressure area on [Individual #1's] bottom only if it is 'open.' Continue to use Barrier Cream."</p> <p>- 1/7/15 at 9:00 a.m., the LPN documented in the MOL "Please do not use tape or Bacracin [sic] on [Individual #1's] Bottom - cover with loose gauze only and barrier cream."</p> <p>From 1/1/15 to 1/7/15, the record only documented one dressing change, on 1/3/15.</p> <p>- 1/9/15 at 9:30 a.m., the LPN documented in the MOL "New Memory foam pad placed on wheelchair seat yesterday, hopefully to held [sic] prevent skin breakdown on Buttocks [sic]. harness [sic] straps unaffected. [Individual #1] states it feels 'really good.' Will continue to monitor."</p> <p>An assessment or order for a memory foam pad could not be found in Individual #1's record. Additionally, there was no documentation of wound treatments from 1/3/15 through 1/9/15.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP stated the LPN brought the cushion in, but he was not aware of an assessment or order for the use of the cushion. The RN, who was present during the interview, stated dressing changes should be documented.</p> <p>- 1/10/15 at 11:29 a.m., DCS documented in the</p>	W 322		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 322	<p>Continued From page 66</p> <p>MOL "Applied Barrier Cream and loose gauze to [Individual #1's] buttocks."</p> <p>- 1/11/15 at 1:41 p.m., DCS documented in the MOL Individual #1's "buttocks is still opened. Bleeds when gets bumped."</p> <p>- 1/12/15 at 11:00 a.m., the LPN documented in the MOL "Continue to use Barrier Cream on Buttocks. Let [Individual #1] lie down as much as possible. Keep attends changed (Dry and Clean)."</p> <p>- 1/13/15 at 8:50 a.m., the LPN documented in the MOL "Pressure area on [left] buttock remains stage II. Continue to use, a good amt., of Barrier cream [sic], do NOT cover with gauze or washcloths. Please continue to Keep [sic] attends clean/dry. Lie down after."</p> <p>- 1/13/15 at 9:00 a.m., the LPN documented in the MOL "Please keep water proof pads under [Individual #1] as flat and smooth as possible."</p> <p>From 1/11/15 through 1/13/15, there was no documentation of dressing changes being completed.</p> <p>- 1/14/15 at 10:00 a.m., the LPN documented in the MOL "Please start using "Working Hands" cream on [Individual #1's] Bottom - as instructed on ADLS sheet."</p> <p>Individual #1's "Non-Prescription Topicals & Treatments" sheet (the ADL sheet), for January 2015, included a handwritten note, undated and unsigned, stating "Working Hand Cream to both sides of Butt [and] pressure area [left] side BID and PRN" in both the a.m. and p.m. sections of</p>	W 322			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 322	Continued From page 67 the form. DCS began signing for the cream on 1/14/15 during the p.m. shift. The manufacturer of Working Hands Cream (www.okeeffescompany.com) indicated it is to be used for dry, cracked hands and feet. There was no indication that the cream was an appropriate treatment for open pressure wounds. Additionally, Individual #1's record did not include a physician's order to use Working Hand Cream on his open pressure wounds. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated she did not know why Working Hands Cream was used and confirmed there was no order for the treatment. The AQIDP, who was present during the interview, stated the dressing changes had been added to the ADL sheet due to a lack of documentation being completed. - 1/14/15 at 1:10 p.m., the AQIDP documented in the MOL "Barrier cream is D'Cd [sic] per [LPN's name] LPN Direction." - 1/17/15 at 10:00 a.m., DCS documented in the MOL "'Working Hand's' cream was applied to [Individual #1's] Right [sic] side of his backside and barrier cream applied to his left groin area. all [sic] done after shower." - 1/17/15 at 3:00 p.m., DCS documented in the MOL "Late entry for 1/16/15. Working Hands lotion applied to [Individual #1's] buttocks." - 1/20/15 at 4:15 p.m., the AQIDP documented in the MOL "Sore on [Individual #1's] bottom is same size the depth seems less."	W 322			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 68</p> <p>- 1/23/15 at 9:28 a.m., DCS documented in the MOL "While toileting it was discovered that the open sore on [Individual #1's] [right] lower buttock was bleeding. Area cleaned [and] dried, 'Working Hands' cream was applied to sore and surrounding area. Continue to monitor."</p> <p>- 1/24/15 at 2:21 p.m., DCS documented in the MOL "After staff got [Individual #1] down to relax staff [staff name] applied peri care for [Individual #1] and noticed that the sore appeared to be deeper than previously so she got a second staff to check area. I looked at [Individual #1's] bottom and noticed that [Individual #1] had what appears to be a bruise at the top of his bottom in the creased area when touched [Individual #1] stated that it didn't hurt. Will continue to monitor."</p> <p>There was no documentation nursing staff had been notified of the new area of concern, or that the nurse had been notified the previous wound appeared to be getting worse and had been bleeding. Additionally, there were no measurements of the wounds.</p> <p>- 1/26/15 at 1:00 p.m., the LPN documented "Please use 'pull-ups' during the day only. Leave [Individual #1's] bottom open to the air while he is in bed. Also turn him on his side and use pillows to prop him up, do this as often as possible. Be very gentle when cleaning [Individual #1's] bottom. Use a good amount of 'Working Hands' cream on pressure areas. may [sic] change to Barrier Cream if area is worse."</p> <p>- 1/26/15 at 4:00 p.m., the AQIDP documented in the MOL "Looked at [Individual #1's] sore it is getting smaller in size. Took Attends off and let him air."</p>	W 322		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 69</p> <p>- 1/28/15, no time indicated, DCS documented "received his working hands cream on buttocks [and] Barrier cream in groin area. also [sic] notice in the center of his upper buttocks right above the line of [Individual #1's] crack tailbone he has a sore an opening it is a small tear. also [sic] applied working hands on it."</p> <p>- 1/28/15 at 2:00 p.m., the LPN documented in the MOL "Pressure improving, Approx dime size Stage II intact, [no] drainage. Continue good genital [sic] peri care - use 'Working hands' cream on area - please keep him off Bottom [sic] as much as possible. There appears to be an abrasion or scratch at bottom of tailbone. Use 'working hands' cream on it as well."</p> <p>- 1/29/15 at 10:00 p.m., DCS documented in the MOL "Applied Working Hands on [Individual #1] [sic] behind, also noticed it appears like skin on abrasion on [Individual #1's] tailbone is puffy or 'shedding.'"</p> <p>- 1/31/15 at 2:51 p.m., DCS documented in the MOL "After giving [Individual #1] his shower staff applied Working hands cream [sic] to his whole bottom as well as the area above the tailbone while doing so staff noticed what appears to be possibly two small sores on the inner part of his [right] buttcheek closer to the interior of gluteus minimus [sic]."</p> <p>There was no additional documentation regarding description or size of the new wounds, or documentation the wounds were reported to nursing staff.</p> <p>- 2/2/15 at 9:20 p.m., DCS documented in the</p>	W 322		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 322	<p>Continued From page 70</p> <p>MOL "It appears to be a blister about the size of a thumb nail on the beginning of his bottom it has a yellow tent [sic] w/some scabbing."</p> <p>There was no additional documentation related to the location of the blister, or documentation the blister was reported to nursing staff.</p> <p>- 2/6/15 at 11:00 a.m., the LPN documented in the MOL "Continue to use 'Working Hands' cream on any reddened or sore areas on [Individual #1's] bottom."</p> <p>- 2/7/15 at 2:10 p.m., DCS documented in the MOL "Applied working hands cream to [Individual #1's] bottom and on soar [sic] at beginning of his buttocks also barrier cream to left groin area.</p> <p>- 2/13/15 at 10:50 a.m., DCS documented in the MOL "sore on his tailbone was weeping clear fluid, the other looks well. Applied 'Working Hands Cream' on both areas after his shower."</p> <p>- 2/16/15 at 5:00 p.m., DCS documented in the MOL Individual #1's "Bed Sore appears to be infected. Nurse [LPN's name] left instructions on care for [Individual #1]. Do not use cream on his sore. Use Bactracin [sic] [and] antibiotic ointment. He is to be laying in bed 2X's a day without his pants [and] underwear too."</p> <p>There was no documentation individual #1's wound was seen by nursing staff, or that the concern of possible infection was reported to a physician. The directions were not clear as to what the second antibiotic ointment was. Additionally, Individual #1's record did not include physician's orders for Bacitracin or another antibiotic ointment.</p>	W 322			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 71</p> <p>Individual #1's "Non-Prescription Topicals & Treatments" for February 2015 included a handwritten note, unsigned and undated, that was added to the a.m. and p.m. sections, stating "use Bacitracin oint to tail bone [sic] BID. Cover with (NS) moist 2x2 dry 4x4. Keep him off his back." Staff had initialed the form on 2/18/15 and 2/19/15 for the a.m. shift and 2/17/15 - 2/28/15 for the p.m. shift. There was no documentation for 2/20/15 - 2/28/15 on the a.m. shift.</p> <p>- 2/17/15 at 7:32 a.m., DCS documented in the MOL "was cleaning his sore, put Bacatrain [sic] cream on it. It look Bigger [sic] than I see [sic] before it is red around the sore and white puss [sic] and glossy goow [sic]. Continue to monitor."</p> <p>- 2/17/15 at 9:00 a.m., the LPN documented in the MOL Individual #1 "has a stage II pressure sore on his coccyx (tailbone), Approx. the size of nickel. Sm. hemotoma [sic] on edge. Wash carefully and gentelly [sic]. Use Bacitracin ointment twice a day and cover with moist 2x2 pads and cover with 4x4 pad. Do Not use Working hands or Barrier cream on tailBone [sic] at this time. Monitor. At this time no foul order [sic] noted. Sm. amt clear white drainage noted."</p> <p>- 2/17/15 at 2:30 p.m., the LPN documented in the MOL "Please use Bacitracin Oint. on tail Bone [sic] twice a day, cover with moist 2x2 (NS) Normal Saline and cover with dry 4x4. Keep him off his back while in bed. Position with fold [sic] towel under hip - turn from side to side. Old pressure on [left] buttock, healing, no redness, closed. Continue use of Working hands on both side of buttocks. Do Not use Working hands or Barrier cream on tailbone at this time. Document</p>	W 322		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 72 what you see."</p> <p>There were no physician's orders for the new wound treatments (wet to dry dressings and Bacitracin ointment). During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN confirmed no orders were present in the record for the treatments being used on Individual #1's wounds.</p> <p>- 2/17/15 at 9:00 p.m., DCS documented in the MOL Individual #1 "had redness from tape on his wound. Per [LPN's name] do not use the tape to hold gauze in place."</p> <p>- 2/18/15 at 11:00 a.m., DCS documented in the MOL "applied Bacitracin Ointment on tailbone and applied Saline Solution onto Gauze [sic] 2x2 and onto wound, and then applied a 4x4 Guaze [sic] over the 2x2s. put [sic] Working Hands cream on to [sic] Buttocks not tailbone wound and Barrier Cream on groin area. His wound has pus did wash and clean area well first."</p> <p>- 2/19/15, no time indicated, DCS documented in the MOL "LATE ENTRY for 2/18/15 applied Bacitracin Ointment on tailbone along with 2x2 gauze of saline solution covered by 4x4 gauze, working hand cream on bottom and Barrier cream to [left] groin area."</p> <p>- 2/20/15 at 3:25 p.m., DCS documented in the MOL "Applied Bacitracin ointment on [Individual #1's] tailbone. Also applied Saline solution [and] a 2x2 guaze [sic] [and] a 4x4 guaze [sic] over the 2x2s."</p> <p>- 2/21/15 at 3:22 p.m., DCS documented in the MOL "Applied Bacitracin ointment with Saline</p>	W 322		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 73</p> <p>Solution on 2x2 gauze covered with 3x3 gauze and applied Barrier cream to groin. Working hand to buttocks excluding tail bone area on which the above mentioned was applied."</p> <p>- 2/23/15 at 1:30 p.m., the LPN documented in the MOL "Please continue treatment of [Individual #1's] coccyx ([left] ischial) with Bacitracin oint. And Normal Saline (wet to dry) dressing. Please use Rolled towel under his hips to turn him off his bottom."</p> <p>- 2/23/15 at 1:40 p.m., DCS documented in the MOL "Applied Bacitracin [and] Saline Solution [and] 2x2 gauze on [Individual #1's] tailbone. This area is looking better; area is not as discolored and the sore seems to be filling in w/very light clear drainage. The sore on his bottom is also heal [sic] well; filling in and no discoloration; However there seems to be a small new one forming in the area."</p> <p>There was no documentation the new wound was reported to nursing staff, and no documentation of the location or size of the wound.</p> <p>- 2/24/15 at 12:38 a.m., DCS documented in the MOL "Applied Bactarasin [sic] and solution on a 2x2 gaze [sic] and a large gaze [sic] on Tailbone then put Hand Cream on the Buttocks [sic] Look [sic] like it is healing Continue [sic] to monitor."</p> <p>- 2/25/15 at 8:30 a.m., DCS documented in the MOL "After [Individual #1's] shower he received his Bacitracin Ointment on his tailbone and 2x2 gauze was put on his wound w/saline solution and then the Dry [sic] 4x4 gauze on top. Working hands cream all over buttocks [and] Barrier cream on groin area."</p>	W 322		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 74</p> <p>- 2/25/15 at 8:30 a.m., DCS documented in the MOL Individual #1's "wound on tailbone is looking much better this morning."</p> <p>- 2/25/15 at 4:00 p.m., DCS documented in the MOL "After [Individual #1] was down for 'downtime' staff assessed [Individual #1's] tailbone it is pink in color looking like it is healing staff applied Bacitracin Ointment on tailbone area, then 2x2 gauze covered in saline solution was applied around with 3x4 gauze and Working hands cream applied to buttocks."</p> <p>- 2/25/15 at 9:15 p.m., DCS documented in the MOL "After putting [Individual #1] in bed for the night staff checked tailbone area; it is still pink in color and appears to be healing. Bacitracin; saline covered 2x2 gauze; 3x4 in gauze [and] working hands cream was applied to [Individual #1's] back side, the latter working hands cream was not applied to tailbone area; he appears to have no pain in the tailbone area."</p> <p>- 2/28/15 at 8:00 a.m., DCS documented in the MOL Individual #1's "tail bone [sic] spot was little [sic] yellow in the middle."</p> <p>- 3/2/15 at 9:25 a.m., DCS documented in the MOL Individual #1's "bottom sores cleaned w/soap [and] water during his A.M. shower. Sore on lower [right] buttock appears to be healing well; no drainage discoloration or smell. Sore on tailbone appears blanched (off white with some light clear drainage [sic]. Applied 'Working Hands' [and] 'Bactracin [sic] [and] Saline Solution' applied to areas respectively."</p> <p>The record documented the nurse was present</p>	W 322		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 75</p> <p>only 3 days in February 2015, and only looked at the wounds on 2/17/15.</p> <p>During an interview on 5/28/15 from 2:04 - 2:15 p.m., DCS A stated she had seen the LPN at the facility during the day shift, but could not state how frequently.</p> <p>During an interview on 5/28/15 from 2:42 - 2:50 p.m., DCS F stated she had only seen the LPN once or twice at the facility.</p> <p>During an interview on 5/29/15 from 9:43 - 9:57 a.m., DCS B stated the LPN was present maybe once a week. DCS B stated the LPN would read staff documentation and if concerns were noted, the LPN asked staff what they thought, but did not look at the individuals for herself.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated it was expected the LPN would be at the facility daily on normal working days (Monday - Friday). The RN stated the LPN should have been looking at the wounds and not relying only on DCS descriptions.</p> <p>- 3/3/15 at 8:50 a.m., DCS documented in the MOL Individual #1's "wound is looking really good now. he [sic] received all his creams on tailbone [and] Buttocks it is healing weel [sic]. no pus no odor no drainage [at] this time."</p> <p>- 3/15/15 (date is correct) at 9:50 a.m., an unsigned entry in the MOL stated Individual #1's "tailbone looks fine, no drainage, no odor, appears to Be Healing [sic] [at] this time."</p> <p>- 3/4/15 at 8:50 a.m., DCS documented in the MOL "applied all creams to designated areas."</p>	W 322		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	Continued From page 76 - 3/6/15 at 10:40 a.m., DCS documented in the MOL Individual #1's "bottom areas cleaned w/soap [and] water during his AM shower. Sore on lower [right] buttock appears to be healing. No drainage, discoloration or smells noted. The sore on his tailbone still appears light in color but no drainage. Batricin [sic] [and] Saline Solution applied with gauze to this area. Will continue to monitor." - 3/11/15 at 9:05 a.m., DCS documented in the MOL Individual #1's "tailbone has no pus, no drainage and looks to be healing so well, applied his creams [and] saline except working hands we didn't have any." - 3/11/15 at 9:29 p.m., DCS documented in the MOL Individual #1's "tailbone is red in color, no pus, no drainage he said it didn't hurt but it Appeared [sic] to have skin peeling from area. Left area that looks to be peeling alone cleaned with soap [and] water applied ointments and saline and covered." - 3/12/15 at 9:00 a.m., the LPN documented in the MOL "Skin check done. [left] tail [sic] healing, Drying [sic], peeling some. No drainage noted. Continue NS dressing and Bactricin [sic] oint. [Right] Buttock clear, [left] Buttock has an old pressure area that has an open edge. Please use Working hands on that area. [Illegible] Buttock." - 3/14/15 at 2:21 p.m., DCS documented in the MOL "Tailbone appears to be healing no pus or bleeding applied Bacitracin to tailbone with Saline solution and 2x2 gauze also applied barrier cream to left groin area."	W 322		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 77</p> <p>- 3/18/15 at 8:48 p.m., DCS documented in the MOL "Tailbone appears to be fine [Individual #1] isn't complaining about it applied Bacitracin and saline solution with 2x2 gauze covered by 4x4 gauze."</p> <p>- 3/20/15 at 10:40 a.m., DCS documented in the MOL Individual #1's "bottom cleaned with soap [and] water during his shower this A.M. The open sore on his tail bone looks a bit waxy [and] purple around the edges of the sore. There is some redness within the sore itself. No drainage or odor [at] this time. Batricin [sic] [and] Saline Solution applied with gauze the area. Will continue to monitor."</p> <p>- 3/21/15 at 3:03 p.m., DCS documented in the MOL Individual #1's "tailbone appears to be red [and] purple on Right [sic] upper side of sore. No complaints of pain by [Individual #1] at this time applied Batricin [sic] [and] Saline Solutions with 2x2 gauze covered by 4x4 gauze."</p> <p>- 3/21/15 at 6:00 p.m., DCS documented in the MOL Individual #1's "tailbone appears to be red [and] purple and bleeding. He says it hurts him."</p> <p>- 3/21/15 at 8:45 p.m., DCS documented in the MOL Individual #1's "tailbone is bleeding. I applied batricin [sic] [and] Saline Solution with 2x2 gauze [and] 4x4 gauze. Before applying I did wipe the area w/soap [and] water."</p> <p>There was no documentation nursing staff was notified of the changes to the wound, the bleeding, or Individual #1's complaints of pain.</p> <p>- 3/24/15 at 10:00 p.m., the LPN documented in</p>	W 322		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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)	
W 322	<p>Continued From page 78</p> <p>the MOL "[Left] pressure sore tailbone (ischial area) healed. New Stage II pressure area on coccyx (center tailbone) now open. Lg. amt. working hands with N.S. gauze placed on area. Will call [Physician's name] tomorrow. Continue saline dressing for now."</p> <p>A Quarterly Nursing Physical, signed by the LPN on 3/24/15, stated "[Left] Buttocks sore healing. Stage II pressure Now [sic] on coccyx." No additional information was present, and there was no indication the form had been reviewed by the RN or physician.</p> <p>A Physician's Order Sheet and Progress Notes, dated 3/25/15 and initialed by the primary physician, included a telephone order to refer Individual #1 to a wound clinic regarding the pressure area on his coccyx.</p> <p>From 10/1/14 through 3/24/15, there was no documentation Individual #1's skin issues or pressure wounds had been reported to, or addressed by, the facility's RN or Individual #1's physician. During this time, all treatment decisions and direction had been provided by the LPN.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated she believed the LPN had previous wound training in another state, but did not know how current or valid the training was. The RN stated she had received verbal reports from the LPN, but had only been told it was a diaper rash and attends issue. The RN and the QIDP, who was present during the interview, both stated they assumed the LPN was reporting wound concerns to the physician.</p>	W 322		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 79</p> <p>- 3/25/15 at 10:00 a.m., the LPN documented in the MOL "Order received from [physician's name] for [Individual #1] to go to [hospital name] wound clinic. Order faxed."</p> <p>A Physician's Order Sheet and Progress Notes, dated 3/26/15 and initialed by the physician, included a telephone order for "Duoderm dressing to coccyx change every 5-7 days."</p> <p>- 3/26/15 at 9:20 a.m., the LPN documented in the MOL "Duoderm dressing placed on coccyx. to [sic] be changed every 5-7 days by Nursing. May shower/get wet. Do Not Remove! If dressing becomes soiled please call nurse."</p> <p>- 3/29/15 at 5:25, a.m./p.m. not specified, DCS documented in the MOL Individual #1's "Duoderm patch was off. Nurse [name of LPN] gave staff permission to replace it. Used half the patch [and] cleaned wound with soap [and] water. Patted it to clean the wound [and] used dry wash cloth to pat dry. This should stay on until his appointment."</p> <p>A wound clinic note, dated 3/31/15, stated Individual #1 had a sacrum stage 2 pressure ulcer measuring 2.2 cm in length, 3.0 cm in width and 0.3 cm in depth. The note stated Aquacel AG (an antimicrobial ionic silver wound treatment) dressing was to be used and changed 4 times per week.</p> <p>- 3/31/15 at 2:00 p.m., the LPN documented in the MOL "Seen today at [name of hospital] Wound Clinic for pressure area on coccyx. Stage II wound cleaned by P.A. [Physician's Assistant] Culture done. Dressing applied by R.N. P.A. wants [Individual #1] to stay home from work for 1</p>	W 322		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 322	<p>Continued From page 80</p> <p>week in bed, turn side to side every 2 hrs. Up in w/c [wheelchair] for only 3 times a day for one hour at [sic] time for meds and meals. [Name of PA] PA [sic] will call with Cx [culture] results if pos[itive]. [Name of PT] PT Accessed [sic] w/c cushion and will call [wheelchair company] regarding cushion."</p> <p>- 3/31/15 at 3:00 p.m., the LPN documented in the MOL Individual #1 "is to be kept home for the next week until next wound clinic Appt., in bed on his sides, turning (Q) every 2 hrs. He may be up 3 times a day for 1 hr each for meals [and]meds. He may not have showers, give Bed Bath keep dressing Dry [sic]. Please give [Individual #1] his meds as soon as he finishes his meals and then back to Bed [sic]. Dressing to be changed 4x weekly. Instructions to follow."</p> <p>- 4/1/15 at 7:30 a.m., DCS documented in the MOL Individual #1 "was repositioned on his sides every 2 hrs as requested by Nurse and he had a very good nights [sic] rest, did not have any complaints with the night."</p> <p>- 4/1/15 at 2:30 p.m., the LPN documented in the MOL "continue to turn every 2 hours on sides use pull sheet. Continue Bed Bath. I will change his dressing in the AM 4/2."</p> <p>- 4/2/15 at 5:00 a.m., DCS documented in the MOL Individual #1 "had a very good night. Repositioned every 2 hrs. No complaints."</p> <p>After the 4/2/15 entry, there was no documentation of position changes or a schedule for positioning.</p> <p>An undated and untimed entry written by the LPN</p>	W 322		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 322	<p>Continued From page 81</p> <p>in the MOL stated "Dressing to Sacrum (tailbone) changed as ordered. Pressure area has mod. amt. pink drainage. No foul oder [sic]. Appears to be Less [sic] deep."</p> <p>An undated and unsigned entry by the LPN in the MOL stated "Dressing change instructions: #1 Wash your hands, #2 put gloves on and remove old dressing, #3 place in clean trash bag, #4 remove gloves from removing old dressing [and] dispose them [sic] in trash bag, #5 cleanse pressure sore with MicroKlenz, dry with 4x4 gauze, #6 cover sore with CalciCare Silver Dressing, #7 cover Silver drsg. with small ABD [an absorbent wound dressing] pad, #8 use skin prep around Bandage, Let dry, it should be Tacky [sic], #9 Tape with Hypafix tape - 2-3 pieces -(use scissors from Suture Removal Kit only). Keep dry and clean. Bed Baths only, Continue to turn every 2 hrs from side to side. May be up 3 hrs daily for meals, snacks and meds. Next drsg change due on Sunday. And PRN. Encourage him to drink fluids." A note written to the side, with a line to #5, stated "use new clean gloves."</p> <p>A Physician's Order Sheet and Progress Notes entry, dated 4/3/15 and signed by the primary physician, stated "Follow up on ulcer buttock...Continue [with] wound care. He requires a contoured seat cushion to prevent recurrence of decubitus ulcer."</p> <p>A Physician's Order Sheet and Progress Notes, dated 4/3/15 and initialed by the physician, stated "Supplement diet with C.I.B., vanilla (only) in Skim Milk or Ensure. Vanilla (only). (may use store Brand). BID to support weight and skin integrity. Not a meal replacement."</p>	W 322		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 82</p> <p>- 4/3/15, time not indicated, the LPN documented in the MOL "Seen by [name of physician] today for Stage II pressure sore coccyx/sacrum, today [sic]. Area continues to be open [with] sm. amt. yellow drainage noted. Re-dressed as ordered. [Individual #1] remains in bed [due to] pressure area. Return to wound clinic Monday 4/6/15."</p> <p>- 4/4/15 at 10:00 a.m., the ILW documented in the MOL "Changed [Individual #1's] dressing this morning. Did not observed much drainage, no odor noticed. Pink around edges of wound, more white in the middle. [Individual #1] did not complain of pain or discomfort when cleaning the area."</p> <p>A wound clinic note, date 4/6/15, stated Individual #1 had a sacral pressure ulcer stage 2. No measurements were indicated. The note stated "keep free from contaminants, strict offloading, reposition [every] 15 minutes, wheelchair cushion modifications, up in wheelchair daily for meds."</p> <p>- 4/6/15 at 4:00 p.m., the LPN documented in the MOL "Seen today at the Wound Clinic. Pressure area on coccyx appears to be healing it is decreased in size. Cleaned by P.A. [name of PA]. Return in 1-2 wks depending on how it looks. Turn q 1-2 hrs. No more than 2 hrs. Change [dressing] x3 wk [week]."</p> <p>The instruction for "strict offloading" provided by the Wound Clinic was not reflected in the LPN's documentation. Additionally, the record did not include a schedule or documentation of turning or positioning.</p> <p>- 4/8/15 at 11:55 a.m., the LPN documented in the MOL "Dressing to Sacral pressure area,</p>	W 322		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 322	<p>Continued From page 83</p> <p>cleansed and redressed as ordered. Sm. amt. old brown drainage noted. No foul odor noted. Wound filling in, edges blanch. Will see again on Friday. Continue to rest in bed, change position often. Staff may change dressing PRN if it becomes soiled or comes off."</p> <p>- 4/10/15 at 1:15 p.m., the LPN documented in the MOL "Sacral dressing changed as ordered. Sm. amt. clear drainage noted - no odor noted. Continue bed rest, up for meals and meds. Encourage drinking water while up."</p> <p>- 4/13/15 at 11:10 a.m., the LPN documented in the MOL "Sacral dressing changed as ordered. Mod. amt. grayish drainage noted on dressing Some order [sic] noted - Wound is granulating with sm. area open on [right] edge."</p> <p>- 3/14/15 (date is correct) at 5:15 p.m., the ILW documented in the MOL Individual #1 "appears to have a reddened area about the size of a dime on his left shoulder blade area. Nurse [name of LPN] was notified. She said to massage barrier cream around and on the area to increase blood flow. Did as instructed. [LPN's name] called back and said to put polymen [sic] foam on it instead and to turn him every hour until she can check it tomorrow 3/15.</p> <p>Individual #1's record did not include an order for polymen foam (a polyurethane foam membrane dressing).</p> <p>- 4/15/15 at 9:15 a.m., the LPN documented in the MOL "[Left] shoulder checked. Does not appear to be pressure area. he [sic] does have a few red spots on the front of his shoulder and on his neck. Little red bumps with white center.</p>	W 322		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 322	<p>Continued From page 84</p> <p>Cleansed and Barrier cream applied."</p> <p>- 4/15/15 at 10:20 a.m., the LPN documented in the MOL "Drsg. to Sacrum [sic] pressure sore, changed as ordered. Area is filling in No [sic] drainage No [sic] odor."</p> <p>- 4/17/15 at 1:18 p.m., the RN documented she had reviewed the MOL.</p> <p>From 10/1/14 through 4/16/15, there was no documentation the RN had been notified or involved in Individual #1's skin concerns or wounds.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated she had received verbal reports, but could not explain the progression of Individual #1's wounds or treatment.</p> <p>A wound clinic note, dated 4/20/15, stated Individual #1 had a sacral Stage 2 pressure ulcer measuring 1.2 x 0.7 x 0.2 cm. The note stated to "keep dry with bathing, strict offloading, turning, repositioning and up in wheelchair 3 hours each day for meals." The note stated to proceed with pressure mapping the following week.</p> <p>- 4/20/15 at 11:45 a.m., the LPN documented in the MOL "Seen at Wound Clinic today. Sacral pressure area improving. [No] drainage, [no] odor. Size decreased well. RTC 2 wks remaining on bedrest. May be out of bed for an additional 15 mins a day. Change dressing 3x wk by nursing [and] PRN by staff."</p> <p>- 4/20/15 at 12:40 p.m., DCS documented in the MOL "returned home from Wound Clinic in</p>	W 322			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 322	<p>Continued From page 85</p> <p>Meridian. Dr. suggested that [Individual #1] should sit upright rather than recline in his chair at 45 [degrees] as this may put pressure on his coccyx [and] pressure sore."</p> <p>The LPN's documentation to increase Individual #1's time out of bed by 15 minutes, and the DCS's documentation regarding sitting upright, were not reflected in the wound clinic note.</p> <p>- 4/24/15 at 11:00 a.m., the LPN documented in the MOL "Drsg. to coccyx for pressure area change as ordered. Scant drainage lt. tan, No order [sic] Noted. Sm. slit in center of sore - pink edges - continue Bed [sic] rest."</p> <p>- 4/27/15 at 9:00 a.m., the LPN documented in the MOL "Drsg. to coccyx changed as ordered. area [sic] healing, small area remains open with red area around it. [No] drainage, [no] odor noted. Continued bed rest."</p> <p>A Physician's Order Sheet and Progress Notes, signed by the physician on 5/1/15, included an order for CIB or ensure, vanilla only, as a supplement for skin irritation and nystatin powder (an antifungal antibiotic drug) BID PRN for skin irritation. No other orders for wound treatment or dressings were noted.</p> <p>A wound clinic note, dated 5/5/15, stated Individual #1 had a sacral pressure ulcer stage II. No measurements were documented. The note stated Individual #1 could be up in his wheelchair "<3 hrs" (less than 3 hours) a day turning and repositioning. The note stated "Consider [decreasing] offloading if new [wheelchair] cushion obtained."</p>	W 322			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 322	<p>Continued From page 86</p> <p>- 5/5/15 at 11:00 a.m., the LPN documented in the MOL "Seen today at [hospital initials] Wound Clinic. Pressure sore on coccyx. It is now 0.3 cm x 0.2 cm and 0.2 cm deep. No drainage/No odor. greatly improved. RTC in 2 wks. Continue bed rest."</p> <p>- 5/12/15 at 8:15 a.m., the LPN documented in the MOL "Pressure sore on coccyx healing. No drainage noted. Sore almost closed. Continue bed rest."</p> <p>- 5/15/15 at 3:00 p.m., the LPN documented in the MOL "Dressing changed as ordered today, moist dressing - Appears a single layer of skin thickness flap. Doing well."</p> <p>A wound clinic note, dated 5/18/15, stated Individual #1 had a "Sacral Stage 2 PU [pressure ulcer] (Healing)." The note stated to keep the site dry when bathing and free from contaminants. The notes stated Individual #1 should have offloading, be up in his wheelchair only 3 hours a day with meals, and should be turned and repositioned every hour. The note stated Individual #1 could visit his work setting once a week for 2 hours, and careful inspection of his skin should be completed when he return to facility.</p> <p>- 5/18/15 at 10:30 a.m., DCS documented in the MOL "to Wound Clinic ...sore is less than .01 mm (pinpoint in size). Lidocane [sic] applied to area per [Individual #1's] request. Dr. ordered to continue with keeping [Individual #1] on his 4 hours sitting up."</p> <p>- 5/20/15 at 10:32, a.m./p.m. not specified, the RN documented in the MOL Individual #1 "can go</p>	W 322			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 322	<p>Continued From page 87 to work two times per week for 2-3 hours a day. Will check and evaluate sore three times per week (Mon., Wed., Fri.)."</p> <p>The DCS and RN documentation was not reflective of the 5/18/15 wound clinic documentation.</p> <p>Individual #1 developed skin concerns and multiple wounds, beginning in October 2014, that appeared to be related to pressure. However, the facility failed to maintain consistent documentation regarding the number and location of the wounds, their description or size. The treatment of the wounds was provided primarily by direct care staff at the direction of the LPN and was without physician's orders. Additionally, wounds continued to develop between 11/25/14 and 3/25/15 when Individual #1 was referred to a wound clinic.</p> <p>An interview was conducted on 6/2/15 from 9:05 a.m. - 12:20 p.m. with the QIDP, AQIDP, QIDP Supervisor and RN. When asked about the lack of effective treatment and preventative action in regards to Individual #1's skin integrity and wound issues, the RN and QIDP both stated they were relying on the LPN without sufficient monitoring and oversight.</p> <p>2. Refer to W323 as it relates to the facility's failure to ensure an individual received annual vision examinations.</p> <p>3. Refer to W345 as it relates to the facility's failure to ensure an RN was utilized to meet individuals' needs.</p> <p>4. Refer to W352 as it relates to the</p>	W 322			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 322	Continued From page 88 facility's failure to ensure dental appointments were completed as recommended.	W 322			
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an annual vision examination was completed for 1 of 4 individuals (Individual #4) whose records were reviewed. This resulted in the potential for the individual's vision difficulties to go undetected. The findings include: 1. Individual #4's IPP, dated 5/7/14, documented a 37 year old male whose diagnoses included profound mental retardation. Individual #4's record contained a vision examination, dated 10/22/10, which included a prescription for eyeglasses "if he will wear." Individual #4's record contained a typed note from the QIDP, dated 6/29/11. The note documented "...The primary concern for [physician name] was the general health of [Individual #4's] eyes and as long as no problems presented themselves [physician name] felt [Individual #4] could live without glasses. The IDT reviews [Individual #4's] vision [examination thoroughly] each year, and [Individual #4] will continue forward without glasses until [Individual #4's] Doctor feels the amount of correction needed must be addressed."	W 323	<u>W323</u> <u>Annual Physical Examinations</u> <u>Corrective Action:</u> There was apparently a misunderstanding related to vision examination expectations based on information given to management staff at this location from a previous RN. Expectations for completion of these types of evaluations have now been clarified and Individual #4 has a vision examination scheduled for 07/01/2015. Additionally, an in-depth quality assurance review of all medical records will be completed by 06/30/15 so that any other medical issues which were not identified during this survey can be corrected. <u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected. <u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. She will be reviewing medical records and service delivery using these systems on a monthly basis. The Administrator will meet with the RN monthly for the next three months or longer until he is	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 323	Continued From page 89 However, a vision examination after 10/22/10 could not be found. During an interview on 5/15/15 from 9:05 a.m. - 12:20 p.m., the QIDP stated Individual #4 had not been back to the optometrist since 10/22/10. The RN, who was present during the interview, stated the general practitioner reviewed general eye health at the annual exam, but did not have a way of assessing the amount of correction Individual #4 needed.	W 323	assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.	
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility failed to ensure Individual #4 received an annual vision examination. The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to obtain special studies as recommended for 1 of 4 individuals (Individual #2) whose medical records were reviewed. This resulted in an individual not receiving laboratory testing as recommended. The findings include: 1. Individual #2's IPP, dated 5/14/14, documented a 71 year old female whose diagnoses included severe mental retardation and a history of seizure disorder. Individual #2's record included the results of her Bone Mineral Density scan, signed by the	W 326	<u>W326</u> <u>Special Studies</u> <u>Corrective Action:</u> The need for a follow-up Vitamin D level was not recorded on the nursing summary by the previous LPN. This was corrected as of 06/19/15 Additionally, an in-depth quality assurance review of all medical records will be completed by 06/30/15 so that any other medical issues which were not identified during this survey can be corrected. <u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected. <u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with	07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 326	Continued From page 90 physician on 11/12/13. The report documented "Vitamin D intake should be adjusted to keep vitamin D 25-OH above 30." Individual #2's Nursing Summary, dated 4/2015, documented Individual #2 received Calcium (a supplemental drug) 600 mg with Vitamin D (a supplemental drug) 200 mg daily. The summary documented the medication was originally prescribed on 11/1/07. However, Individual #2's record did not include documentation that her Vitamin D level had been tested. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN reviewed Individual #2's record and stated she did not see that Vitamin D levels had been completed. The facility failed to ensure Individual #2 received a Vitamin D level blood test to monitor her level as recommended by her physician.	W 326	the RN Supervisor 06/17/15. She will be reviewing medical records and service delivery using these systems on a monthly basis. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. 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 4 individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in a lack of clear direction related to interventions and lack of follow-up necessary to meet individuals' health needs. The findings include:	W 331	<u>W331</u> <u>Clarification of Med Admin Instructions</u> <u>Corrective Action</u> The issues identified in this citation relate to documenting the reason for and use of PRN medications for headache, pain, and cold symptoms. We have evaluated our current system and have determined that some structural changes are needed in the physician's order form and in how PRN medications are authorized.	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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)
W 331	<p>Continued From page 91</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's medical record, from 10/1/14 - 5/20/15, documented on-going skin breakdown and pressure-related wounds. However, the record did not include documentation physician's orders had been obtained for the treatments being provided by the facility, as follows:</p> <p>- 11/25/14 at 8:20 a.m., DCS documented in the MOL "has an open sore the size of a quarter. Barrier creme [sic] was applied."</p> <p>A Physician's Order Sheet and Progress Note, signed by the physician on 11/7/14, included an order for nystatin (an antifungal antibiotic drug) powder BID PRN for skin irritation, but no other orders for wound treatment or dressings could be found.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated Barrier Cream (a moisture barrier) was not designed to treat open wounds and there was no order for it.</p> <p>- 11/28/14, no time documented, the LPN documented in the MOL "Please continue to use the barrier cream on open area on [Individual #1's] Bottom [sic]."</p> <p>- 12/2/14 at 8:30 p.m., DCS documented in the MOL "Put on his butt bacitracin [sic] and MexSana power [sic]. Continue to monitor."</p>	W 331	<p>We have reviewed each physician order form and have now identified under which situations PRN medications can be given by Medication Assistants without additional authorization (i.e., Ibuprophen for complaints or observations of pain; Acetaminophen for temperature above 100.5 degrees; cold medicine for nasal drainage, observations of a stuffy nose, complains of or observations of a sore throat, coughing; medication for constipation, etc.).</p> <p>We have also identified when a nurse needs to authorize the use of a PRN (i.e., if an individual has both a prescription for an allergy medication and a cold medication, if an individual has multiple choices for treatment of constipation, etc.)</p> <p>All Physicians' Orders for this location have been reprocessed and the primary physician will sign these orders before July 2, 2015. A sample is attached (Attachment A).</p> <p>We have updated instructions in the "Assistance with Oral Medication Module" related to the use and documentation of PRN medications. This update is Attachment B.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p>

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 331	<p>Continued From page 92</p> <p>- 12/5/14 at 10:55 a.m., DCS documented in the MOL "Applied Bactriactin [sic] [and] Mexana [sic] Powder to the open sore on [Individual #1's] lower buttock; looks better today."</p> <p>Individual #1's record did not include physician's orders for Bacitracin (an antibiotic ointment) or Mexsana (a medicated starch based skin protectant powder).</p> <p>- 12/9/14 at 3:45 p.m., the LPN documented in the MOL "Area on [right] inner buttock is now open, draining light pink drainage, the area is about a dime size pressure area, Stage II. Cleansed and dried well. Tegaderm drsg [dressing] applied...Change tegaderm every 4-7 days. (Tegaderm is a clear plastic dressing pad, it is in his Basket at bedside [sic]."</p> <p>- 12/12/14 at 11:00 a.m., DCS documented in the MOL Individual #1's "Tegaderm dressing applied (replaced) to open wound on [right] inner buttock. Had a foul smell to this area..."</p> <p>- 12/13/14 at 10:35 a.m., DCS documented in the MOL Individual #1's "Tezaderm [sic] dressing was replaced on open wound on [right] inner buttocks. Had a yellow colored discharge and a foul smell to that area..."</p> <p>Individual #1's record did not include a physician's order for Tegaderm.</p> <p>- 12/15/14 at 1:00 p.m., the LPN documented in the MOL "Please remove Tegaderm. Wash with soap [and] water. Dry well, then use Bacitracin, then a small amount of Barrier Cream, cover with dry 4x4 and change as needed. Use Bacitracin</p>	W 331	<p><u>System Changes:</u> Please refer to corrective Actions.</p> <p><u>Monitoring:</u> The RN Supervisor attends physician's clinics for individuals at this location and will review all Physicians' Orders to assure they are prepared according to these revised expectations prior to the LPNs recap meeting with the primary physician.</p>	
-------	---	-------	---	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 331	<p>Continued From page 93 antibiotic oint. twice daily."</p> <p>The MOL documented Bacitracin was applied on 12/17/14 - 12/24/14, 12/27/14 - 12/29/14, and 1/3/15.</p> <p>However, Individual #1's record did not include a physician's order for the use of Bacitracin.</p> <p>- 1/14/15 at 10:00 a.m., the LPN documented in the MOL "Please start using 'Working Hands' cream on [Individual #1's] Bottom - as instructed on ADLS sheet."</p> <p>The manufacturer of Working Hands Cream (www.okeeffescompany.com) indicated it is to be used for dry, cracked hands and feet. There was no indication that the cream was an appropriate treatment for open pressure wounds.</p> <p>Individual #1's ADL sheets documented staff applied Working Hands Cream from 1/14/15 - 5/27/15.</p> <p>Individual #1's record did not include a physician's order to use Working Hands Cream on his open pressure wounds.</p> <p>- 2/16/15 at 5:00 p.m., DCS documented in the MOL Individual #1's "Bed Sore appears to be infected. Nurse [LPN's name] left instructions on care for [Individual #1]. Do not use cream on his sore. Use Bactracin [sic] [and] antibiotic ointment."</p> <p>Individual #1's record did not include a physician's order for Bacitracin.</p> <p>Individual #1's "Non-Prescription Topicals &</p>	W 331		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 331	<p>Continued From page 94</p> <p>Treatments" for February 2015 included a hand written note, unsigned and undated, that was added to the a.m. and p.m. sections, stating "use Bacitracin oint to tail bone [sic] BID. Cover with (NS) moist 2x2 dry 4x4. Keep him off his back."</p> <p>Individual #1's record did not include orders for the use of wet-to-dry dressings over Bacitracin.</p> <p>A Physician's Order Sheet and Progress Notes, dated 3/25/15 and initialed by the primary physician, included a telephone order to refer individual #1 to a wound clinic regarding the pressure area on his coccyx.</p> <p>From 11/25/14 through 3/25/15 (when Individual #1 was referred to a wound clinic), there was no documentation the treatments being used for Individual #1's pressure wounds had been ordered by the physician.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated she assumed the LPN was reporting wound concerns to the physician. The RN confirmed there were no physician's orders for the treatments being used.</p> <p>The facility failed to ensure all drugs were administered only with a physician's order.</p> <p>2. Individual #1 - #3's physician's orders were reviewed. The Physician's Order Sheet and Progress Notes 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 Notes, signed by the physician on 5/1/15, stated he was to receive</p>	W 331		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 331	<p>Continued From page 95</p> <p>Tylenol (an analgesic drug) 650 mg for discomfort every 4 - 6 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 #2's Physician's Order Sheet and Progress Notes, signed by the physician on 5/1/15, stated she was to receive Tylenol 650 mg for pain every 4 hours. The section stated Individual #2 could also receive Ibuprofen 600 mg for pain every 6 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 #3's Physician's Order Sheet and Progress Notes, signed by the physician on 5/1/15, stated he was to receive Tylenol 650 mg for pain every 4 hours. The section stated Individual #3 could also receive Ibuprofen 600 mg for pain every 6 hours. The orders did not include specific information regarding how to determine which medication to use and when.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.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 included clear instructions for use.</p> <p>3. Refer to W334 as it relates to the facility's failure to ensure an individual received a direct physical examination on a quarterly basis.</p>	W 331			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 331	Continued From page 96	W 331		
W 334	<p>4. Refer to W338 as it relates to the facility's failure to make referrals for outside medical care when needed.</p> <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 #1) 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 #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's record included Quarterly Nursing Physicals dated 6/24/14, 9/5/14 and 3/24/15. However, the record did not include a direct physical examination for the 4th quarter (October, November, December) of 2014.</p> <p>During an interview on 6/2/15 from 9:05 a.m. -</p>	W 334	<p><u>W334</u></p> <p><u>Nursing Services/Direct Observation</u></p> <p><u>Corrective Actions</u></p> <p>1. The LPN who was working at this is no longer employed. An experienced CCI LPN will be providing nursing oversight.</p> <p>2. The Administrator and QIDP Supervisor met with the RN Supervisor 06/17/15 and discussed the proper implementation of oversight systems.</p> <p>3. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.</p> <p>4. An in-depth quality assurance review of all medical records will be completed by 06/30/15 so that any other medical issues which were not identified during this survey can be corrected.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>System Changes:</u> Please refer to corrective Actions.</p>	07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 334	Continued From page 97 12:20 p.m., the RN stated Individual #1 saw the physician for an annual exam on 12/9/14, which would take the place of the Quarterly Nursing Physical. However, Individual #1's Physician's History and Physical Examination form, dated 12/9/14, did not document that a full physical examination was completed. The facility failed to ensure quarterly exams were completed by direct physical examination for Individual #1.	W 334	<u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. She will be reviewing medical records and service delivery using these systems on a monthly basis. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.		
W 338	483.460(c)(3)(v) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals' health problems were reviewed to address the needs of 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in a delay in treatment. The findings include: 1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility. Individual #1's MOL documented the development of wounds to his left and right	W 338	<u>W338</u> <u>Nursing Services/Medical Care Plan</u> <u>Corrective Actions</u> A medical care plan should have been developed for this individual. We have taken the following actions to correct this situation. 1. The LPN who was working at this is no longer employed. An experienced CCI LPN will be providing nursing oversight. 2. The Administrator and QIDP Supervisor met with the RN Supervisor 06/17/15 and discussed the proper implementation of oversight systems. 3. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C. 4. An in-depth quality assurance review of all medical records will be	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 338	<p>Continued From page 98 buttocks and tailbone, as follows:</p> <ul style="list-style-type: none"> - 11/21/14 at 8:45 a.m., DCS documented in the MOL "black attends cover has left deep set red marks on left hip [and] thigh from elastic bands. not [sic] so bad on right but visible." - 11/21/14 at 3:30 p.m., the AQIDP documented in the MOL Individual #1 "has small round dip (in color) red mark on his left bottom down by leg area." - 11/22/14 at 11:30 a.m., DCS documented in the MOL Individual #1 "has two small round dark red marks on his right side by his bottom on the hind part of his thigh close under his buttocks. he [sic] hasn't complained of any discomfort due it [sic] them. noticed [sic] when getting him dressed after shower." - 11/24/14 at 9:45 p.m., DCS documented in the MOL that Individual #1 "has a sore on his right buttox [sic] about 1" wide." - 11/25/14 at 8:20 a.m., DCS documented in the MOL that Individual #1 "has an open sore the size of a quarter. Barrier creme [sic] was applied." <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the AQIDP and QIDP both stated there were areas of concern on both the left and right sides of Individual #1's buttocks as a result of the attends cover.</p> <p>Individual #1's record included a Quarterly Nursing Physical, signed by the LPN on 12/9/14, which documented Individual #1 had a "dime size pressure area [left] inner buttocks."</p>	W 338	<p>completed by 06/30/15 so that any other medical issues which were not identified during this survey can be corrected.</p> <p>5. Using Wound Care Clinic instruction as the basis for care when Individual #1 is experiencing skin breakdown instructions to staff will be documented in a variety of locations including 1) on the MARs (physician's orders) ;2) on the ADL form (nurses instructions, Attachment L); 3) in a "Mechanical Equipment" use protocol; 4) in a skin care check protocol; 5) on any other protocols deemed necessary by nursing staff under the supervision of the RN Supervisor; and 5) referrals to any specialty medical services will be made as discussed with and deemed necessary by the primary physician.</p> <p>Additionally instructions have been developed related to prevention and observing for skin issues in the following documents: "Skin Care Protocol" (Attachment K); Repositioning when on "bed rest" (Attachment M), and repositioning when not on bedrest (Attachment N).</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>System Changes:</u> Please refer to corrective Actions.</p>	
-------	--	-------	---	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 338	Continued From page 99 The following Quarterly Nursing Physical, signed by the LPN on 3/24/15, documented "[left] buttocks sore healing. Stage II pressure now on coccyx." Individual #1's MOL included an entry, dated 3/24/15 and timed 10:00 p.m., which documented "[Left] pressure sore tailbone (ischial area) healed. New Stage II pressure area on coccyx (center tailbone) now open. [Large amount] working hands with gauze placed on area. Will call [physician name] tomorrow." A subsequent entry, dated 3/25/15 and timed 10:00 a.m., documented "Order received from [physician name] for [Individual #1] to go to [hospital name] wound clinic. Order faxed." However, documentation of a referral for wound treatment prior to 3/24/15 could not be found in Individual #1's record. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP and RN both stated the LPN had been directing treatment of the wounds prior to the referral to a wound clinic obtained on 3/25/15. The RN stated she had received verbal reports about the wounds, but was told only that it was diaper rash from an attends issue. The RN stated a referral for treatment should have been sought sooner. The facility failed to ensure Individual #1 was referred to outside medical services for treatment of his pressure areas.	W 338	<u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. She will be reviewing medical records and service delivery using these systems on a monthly basis. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.		
W 345	483.460(d)(3) NURSING STAFF The facility must utilize registered nurses as appropriate and required by State law to perform	W 345	<u>W345</u> <u>RN Supervision</u>	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 345	<p>Continued From page 100 the health services specified in this section.</p> <p>This STANDARD is not met as evidenced by: Based on review of Board of Nursing Rules and Regulations, record review and staff interviews, it was determined the facility failed to ensure the registered nurse was utilized as per this standard and as required by state law. This directly impacted 4 of 4 individuals (Individuals #1 - #4) whose medical records were reviewed, and had the potential to impact all individuals (Individuals #1 - #8) residing at the facility. This resulted in the potential for individuals to experience negative impacts to their health. The findings include:</p> <p>The Idaho Board of Nursing Rules and Regulations (IDAPA 23.01.01) state, at IDAPA 23.01.01.401, that "In addition to providing hands-on nursing care, licensed registered nurses work and serve in a broad range of capacities including, but not limited to, regulation, delegation, management, administration, teaching, and case management. Licensed registered nurses, also referred to as registered nurses or as 'RNs,' are expected to exercise competency in judgment, decision making, implementation of nursing interventions, delegation of functions or responsibilities, and administration of medications and treatments prescribed by legally authorized persons."</p> <p>IDAPA 23.01.01.401.02(a) states the functions of the RN include "Assesses the health status of individuals and groups" and IDAPA 23.01.01.401.02(b) states the RN "Utilizes data obtained by assessment to identify and document nursing diagnoses..."</p>	W 345	<p>1.2.A.The Administrator and QIDP Supervisor met with the RN Supervisor 06/17/15 and discussed the proper implementation of oversight systems.</p> <p>1.2.B. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.</p> <p>1.2.C. An in-depth quality assurance review of all medical records will be completed by 06/30/15 so that any other medical issues which were not identified during this survey can be corrected.</p> <p>3. Please refer to W331</p>	
-------	---	-------	---	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 345	Continued From page 101 IDAPA 23.01.01.460 states "Licensed practical nurses function in dependent roles. Licensed practical nurses, also referred to as LPNs, provide nursing care at the delegation of a licensed registered nurse..." IDAPA 23.01.01.460.02(a) states the function of the LPN included "Contributes to the assessment of health status by collecting, reporting and recording objective and subjective data." The facility failed to utilize registered nurses as required by State law, as follows: 1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility. Individual #1's medical record documented on-going skin breakdown and pressure-related wounds. However, the record did not include documentation the RN had provided sufficient oversight and delegation of tasks related to Individual #1's pressure wound issues. Examples included, but were not limited to, the following: Between 11/21/14 and 11/25/14, Individual #1's MOL documented he developed an open wound the size of a quarter on his buttocks. However, the documentation did not indicate the location of the open wound, and previous documentation indicated areas of concern on both the left and the right side. It was not clear if one or more wounds and/or areas of concern were present. Additionally, there was no documentation nursing	W 345		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 345	<p>Continued From page 102</p> <p>staff had been notified regarding the areas of concern or the open wound.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the AQIDP and QIDP both stated there were areas of concern on both the left and right sides of Individual #1's buttocks. The AQIDP stated DCS would have left notes for the nurse, but should have documented calls to the nurse in the MOL.</p> <p>On 11/28/14, the LPN made an untimed entry in the MOL providing instruction to use Barrier Cream (a skin protectant) on the open wound. However, there was no indication the LPN had gathered information related to size or description of the wound, or had contacted the RN.</p> <p>On 12/12/14 and 12/13/14, the DCS documented in the MOL that the wound had odor and drainage. However, there was no documentation nursing staff had been notified of the changes to the wound.</p> <p>Additionally, on 1/24/15 at 2:21 p.m., DCS documented in the MOL that Individual #1 had a bruise "at the top of his bottom in the creased area." However, there was no documentation to indicate the bruise (unexplained bruising) was reported or investigated.</p> <p>From 11/21/14 - 3/24/15, Individual #1's record documented multiple wounds in various stages of development and healing. The record documented various treatment modalities, including Barrier Cream to the open wounds, Bacitracin ointment (an antibiotic drug), Working Hands Cream (an over-the-counter hand cream designed for dry, cracked hands and feet),</p>	W 345		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 345	<p>Continued From page 103</p> <p>Tegaderm (a transparent wound dressing), and wet-to-dry dressings (application of saline soaked gauze covered with dry gauze).</p> <p>However, all of the treatment was directed by the LPN and completed without physician's orders. There was no documentation to support the RN had reviewed Individual #1's record or had provided written delegation to DCS to change dressings and provide treatment as instructed by the LPN.</p> <p>On 3/25/15 the LPN received an order from Individual #1's physician to refer him to a wound clinic. A Physician's Order Sheet and Progress Notes, dated 3/26/15 and initialed by the physician, included a telephone order for "Duoderm dressing to coccyx change every 5-7 days."</p> <p>On 3/26/15 at 9:20 a.m., the LPN documented in the MOL "Duoderm dressing placed on coccyx. to [sic] be changed every 5-7 days by Nursing. May shower/get wet. Do Not Remove! If dressing becomes soiled please call nurse."</p> <p>On 3/29/15 at 5:25, a.m./p.m. not specified, DCS documented in the MOL Individual #1's "Duoderm patch was off. Nurse [name of LPN] gave staff permission to replace it. Used half the patch [and] cleaned wound with soap [and] water. Patted it to clean the wound [and] used dry wash cloth to pat dry. This should stay on until his appointment."</p> <p>However, the Individual #1's record did not include documentation the RN had reviewed the treatment or provided written delegation allowing DCS to change Duoderm dressings.</p>	W 345		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 345	<p>Continued From page 104</p> <p>Individual #1 was seen at the wound clinic on 3/31/15 where aggressive treatment and strict offloading (only allowed into his wheelchair for 3 one-hour periods each day and positioned side-to-side in bed the rest of the time) was initiated.</p> <p>A wound clinic note, dated 3/31/15, stated Individual #1 had a sacrum stage 2 pressure ulcer measuring 2.2 cm in length, 3.0 cm in width and 0.3 cm in depth. The note stated Aquacel AG (an antimicrobial ionic silver wound treatment) dressing was to be used and changed 4 times per week.</p> <p>- 3/31/15 at 2:00 p.m., the LPN documented in the MOL "Seen today at [name of hospital] Wound Clinic for pressure area on coccyx. Stage II wound cleaned by P.A. [Physician's Assistant] Culture done. Dressing applied by R.N. P.A. wants [Individual #1] to stay home from work for 1 week in bed, turn side to side every 2 hrs. Up in w/c [wheelchair] for only 3 times a day for one hour at [sic] time for meds and meals. [Name of PA] PA [sic] will call with Cx [culture] results if pos[itive]. [Name of PT] PT Accessed [sic] w/c cushion and will call [wheelchair company] regarding cushion."</p> <p>- 3/31/15 at 3:00 p.m., the LPN documented in the MOL Individual #1 "is to be kept home for the next week until next wound clinic Appt., in bed on his sides, turning (Q) every 2 hrs. He may be up 3 times a day for 1 hr each for meals [and] meds. He may not have showers, give Bed Bath keep dressing Dry [sic]. Please give [Individual #1] his meds as soon as he finishes his meals and then back to Bed [sic]. Dressing to be changed 4x</p>	W 345			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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)	
W 345	<p>Continued From page 105 weekly. Instructions to follow."</p> <p>An undated and unsigned entry by the LPN in Individual #1's MOL included directions to DCS on how to change the dressing on his pressure wound.</p> <p>However, there was no documentation the RN had reviewed the instructions or had provided written delegation allowing DCS to changes Individual #1's dressing.</p> <p>On 4/17/15 at 1:18 p.m., the RN documented she had reviewed the MOL. There was no documentation the RN had provided any form of oversight and monitoring regarding Individual #1's pressure wounds prior to 4/17/15.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated she had not been to the facility for several months prior to 4/17/15. The RN stated she had not reviewed any documentation regarding Individual #1's pressure wound issues prior to that time. The RN stated she had received verbal reports from the LPN, but was told Individual #1 had diaper rash due to an attends issue. There was no written delegation of tasks.</p> <p>The facility failed to ensure the RN provided sufficient monitoring and oversight for medical issues.</p> <p>2. The RN did not review documentation and provided nursing oversight, as follows:</p> <p>a. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy,</p>	W 345		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015	
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 345	<p>Continued From page 106</p> <p>bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>Individual #1's Quarterly Nursing Physicals, dated 12/9/14 and 3/24/15 and signed by the LPN, did not include documentation the RN had reviewed the forms. Additionally, Individual #1's monthly Nursing Summary forms, dated 10/2014 - 4/2015, were reviewed. The forms were completed and signed by the LPN, but the RN Review sections for each form were blank.</p> <p>Individual #1's MOL documented the RN reviewed the record on 4/17/15.</p> <p>b. Individual #2's 5/14/14 IPP stated she was a 71 year old female whose diagnoses included severe mental retardation and dementia.</p> <p>Individual #2's Quarterly Nursing Physicals, dated 11/5/14 and 5/11/15 and signed by the LPN, did not include documentation the RN had reviewed the forms. Additionally, Individual #2's monthly Nursing Summary forms, dated 10/2014 - 4/2015, were reviewed. The forms were completed and signed by the LPN, but the RN Review sections for each form were blank.</p> <p>c. Individual #3's 5/14/14 IPP stated she was a 52 year old female whose diagnoses included moderate mental retardation, cerebral palsy, quadriplegia, osteoporosis, seizure disorder, and major depressive disorder.</p> <p>Individual #3's Quarterly Nursing Physicals, dated 11/5/14 and 5/11/15 and signed by the LPN, did not include documentation the RN had reviewed the forms. Additionally, Individual #3's monthly</p>	W 345		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 345	<p>Continued From page 107</p> <p>Nursing Summary forms, dated 10/2014 - 4/2015, were reviewed. The forms were completed and signed by the LPN, but the RN Review sections for each form were blank.</p> <p>d. Individual #4's 5/7/14 IPP stated he was a 37 year old male whose diagnoses included profound mental retardation, autism, and OCD.</p> <p>Individual #4's Quarterly Nursing Physicals, dated 10/29/14 and 4/27/15 and signed by the LPN, did not include documentation the RN had reviewed the forms. Additionally, Individual #4's monthly Nursing Summary forms, dated 10/2014 - 4/2015, were reviewed. The forms were completed and signed by the LPN, but the RN Review sections for each form were blank.</p> <p>None of Individual #1 - #4's Quarterly Nursing Examinations or Nursing Summaries documented they had been reviewed by the RN. Additionally, documentation that the RN had been present in the facility or reviewed any aspect of Individual #1 - #4's records from 10/1/14 to 4/17/15 could not be found.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated she had not been in the facility to review records or see individuals for several months. The RN stated she had been relying on verbal reports from the LPN.</p> <p>The facility failed to utilize the registered nurse as appropriate and required by State law.</p> <p>3. Refer to W331 as it relates to the facility's failure to ensure individuals received nursing services in accordance with their identified needs.</p>	W 345			

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 352 W 352	Continued From page 108 483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure dental examinations were completed as recommended for 1 of 4 individuals (Individual #2) whose dental records were reviewed. This resulted in the potential for an individual's dental needs to go undetected. The findings include: 1. Individual #2's IPP, dated 5/14/14, documented a 71 year old female whose diagnoses included severe mental retardation. Individual #2's medical record included a dental note, dated 8/20/14, which documented the "Recommended recall" for the next visit was 6 months. However, documentation of a dental examination after 8/20/14 could not be found in Individual #2's record. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated Individual #2's Nursing Summary, dated 4/2015, documented a recommended dental follow-up of one year. She stated the follow-up time was documented incorrectly by the LPN. The AQIDP, who was also present during the interview, stated if the information on the Nursing Summary was incorrect, the appointment would have been	W 352 W 352	<u>W352</u> <u>Dental Exams</u> <u>Corrective Action:</u> An appointment has been scheduled for 07/07/15. The correct information for follow-up was not entered on the Nursing Summary by the previous LPN. An in-depth quality assurance review of all medical records will be completed by 06/30/15 so that any other dental issues which were not identified during this survey can be corrected. <u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected. <u>System Changes:</u> Please refer to corrective Actions. <u>Monitoring:</u> The Administrator and QIDP Supervisor reviewed established monitoring systems with the RN Supervisor 06/17/15. She will be reviewing medical records and service delivery using these systems on a monthly basis. The Administrator will meet with the RN monthly for the next three months or longer until he is assured that these reviews are being done completely and correctly and will keep a record of these reviews. See Attachment C.	07/06/15
----------------	---	----------------	--	----------

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 352	Continued From page 109 missed.	W 352			
W 436	<p>The facility failed to ensure Individual #2 was provided with dental follow-up as recommended.</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals were provided with appropriate adaptive equipment for 1 of 2 individuals reviewed (Individual #1) who required the use of adaptive mobility equipment. This resulted in an individual's wheelchair being in ill-repair. The findings include:</p> <p>1. Individual #1's 5/28/14 IPP stated he was a 30 year old male whose diagnoses included profound mental retardation, cerebral palsy, bipolar disorder, seizure disorder, scoliosis and osteoporosis. He was non-ambulatory and utilized a power wheelchair for mobility.</p> <p>A Physical Therapy report, dated 9/9/14, stated Individual #1's wheelchair had a power tilt feature and a "Contour U seating system and a recess to accommodate the shortened left lower extremity." The report stated "Frequent maintenance is required for the chair."</p>	W 436	<p><u>W436</u></p> <p><u>Adaptive Equipment</u></p> <p><u>Corrective Actions:</u> This cushion was delivered 06/15/15 after the Administrator contacted the company who was making it. Any future needs for such equipment will be discussed at Trending/Tracking meetings and the Administrator will be notified if the equipment is not delivered in a timely manner for problem resolution.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>System Changes:</u> Please refer to corrective Actions.</p> <p><u>Monitoring:</u> The QIDP Supervisor and RN Supervisor will attend scheduled Trending/Tracking meetings, will review IDT and IPP documentation related to status change, and will involve the Administrator when necessary in problem resolution.</p>	07/06/15	

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 436	<p>Continued From page 110</p> <p>An MOL entry, dated 10/10/14 at 12:00 p.m. and signed by the AQIDP, stated "called [medical equipment company] and they have an addendum [sic] that they will check on and let us know where we may help."</p> <p>When asked during an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the AQIDP stated this addendum was paperwork the medical equipment company needed in order to make a new cushion for Individual #1's wheelchair. The AQIDP stated the facility identified the need for a new cushion in June 2014.</p> <p>Individual #1's record documented multiple recurring skin issues and pressure wounds to his buttocks and coccyx between 10/1/14 and 5/20/15. During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the AQIDP, QIDP and RN all confirmed Individual #1's wheelchair cushion needed to be replaced and was a contributing factor in his continued skin integrity and pressure wound issues.</p> <p>Individual #1's record included the following documentation regarding maintenance issues for his power wheelchair:</p> <p>- 10/16/14 at 2:25 p.m., the AQIDP documented in the MOL "[Medical equipment company] will be installing new switch to sensors tomorrow between 12p-2p at [name of day program]." The record did not include documentation indicating if the switches had been replaced or not.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the AQIDP stated the sensors for Individual #1's tilt-in-space function were not</p>	W 436		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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)	
W 436	<p>Continued From page 111</p> <p>working properly and would, at times, prevent his wheelchair from coming to a full upright position.</p> <p>- 12/31/14 at 11:43 a.m., DCS documented in the MOL "Went to [medical equipment company]...They looked at [Individual #1's] wheelchair moved a wire and it would not stop again. If it does it again call them so they can document it. Asked about his cushion on the chair they said they are whating [sic] for Documents from the phyision [sic] - Continue to monitor."</p> <p>- 1/2/15 at 3:53 p.m., the AQIDP documented in the MOL "Spoke with [medical equipment company] about physicians [sic] order. They need a better PT one. So gave them [PT's name] PT number so we can get documents needed. They will call him a [sic] set a meeting with him [and] [Individual #1]."</p> <p>- 1/8/15 at 1:14 p.m., DCS documented in the MOL "Went to [medical equipment company] to check his Tilt they said if it happeds [sic] again it could be the pads and mess with the pads if the tilt stops again."</p> <p>- 1/9/15 at 9:30 a.m., the LPN documented in the MOL "New Memory foam pad placed on wheelchair seat yesterday, hopefully to held [sic] prevent skin breakdown on Buttocks [sic]. harness [sic] straps unaffected. [Individual #1] states it feels 'really good.' Will continue to monitor."</p> <p>There was no documentation indicating the memory foam pad supplied by the LPN had been assessed as appropriate for Individual #1's needs.</p>	W 436		

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 436	<p>Continued From page 112</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP stated he was not aware of where the LPN obtained the memory foam cushion and was not aware if it had been assessed as appropriate to meet Individual #1's needs.</p> <p>- 1/23/15 at 12:23 p.m., DCS documented in the MOL "[Individual #1] went to [medical equipment company] to get his chair looked at they said that [sic] are going to order part from the lift and sencer [sic] pads. They will call when part come [sic] in. Continue to monitor."</p> <p>From 10/13/14 - 1/23/15, the record documented the sensor switches for Individual #1's tilt function were malfunctioning. The switches were supposed to be replaced 10/14/14, but there was no documentation that this had occurred. There was no documentation regarding the continued malfunctioning of the switches and the lack of repair.</p> <p>- 1/27/15 at 8:00 a.m., the AQIDP documented in the MOL "[Medical equipment company] will be here 2/3/15 to meet w/[Individual #1] and [PT's name] for Chair."</p> <p>The facility was notified by the medical equipment company on 1/2/15 that a "better" PT evaluation was needed in order to address the cushion issue. The facility provided the PT's phone number to the medical equipment company, but there was no documentation to explain the one month delay in setting the appointment to obtain the needed information.</p> <p>- 2/3/15 at 11:30 a.m., the AQIDP documented in the MOL "[Name] from [medical equipment</p>	W 436		
-------	---	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 436 Continued From page 113

company] meet [sic] w/[PT's name] and they meet [sic] w/[Individual #1] about his chair cushions [sic]. They wrote a new report to go Medicaid [sic] to see if they will approve replacing cushion [sic]."

- 2/3/15, no time indicated, the AQIDP documented in the MOL "Also [medical equipment company staff] and [PT's name] both said it was also possible to be a cause of pressure sore due to not all of cushion [sic] there."

A Letter of Medical Necessity, dated 2/3/15 and signed by the Physical Therapist, stated "The current backrest and seat cushion were provided when his wheelchair was provided and are 6+ years old and in disrepair. The seat and back cushion have a laminated cover that is peeling off of the foam mold and causing the foam to become exposed, causing it to break apart/crumble. The seating system is in need of replacement...The breakdown of his present cushion has been reported by caregivers to be causing skin pressure issues currently."

However, the Letter of Medical Necessity was not approved and signed by the Physician as concurring until 4/2/15.

During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP stated the AQIDP had been handling all issues related to Individual #1's wheelchair. When asked about the delay in obtaining the physician's signature on the Letter of Medical Necessity, the AQIDP, who was present during the interview, was unable to answer. When asked if the delay in signature was part of the delay in obtaining the needed

W 436

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 436	<p>Continued From page 114 wheelchair cushion, the AQIDP could not say.</p> <p>- 3/11/15 at 1:55 p.m., DCS documented in the MOL "Called [medical equipment company] about his sensors [sic] on his chair the part and Arm rest They [sic] said they are waiting for Authorization from Medicare. We will check in a week and call them back."</p> <p>The record did not indicate if this was a new issue with Individual #1's tilt sensors, or a continuation from the 1/23/15 documentation indicating the sensors had been ordered.</p> <p>- 3/31/15 at 2:00 p.m., the LPN documented in the MOL "[PT's name] PT Accessed [sic] w/c cushion and will call [medical equipment company] regarding cushion."</p> <p>A Physician's Order Sheet and Progress Notes entry, dated 4/3/15 and signed by the primary physician, stated "Follow up on ulcer buttock...He requires a contoured seat cushion to prevent recurrence of decubitus ulcer."</p> <p>A Wound Clinic Note, dated 4/20/15, stated to proceed with pressure mapping the following week with the medical equipment provider.</p> <p>- 4/22/15 at 9:26 a.m., DCS documented in the MOL "[Individual #1] went to [medical equipment company] to get molded for some New cushions [sic] for his chair. They did mold his body to the chair ...They said the mold of the chair should take about 4 to 5 days and then they said 2 to 3 weeks."</p> <p>Wound Clinic Note, dated 5/5/15, stated Individual #1 had a sacral pressure ulcer stage II.</p>	W 436		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 436	<p>Continued From page 115</p> <p>The note stated Individual #1 was to be up in his wheelchair "<3 hrs" (less than 3 hours) per day, turning and repositioning. "Consider decreasing offloading if new wheelchair cushion obtained."</p> <p>The facility identified a need to replace Individual #1's wheelchair cushion in June 2014. The record documented signification gaps in obtaining repairs to the tilt sensors and with follow through on assessments and documentation needed to have the cushions made. This resulted in molds for the cushions not being made until 4/22/15, ten months after the need for new cushions had been identified. As indicated in the MOL and wound clinic notes, this impacted skin integrity, wound development and healing, and increased time required out of his wheelchair during the healing process.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the QIDP and AQIDP stated they were aware the cushion was an issue and attempted to build it up with foam and duct tape. The AQIDP stated there was no additional documentation of efforts other than re-faxing documents to the medical equipment company and physician as needed. The QIDP Supervisor, who was present during the interview, stated there had been problems with the medical equipment company which were sometimes resolved if the Administrator called them, but stated no calls by the Administrator had been made for Individual #1.</p> <p>The facility failed to ensure Individual #1's wheelchair was maintained and repaired sufficient to meet his needs.</p>	W 436		
W 455	483.470(I)(1) INFECTION CONTROL	W 455	<p><u>W455</u></p> <p><u>Glove Use</u></p>	07/06/15

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR		STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
W 455	<p>Continued From page 116</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases, which directly impacted 8 of 8 individuals (Individuals #1 - #8) residing in the facility. That failure had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:</p> <p>1. Observations were conducted at the facility on 5/26/15 from 5:45 - 7:05 p.m. and on 5/27/15 from 7:00 - 8:10 a.m. During those times, DCS were not observed to appropriately utilize gloves for infection control. Examples included, but were not limited to, the following:</p> <p>a. Dinner set-up and service was observed on 5/26/15 from 5:45 - 7:05 p.m. During that time, the direct care staff working with individuals on the east side of the facility were observed to change gloves without completing appropriate hand hygiene, as follows:</p> <p>- At 6:05 p.m., DCS A donned gloves and assisted Individual #1 to don a pair of gloves as well. Neither DCS A or Individual #1 completed hand hygiene prior to putting on gloves. Individual #1 brought her gloved hand to her mouth. At 6:10 p.m., DCS A removed her own gloves and provided Individual #1 with a new pair. Hand hygiene was not completed.</p>	W 455	<p><u>Corrective Actions:</u> The RN Supervisor has prepared a "Glove use in the kitchen" handout and we have located some poster materials from the State of Idaho. Use of gloves was inserviced with CCI #7 staff on 06/10/15 and the QIDP has been doing observations and providing staff training related to this issue on his days at this location.</p> <p><u>Identifying Others Potentially Affected:</u> All individuals at this location are potentially affected.</p> <p><u>System Changes:</u> See corrective actions.</p> <p><u>Monitoring:</u> The proper use of gloves during medication passes and mealtime activities has become part of the observations for both of these types of activities. Observations are done monthly and reviewed by the QIDP, AQIDP, and RN Supervisor. Noted issues will result in further staff training.</p>

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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
--------------------	--	---------------	---	----------------------

W 455	Continued From page 117 - At 6:13 p.m., DCS A donned a new pair of gloves without completing hand hygiene. At 6:15 p.m., Individual #1 touched her face with her gloves. DCS A completed a glove change for herself and Individual #1. Hand hygiene was not completed. - At 6:30 p.m., DCS A removed her gloves. DCS A then donned a new pair of gloves at 6:35 p.m. Hand hygiene was not completed. - At 6:40 p.m., DCS A completed two consecutive glove changes without hand hygiene between. b. Dinner set-up and service was observed on 5/26/15 from 5:45 - 7:05 p.m. During that time, the direct care staff working with individuals on the west side of the facility were observed to change gloves without completing appropriate hand hygiene, as follows: - At 6:05 p.m., DCS C assisted Individual #6 to don gloves to assist with meal preparation. Individual #6 did not, and was not cued or assisted to, complete hand hygiene prior to putting on gloves. - At 6:25 p.m., DCS B assisted Individual #7 to don a pair of gloves before putting a pair of gloves on herself. DCS B was not observed to complete hand hygiene. - At 6:35 p.m., DCS B removed her gloves and then donned a new pair. Hand hygiene was not completed. DCS C donned gloves, without hand hygiene, and began gathering items to set the table.	W 455		
-------	--	-------	--	--

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

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE 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	
W 455	<p>Continued From page 118</p> <p>- At 6:50 p.m., DCS B and DCS C both changed their gloves without hand hygiene between. Minutes later, DCS C completed a second glove change, again without hand hygiene being done.</p> <p>c. On 5/27/15 from 7:00 - 8:10 p.m., Individual #6 was observed to participate in a medication administration routine. During that time, DCS B donned gloves to administer Individual #6's nasal spray. Upon completing Individual #6's medication administration, DCS B changed to a new pair of gloves to complete medication administration with Individual #1. However, no hand washing or hand sanitizing was completed.</p> <p>d. Individual #1's MOL included an unsigned and undated set of dressing change instructions written by the LPN. The instructions stated staff were to wash their hands, apply gloves and remove the soiled dressing. Staff were to remove the soiled gloves and don new gloves.</p> <p>However, the instructions did not include any information related to hand hygiene prior to donning new clean gloves.</p> <p>During an interview on 6/2/15 from 9:05 a.m. - 12:20 p.m., the RN stated staff should be washing hands during medication pass between each individual, before working in the kitchen, any time hands become soiled, and after removing gloves. The RN stated handwashing and infection control practices were not being followed appropriately.</p> <p>The facility failed to ensure staff were appropriately using gloves and completing appropriate hand hygiene.</p>	W 455			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	---	--

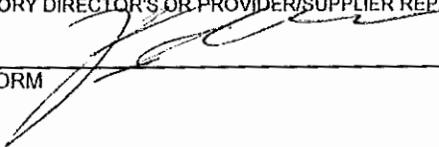
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE NAMPA, ID 83686
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 5/26/15 to 6/2/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Ashley Henscheid, QIDP	M 000		
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W122 and W149.	MM177	MM177 Please refer to W122 and W149	07/06/15
MM190	16.03.11.075.09 (b)(ii) Body Alignment Mechanical supports used in normative situations to achieve proper body position and balance are not considered to be restraints, but must be designed and applied: In accordance with principles of good body alignment, concern for circulation, and allowance for change of position. This Rule is not met as evidenced by: Refer to W243, W244 and W245.	MM190	MM190 Please refer to W243, W244, and W245	07/06/15

RECEIVED
JUN 25 2015
FACILITY STANDARDS

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



TITLE
Administrator

(X6) DATE
6/24/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE NAMPA, ID 83686
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

MM212	Continued From page 1	MM212		
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W195, W196 and W249.	MM212	MM212 Please refer to W195, W196, and W249	07/06/15
MM238	16.03.11.080.03(h) Access to Resident's Records To be given access to all of the resident's records that pertain to his active treatment, subject to the requirements specified in Idaho Department of Health and Welfare Rules, Section 05.01.300 through Subsection 05.01.301,06, and Sections 05.01.310 through 05.01.339, "Rules Governing Protection and Disclosure of Department Records." This Rule is not met as evidenced by: Refer to W250.	MM238	MM238 Please refer to W250	07/06/15
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429	MM429 Please refer to W436	07/06/15
MM512	16.03.11.200 Administration The administration of ICF/ID facilities must provide for individual program planning,	MM512	MM512 Please refer to W100	07/06/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE NAMPA, ID 83686
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

MM512	Continued From page 2 implementation and evaluation. Individual programs must be based on relevant assessment of needs and problems and must reflect the participation of the individual, the service providers, and where possible, the individual's family or surrogate. Individual program planning must include provisions for total program coordination and continuous, self-correcting processes for review and program revision. Programming for individuals must incorporate the resident's legal rights of due process, appropriate care, training and treatment. This Rule is not met as evidenced by: Refer to W100.	MM512		
MM520	16.03.11.200.03(a) Establishing and implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W102 and W104.	MM520	MM520 Please refer to W102 and W104	07/06/15
MM539	16.03.11.210.01(d) Resident's Record All entries in the resident's record must be legible, dated, and authenticated by the signature and professional designation of the individual making the entry. This Rule is not met as evidenced by: Refer to W114.	MM539	MM539 Please refer to W114	07/06/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE NAMPA, ID 83686
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM570	16.03.11.210.05(b) Medications and Treatments A record of all medications and treatments prescribed and administered; and This Rule is not met as evidenced by: Refer to W111.	MM570	MM570 Please refer to W111	07/06/15
MM598	16.03.11.230 Personnel The facility will recruit and employ qualified personnel, provide initial orientation for new employees, provide a continuing inservice training program for all employees, and provide competent supervision designed to improve resident care and employee efficiency. This Rule is not met as evidenced by: Refer to W169 and W345.	MM598	MM598 Please refer to W169 and W 345	07/06/15
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	MM725 Please refer to W159	07/06/15
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by:	MM730	MM730 Please refer to W253	07/06/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE NAMPA, ID 83686
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM730	Continued From page 4 Refer to W253.	MM730		
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are 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 W318, W322 and W338.	MM735	MM735 Please refer to W318, W322 and W338	07/06/15
MM749	16.03.11.270.02(d)(i) Examination of Vision and Hearing Examination of vision and hearing; and This Rule is not met as evidenced by: Refer to W323.	MM749	MM749 Please refer to W323	07/06/15
MM760	16.03.11.270.03 Nursing Services Residents must be provided with nursing services in accordance with their needs. There must be a responsible staff member on duty at all times who is immediately accessible, to whom residents can report injuries, symptoms of illness, and emergencies. The nurse's duties and services include: This Rule is not met as evidenced by: Refer to W165 and W331.	MM760	MM760 Please refer to W165 and W331	07/06/15
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio	MM769	MM769 Please refer to W455	07/06/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #7 COUGAR	STREET ADDRESS, CITY, STATE, ZIP CODE 2903 & 2907 COUGAR AVENUE NAMPA, ID 83686
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM769	Continued From page 5 Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769		
MM785	16.03.11.270.04(b)(i) Provision for Dental Treatment Provision for dental treatment; and This Rule is not met as evidenced by: Refer to W352.	MM785	MM785 Please refer to W352	07/06/15
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W240.	MM855	MM855 Please refer to W240	07/06/15
MM861	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments. This Rule is not met as evidenced by: Refer to W260.	MM861	MM861 Please refer to W260	07/06/15