IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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FILE COPY

August 26, 2015

Joseph Frasure, Administrator
Aspen Transitional Rehabilitation
2867 East Copper Point Drive
Meridian, ID 83642-1716

Provider #: 135130

Dear Mr. Frasure:

On **August 13, 2015**, a survey was conducted at Aspen Transitional Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 8, 2015.** Failure to submit an acceptable PoC by **September 8, 2015,** may result in the imposition of civil monetary penalties by **September 28, 2015.**

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.
- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

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

A 'per instance' civil money penalty of $1500.00

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 13, 2016**, if substantial compliance is not achieved by that time.

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

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

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

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

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

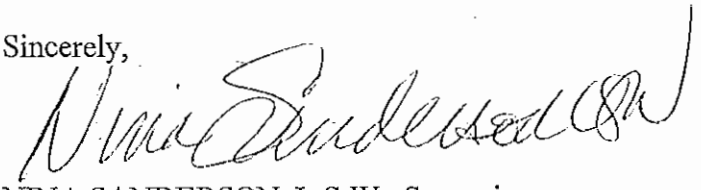
- BFS Letters (06/30/11)

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

This request must be received by **September 8, 2015**. If your request for informal dispute resolution is received after **September 8, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

NS/dmj
Enclosures

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

PRINTED: 12/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135130		C 08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN TRANSITIONAL REHABILITATION	2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642

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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility on August 10-13, 2015. The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Rebecca Thomas, RN Kendra Deines, RN, BSN This report reflects changes resulting from the Informal Dispute Resolution (IDR) process conducted on December 17, 2015. Survey Abbreviations: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing E = Employee IDT = Interdisciplinary Team LN = Licensed Nurse LSW=Licensed Social Worker MAR = Medication Administration Record MCO=Manager of Clinical Operations MDS = Minimum Data Set assessment MG=Milligrams PRN = As Needed RD = Registered Dietician RUC = Resource Utilization Coordinator TAR = Treatment Administration Record	F 000	"This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to Home Health Agencies. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the agency that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the severity of the deficiencies cited is correctly applied." RECEIVED JAN - 8 2016 FACILITY STANDARDS	
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250		~~9/14/15~~ 1/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 09/07/2015

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

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F 250	Continued From page 1 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to ensure medically related social services were provided to residents. This was true for 2 of 11 sampled residents (#s 6 & 7). The deficient practice had the potential for harm when the facility failed to monitor, evaluate and assist residents with discharge planning or arrange medically-related social services for a resident who needed grief counseling after the death of his wife. Findings included: 1. Resident #7 was admitted to the facility on 12/20/14 with diagnoses of rehabilitation and congestive heart failure. The resident's most recent Admission MDS Assessment, dated 12/27/14, documented the resident was cognitively intact with a BIMS Score of 14. The resident required extensive assistance of two staff for bed mobility, transfers, and toilet use, and required extensive assistance of one staff for dressing, personal hygiene and bathing. The 1/2/15 Discharge Care Plan documented Resident #7 would be discharged to a private home with spouse. Interventions included: Scheduled IDT meeting to monitor and progress toward discharge; Arrange for family and or patient care conferences as needed; Coordinate discharge goals and needs with patient and/or family; Educate patient and/or family regarding recommendations for discharge care needs and	F 250	F 250 Patient Specific: Patients numbers 6 and 7 have been discharged. Other Patients: All current patients charts have been reviewed for: 1. Appropriate discharge planning in place. 2. Any residents' in need of grief counseling that is not able to be provided by staff have been referred to outside resources. (if any). All new patients will have charts reviewed using MDS section D and will have a "Grief Screen" from completed on admit. Systemic Changes: Licensed staff have been inserviced in completion of appropriate discharge processes and the availability of outside resources to assist with discharges, as well as outside resources for patients needing	

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F 250	Continued From page 2 instructions; and, Assist patient and/or family in arranging for discharge care needs as recommended. (Durable medical equipment, prescriptions, home health care and support services). A 1/2/15 Weekly PT (Physical Therapy) Summary, documented the resident exhibited self-limiting, unsafe behaviors and spouse/family agreed these behaviors were not new. The summary documented the resident argued with nursing staff which required PT to intervene and redirect, and demonstrated a lack of interest for a progressive rehab program. PT had a conference with the family in regard to the discharge plan, and advocated the resident not insist on more assistance with daily cares from his spouse than reasonable. On 8/13/15 at 9:35 AM, the PT #3 was unable to recall whether any other facility staff participated in the conference or any other family members. A 1/4/15 Daily PT Treatment Note documented a telephone conference with the resident's daughter regarding the discharge plan, and stated the resident was not able to return home. PT suggested a skilled nursing facility. A 1/5/15 Progress Note (PN), documented the resident's daughter called to inform the IDT the resident would be discharged to a nursing home in Nampa. The family was concerned the resident's spouse would not be able to manage the resident's care needs at home. On 1/6/15, the resident's physician wrote an order to discharge home 1/8/15 with home health. A 1/7/15 PN, documented the family had decided	F 250	additional grief counseling. All patients will be assessed using MDS section D to identify patients' mood needs. A "Grief Screen" will be used to identify patients with potential grief issues. Any affirmative answers on the "Grief Screen" will lead to a "Geriatric Depression Scale" being completed for the identified patients. Patients scoring a10 or higher on the PHQ-9 test in MDS section D and patients scoring a 10 or higher on the "Geriatric Depression Scale" will be reviewed by a licensed social worker or the patient's physician/physician extender.	

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F 250	Continued From page 3 the resident would return home. The PN documented the resident was offered the option to extend his inpatient rehabilitation, but was adamant on his return to home. A Discharge Summary, dated 1/7/15, by a Nurse Practitioner (NP), documented the resident didn't know if he was quite ready for discharge. Facility staff did not have concerns for the resident to discharge to longterm care and felt he would definitely benefit from an extended level of assistance. A 1/8/15 PT Discharge Summary, documented the resident had the potential to achieve independence with ambulation, but would tell his family he couldn't walk and consistently asked for staff assistance. The family was informed the resident would not be returning home. The summary documented the resident was adamant to return home. On 8/12/15 at 2:20 PM, the Admission, Discharge Coordinator (ADC), with the RUC in attendance, stated an IDT meeting was held for every resident on Wednesdays. She stated she documented the information they discussed on the daily census list, which she kept in her office. She stated the IDT information was not documented in the resident's clinical record. She stated a Discharge Planner form was filled out at the time of discharge. The ADC stated families were not involved in IDT meetings because they talked about all the residents on the census list. She stated if residents had problems with family dynamics, they would schedule a care plan meeting. She stated the LSW worked on an as needed basis and was not involved with discharge planning unless there was a need for	F 250	Monitors: The Director of Nursing or her designee will audit 25% of the patients a week times four then monthly times five to ensure that appropriate discharge planning and resources are in place as well as ensuring that outside resources have been utilized on any patients needing additional grief counseling. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date of Compliance: 10/19/15	

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F 250	Continued From page 4 counseling. On 8/12/15 at 2:55 PM, the ADC stated Resident #7's discharge plan was for the resident to go home, but on 1/5 the plan suddenly changed from the resident going home to a longterm care facility. The ADC stated the resident was borderline i n his functional abilities, and could have discharged home with home health or could have gone to an assisted living facility. She stated she discussed discharge plans with the resident and let him decide. When asked if the facility had met with the family and the resident, to discuss discharge plans, as the resident's son-in-law was the POA, the ADC stated she tried to protect the resident's wishes. When asked if options for assisted living facilities had been discussed, the ADC stated, "No." When asked how staff responsible for social work monitored the resident's progress, the ADC and Administrator did not respond. On 8/12/15 at 5:00 PM, the Administrator stated the licensed social worker (LSW) was listed as PRN, would see a resident for a specific issue, and only if it was something someone at the facility couldn't handle. The facility did not provide the criteria which would prompt a social work referral. On 8/13/15 at 9:35 AM, PT #3 stated Resident #7 had problems with safety awareness and had not demonstrated safety to the point of independence. She stated the resident needed stand-by assist, but was safe to discharge home. She stated she felt the resident was able to do more activity than what he said he could do, and exhibited self-limiting behaviors, which she described as the resident would fall back from a	F 250		

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F 250	Continued From page 5 sit-to-stand (lifting assistance machine, which was not made available to the resident at home.) PT #3 stated the resident had the right to fail and she could not tell the resident he couldn't go home. She stated she gave the resident and his wife the best options possible, and did talk with them about going to an assisted living facility. PT #3 was asked about the 1/8 Discharge Summary note where the family informed the facility the resident would not be going home. She stated one daughter said he couldn't go home, and other family had concerns, and that she educated the daughter the resident was his own legal decision maker. When asked if a LSW should have been involved to help with the resident and family psychosocial dynamics, PT #3 stated, "I don't know why I would." She stated she used the Administrator to fill the social work role. When asked how the family was involved in the discharge process, PT #3 stated if it wasn't written in the weekly notes, then it wasn't done. She stated, "I can't say okay family, patient come together. I educate daily." PT #3 stated the spouse was competent. When asked who filled the role of case management, PT #3 stated if she had concerns she would bring them to the Administrator. When asked if there was a set of criteria for referral to a social worker, PT #3 stated, "We work as a team." When asked how she knew when to get the Administrator involved, PT #3 stated the Administrator wanted to be involved, and would let him know of potential areas of concern. On 8/13/15 at 11:20 AM, the Administrator stated a home evaluation wasn't done for Resident #7 because there wasn't a need for one. The facility did not provide evidence of an evaluation of resident and care giver abilities to function in an	F 250		

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F 250	Continued From page 6 independent environment. 2. Resident #6 was admitted to the facility on 7/7/15 with multiple diagnoses including rehabilitation, aftercare for musculoskeletal surgery, insomnia, depressive disorder, and anxiety state. The resident's Admission MDS Assessment, dated 7/14/15, documented the resident was cognitively intact with a BIMS score of 15 and a mood severity score of 3, which reflected minimal depression. Resident #6's August 2015 recapitulation Physician's Orders documented: Trazodone 100 mg: Take 1 tablet orally at bedtime for insomnia. Venlafaxine 75 mg: Take 1 1/2 capsule (112.5 mg) orally once a day for depression. Alprazolam 1 mg: Take 1 mg every 6 hours as needed for anxiety. Resident #6's July and August 2015 MAR documented: The Trazodone and Venlafaxine medications were administered daily in July and August. The PRN Alprazolam was administered daily and even up to 4 times a day in July and August, except for on 7/7, 7/10, and 7/31/15. Resident #6's Depression, Anxiety, and Mood Care Plans documented: *The goals for the Depression and Anxiety Care Plans documented the "Patient's mood status will remain stable and positive without increased signs and/or symptoms of" depression or anxiety	F 250		

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F 250	Continued From page 7 throughout his/her stay. *The approaches for Depression and Anxiety were documented as, Administer medication per MD order; Encourage family and/or friends to visit regularly; Encourage patient to express current needs and feelings; and Monitor for adverse side effects of psychotropic medication(s). *The goal for the Mood Care Plan-Recent Loss of Wife documented the "Patient will progress through stages of grieving process in his/her own way. Patient will express feelings about loss." *The approaches for Mood State were documented as, Encourage family members to be involved; Encourage participation in facility activities and daily life; Encourage patient to establish goals and be active in care; Encourage patient to express feeling about loss; Monitor for signs and/or symptoms of dysfunctional grieving and depression; Support coping behaviors; and, Validate concerns and fears. The resident's Nursing Progress Notes documented: 7/7/15 4:53 PM - "...shared his wife just passed away 1 1/2 weeks ago..." 7/13/15 1:54 PM - "...medicated X [times] 1 with prn Xanax per his request d/t [due to] anxiety r/t [related to] recent loss of his spouse...provided with emotional support and therapeutic communication..." 7/16/15 1:04 PM - "...very tearful while talking about his current situation stating it is imperative he go home to "take care of things"...hopes to d/c [discharge] home next week..."	F 250		

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F 250	Continued From page 8 7/18/15 12:52 PM - "...really misses his wife. No tearful outbursts noted..." 7/19/15 1:29 PM - "...talked about his wife...states he misses her every day..." 7/21/15 4:08 PM - "...Patient states feeling anxiety today and was weepy on and off..." Resident #6's Nurse Practioner's Progress Note documented: 7/24/15 - "...misses his wife, she died a few weeks ago while he was in the hospital and he wasn't ready for her to die. He's very upset about this and tearful...sounds like during the day he does have periods of extreme emotion...Assessment/Plan-...leg wound with wound V.A.C. in place...Depression...very normal for him to feel sad or angry and have a range of emotions at this time that his wife has died and that if he feels like he needs to have some alone time or if he feels like he needs to cry that he's free to do that. He does get anxiety occasionally...discuss with him that it's ok to feel emotion and that sometimes taking Xanax is not necessarily needed and he just works through the emotion sometimes that anxiety and that tearfulness will go away." The Nursing Notes continued to document: 7/24/15 8:11 AM - ",,,tearful this morning thinking about his deceased wife. Pt has not had time to properly grieve his loss and is having a hard time coping off and on during day..." 7/26/15 11:14 AM - "medicated...Xanax per his request r/t [related to] anxiety..." 8/2/15 3:07 PM - "Patient weepy this AM. Received Xanax per request. Spent 1 to 1 time with the patient and allowed his verbalizations of sadness..." 8/6/15 1:31 PM - "...medicated...with prn Xanax	F 250		

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F 250	Continued From page 9 for anxiety-with effect..." 8/9/15 11:54 AM - "Pt requesting assist with this [sic] pants...Nurse noted that wound vac had been disconnected. Asked pt about this and he stated that he does this every morning to assist with getting his pants on. Encourage pt to no [sic] do this as his wound could get infection..." 8/10/15 2:15 PM - "...states..."good days and bad days and misses his wife every day..." 8/12/15 9:57 AM - "...asked if nurse could put on his tubi grips. Pt declined stating that he was nervous about his wound clinic appointment today. Pt began to cry. Offered support and education on the edema..." 8/12/15 2:55 PM - "Pt [Patient] dc'd [discharged] with all his belongings...pt to the facility van and he was transported over to [hospital's name]...Pt is very emotional today. Stated he was worried about his appointment today at the wound clinic... [Family member] stated that currently there is some serious "ugly" issues with [another family member]. That also affect pt mood..." On 8/10/15 at 9:55 AM and 2:55 PM, Resident #6 shared with the surveyor, he had lost his wife while he was in the hospital because of his unfortunate accident. The resident stated this had been horrible for him and he was grief stricken because he wasn't at home when she had passed. The resident said that his wife had a lady that was helping take care of her, but he had been her primary provider and he was independent at home until the accident and now worried about the changes that would need to take place. Resident #6 stated he couldn't even get dressed by himself now because he had messed up with the wound vac and felt he was strongly discouraged from getting up before his preferred time of 6:00 AM, since he needed staff	F 250		

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	135130		C 08/13/2015

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F 250	Continued From page 10 assistance. On 8/12/15 at 10:05 AM, LN #7 was interviewed in regards to Resident #6 and if he had ever been offered grief counseling for the loss of his spouse and independence. The LN stated counseling would be done by the nurses, NP and/or MD, or even the Administrator. The more difficult issues could be addressed by a Licensed Social Worker and they had one that could come in when needed. The LN said for Resident #6, the NP and a LN made rounds on the resident and a conversation would take place regarding the medications and they would also determine if counseling needed to be addressed. The facility IDT team would also discuss residents' needs at their weekly meeting, in which the Licensed Social Worker was not typically in attendance. LN #7 did not remember a counseling referral being made for Resident #6. Resident #6's medical record did not have any documentation to reflect the nurses and NP's grief counseling services had maintained or improved the resident's everyday physical, mental, and psychosocial needs.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279	F 279 Patient Specific: Patient number 3 has been discharged. Other Patients: All patients have been reviewed and have appropriate care plans in place for behaviors and corresponding interventions.	9/14/15

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F 279	Continued From page 11 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and resident review, it was determined the facility failed to initiate the discharge care plan and interventions for feelings of anxiety for 1 of 12 sampled residents (Resident #3). This practice created the potential for the resident's assessed needs to not be met due to lack of direction in the care plans. Findings include: Resident #3 was admitted 7/7/15 with multiple diagnoses including hip joint replacement and depression. The resident's 6/20/15 MDS Admission Assessment coded the resident received antidepressant medication and had an active discharge plan in place. The CAA documented the resident triggered for psychotropic drug use and would be reflected in the care plan; discharge was not triggered in the CAA. a. The resident's July 2015 physician recapitulation orders documented the resident had feelings of anxiety and was overwhelmed in	F 279	Systemic Changes: The comprehensive care plan includes an area for behaviors and corresponding interventions as well as for discharge planning. The root cause analysis demonstrated this information was available and used by nursing staff to care for and discharge patient #3. The root cause analysis also demonstrated that staff responsible for using this information from the medical record to complete the comprehensive care plan did not understand this process as it pertains to the comprehensive care plan referred to in this citation. Licensed staff have been inserviced in regards to the above care plan processes. Care planning has been added to the inservice given to licensed nurses on hire as well as the annual inservicing schedule for all licensed staff. The root cause analysis also showed that a simple human error occurred so, a nurse responsible for care planning will review all new orders and verify that the care plans have been updated.	

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F 279	Continued From page 12 the mornings as a target behavior, and that this should be monitored every shift. The resident received Citalopram, an anti-depressant medication, for this behavior. The July 2015 care plan did not document this behavior or corresponding interventions for this behavior. On 8/12/15 at 3:00 p.m., the DON confirmed there was no care plan or interventions in place if the resident felt overwhelmed or anxious. b. The resident's August 2015 care plan did not have information about discharge planning. On 8/10/15 at 9:00 a.m., the resident stated she was planning on discharge from the facility on 8/14/15. On 8/13/15 at 9:30 a.m., the MDS Coordinator said the discharge care plan should have been initiated when the resident was admitted, but was not.	F 279	Monitors: The Director of Nursing or her designee will perform audits of 25% of the current patients weekly times four then monthly times five to ensure that patients have appropriate care plans in place for behaviors and corresponding interventions as well as discharge planning. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date of Compliance: 10/19/15	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		9/14/15

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F 280	Continued From page 13 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to individualized or revise care plans for 8 of 11 sampled residents (#s 1-4, 6-9, & 11). The care plans lacked individualized goals and discharge interventions for Resident #s 1-4, 6-9 & 11. Additionally, the care plans did not reflect Resident #3's CPAP (Continuous Positive Airway Pressure) had been discontinued or Resident #6's safety alarms had been discontinued. This had the potential for harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included: 1. Resident #7 was admitted to the facility on 10/3/14 and 12/20/14 with diagnoses of rehabilitation and congestive heart failure. The resident's most recent Admission MDS Assessment, dated 12/27/14, documented the resident was cognitively intact with a BIMS Score of 14. The resident required extensive assistance of two staff for bed mobility, transfers, and toilet use, and required extensive assistance of one staff for dressing, personal hygiene and bathing.	F 280	F 280 Patient Specific: Patient #s 1-4, 6-9, & 11 have all been discharged. Other Patients: All current patients care plans have been reviewed to ensure that they are up to date and accurate in regards to CPAP's and safety alarms and discharge care plans have been reviewed and updated to include individualized goals and discharge interventions.	

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F 280	Continued From page 14 Review of Resident #7's Discharge Care Plan, dated 1/2/15, documented a generic pre-printed form with boxes that had been checked indicating the resident would be discharged to a private home with spouse. There was only one option in the "goal" column, which was checked. The checked interventions included: Scheduled IDT meeting to monitor and progress toward discharge; Arrange for family and or patient care conferences as needed; Coordinate discharge goals and needs with patient and/or family; Educate patient and/or family regarding recommendations for discharge care needs and instructions; and, Assist patient and/or family in arranging for discharge care needs as recommended. (Durable medical equipment, prescriptions, home health care and support services). On 8/13/15 at 9:00 AM, the DON and MDS Coordinator were shown Resident #7's Discharge Care Plan. The MDS Coordinator stated the discharge goal to have a safe and coordinated discharge would be between nursing and therapy. The DON stated therapy would do their note on a discharge and she would not expect to see resident specific goals on the care plan. The MDS Coordinator was asked how the facility ensured the resident met their goals, if they were not listed on the care plan. She stated the facility's IDT met every Wednesday as a team, therapy, nursing, Administrator, and would discuss any concerns at that time. She stated the IDT discussed discharge dates and home health needs. When asked how the discharge care plan was individualized for resident functional and cognitive needs, the DON stated therapy documented in their notes and the facility considered their current casre plan forms to be individualized.	F 280	Systemic Changes: The root cause analysis demonstrated that staff had all the information required for the comprehensive care plan. This information was available and used by nursing staff to care for and discharge the above patients. The root cause analysis also demonstrated that staff responsible for using this information from the medical record to complete the comprehensive care plan did not understand this process as it pertains to the comprehensive care plan referred to in this citation. Licensed staff have been inserviced in regards to; 1. Proper updating of care plans when alarms or CPAP's are d/c'd. 2. Proper completion of discharge care plans with individualized goals and discharge interventions.	

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F 280	Continued From page 15 Resident #s 1-4, 6, 8, 9, and 11 had the same exact form in their records, with the only changes being which boxes were checked for the disharge loacation, and the name of the resident on the bottom of the form. Computerized care plans have replaced the former preprinted care plans but contain the same wording as the former pre-printed care plans. 2. Resident #3 was admitted to the facility 7/7/15 with multiple diagnoses including hip joint replacement. The resident's August 2015 respiratory care plan documented the resident was to receive CPAP per MD order, related to obstructive sleep apnea. The August 2015 physician recapitulation orders documented orders for "CPAP at night per home settings" (initiated and discontinued on 7/7/15). On 8/10/15 at 9:00 a.m., Resident #3 stated at times she wore oxygen at night, and did not wear the CPAP. On 8/12/15 at 3:00 p.m., the DON said the CPAP intervention should not be in the care plan because it was discontinued. 3. Resident #6 was admitted to the facility on 7/7/15 with multiple diagnoses including rehabilitation, aftercare for musculoskeletal	F 280	The above 2 care planning topics have been added to the inservice given to licensed nurses on hire as well as the annual inservicing schedule for all licensed staff. The root cause analysis also showed that a simple human error occurred so, a nurse responsible for care planning will review all new orders and verify that the care plans have been updated.	

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F 280	Continued From page 16 surgery and insomnia. The resident's August 2015 recapitulation Physician's Orders documented: 7/11/15 - "Bed alarms for safety. Dx: [Diagnosis] Recent fall." 7/13/15 - "Pt [Patient] self transferring from the w/c without assistance...Tag alarms to w/c. Pressure devices to bed." 7/20/15 - "...Communicate c [with] PT/OT prior to removing alarms (per pt & family request)." The resident's August 2015 Fall Care Plan approaches documented: "Safety alarm to bed." "Safety alarm to wheelchair." On 8/10/15 at 9:55 AM, 10:25 AM, and 1:30 PM, and 8/11/15 at 1:35 PM, Resident #6 was observed in his bed, wheelchair, and recliner and he did not have safety alarms in place. On 8/12/15 at 8:30 AM, the DON was interviewed about the bed and wheelchair safety alarms for Resident #6. The DON stated the alarms had been discontinued in July and they should also have been taken off of the care plan.	F 280	Monitors: The Director of Nursing or her designee will audit 25 % of the current patients weekly times four then monthly times 5 to ensure that staff have: 1. Properly updated care plans when CPAP's or safety alarms are d/c'd. 2. Properly completed discharge care plans with individualized goals and discharge interventions. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date of Compliance: 10/19/15	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined the	F 281		9/14/15

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F 281	Continued From page 17 facility failed to ensure residents received their personal prescribed medications and medications that were not expired. This was true for 2 of 11 (# 5) sample residents and any other resident who needed medications from the Pyxis. The deficient practice had the potential for harm with possibility of decreased efficacy and increased risks for adverse reactions and side effects. Findings included: Resident #5 was admitted to the facility on 7/28/15 with multiple diagnoses including rehabilitation after surgery. During the medication pass observation on 8/10/15 at 10:40 AM, LN #4 was observed as she dispensed one tablet of Ondansetron 4 mg from a blister pack of 10 tablets in preparation for Resident #5. The name of the resident on the Ondansetron blister pack was not Resident #5, but Resident #9. The surveyor intervened before the medication was administered. The LN disposed of the medication and stated Resident #5 did not have any Ondansetron in a blister pack, so she would need to retrieve the medication from the facility's Pyxis. LN #4 proceeded to the Pyxis, the Pyxis computer screen showed the Ondansetron 4 mg available but also showed an expiration date of 7/21/15. The LN did not observe the date on the Pyxis screen nor did she observe the expired date of 7/21/15 on the individual packet. LN #5 prepared to administer the expired Ondansetron when the surveyor intervened again before the medication was administered. There were a total of 4 expired Ondansetron tablets in the Pyxis and 2 tablets which had not expired. On 8/10/15 at 10:45 AM, the LN was interviewed	F 281	F 281 Patient Specific: Patient number 5 has been discharged. Other Patients: All patients are given medications prior to their expiration date. Systemic Changes: Licensed staff have been reinserviced on the "rights of medication administration" which includes checking the expiration date of any medications. Pharmacy has been notified of the expired medications and they immediately checked all medications in the facility to	

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F 281	Continued From page 18 about the expired medications. LN #4 said the pharmacy managed the Pyxis and it was their responsibility to ensure the medications were not expired. The LN added that she also should have checked the expiration date and the responsibility was not just the pharmacy's concern. On 8/10/15 at 10:55 AM, Resident #5 was observed as she was administered a Ondansetron tablet. The resident stated she was feeling nauseated because of the pain medications and was hopeful she would get relief by taking the nausea medication. On 8/10/15 at 11:10 AM, the DON was asked to access the Pyxis and medication refrigerator in order for the surveyors to review expiration dates. The Pyxis and medication refrigerator had a total of 753 tablets, capsules, vials, and insulin pens which had expired in May, June, and July 2015. These medications were still available to be administered to residents. The DON said she was unable to say why the pharmacy had not pulled the medications that were expired. The DON stated she was going to call the pharmacy immediately and have them come to take care of the problem. Refer to F425 as it relates to Pharmacy Services.	F 281	ensure proper expiration dates. They will perform independent audits weekly to ensure continued compliance. Monitors: The Director of Nursing or her designee will perform weekly rounds times four then monthly times five to ensure that medications are not past their expiration date. These rounds will include an examination of medication expiration dates in both the med carts, medication refreigerator, and the emergency supply. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Date of Compliance: 10/19/15	/14/15

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F 309	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined the facility failed to ensure laboratory results were known to ensure appropriate treatment of an infection (UTI) and hypertensive medications were held for blood pressure parameters. This was true for 3 of 11 (#s 2, 4, and 9) sample residents. 1. Resident #9 was admitted on 7/21/15 and readmitted to the facility on 8/3/15 with diagnoses including septic shock and urinary tract infection. Resident #9's admission MDS assessment, dated 8/10/15, documented moderately impaired cognition with a BIMS score of 10, 1 person extensive assistance for toileting needs, and always continent of urine and bowel. The resident's Care Plan for Altered Urinary Status documented the following approaches: *Administer medication per MD order; *Educate patient on proper hygiene practices to minimize risk as needed; *Encourage fluids and offer cranberry juice; *Labs per MD order; *Monitor for side effects of medication; *Monitor for signs and/or symptoms of UTI, (ie. frequency, burning, foul odor, cloudy urine, increased confusion, flank/abdominal pain, etc.); and, *Provide incontinent products and assist with peri-care as needed. On 7/22/15, the resident's Nurse Practioner's	F 309	F 309 Patient Specific: Patient numbers 2, 4, and 9 have been discharged. Other Patients: All patients blood pressure have been reviewed and have parameters in place and are given or held as ordered. All patients with a UTI (if any) are receiving appropriate treatment. Any patient with physician ordered labs have been reviewed and lab results are received in a timely manner. If a physician orders a PICC line d/c'd and the patient has pending labs the order will be re-verified with the phsysician before d/c'ing.	

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F 309	Continued From page 20 Progress Note documented, "...She was hospitalized for septic shock related to a urinary tract infection. It sounds from her H&P [history & physical] that she was a very sick woman...PICC line to left upper extremity...Assessment/Plan- 1. Septic shock secondary to urinary tract infection. She does continue to be on IV Rocephin. 2. Acute kidney injury from the hospital..." On 8/3/15 , a Physician's Order (PO) documented a urinalysis (UA) to be collected 8/5/15. The first laboratory report documented the urinalysis was collected on 8/5/15, received at the laboratory 3:40 AM on 8/6/15 and reported to the facility on 8/6/15 at 8:00 AM documented, "Urine culture to follow." The report was noted by a LN at the facility on 8/6/15. The second laboratory result for the urine culture, reported on 8/6/15 at 1:00 PM documented, "no growth after overnight incubation...This is a preliminary report." The report was noted by a LN at the facility on 8/6/15. The third laboratory result for the urine culture reported on 8/7/15 at 11:00 AM documented, "50,000 CFU/ML Non-lactose Fermenter, Identification to follow...This is a preliminary report." The report was noted by a LN at the facility on 8/7/15. On 8/7/15, a PO documented, "Discontinue PICC (Peripherally Inserted Central Catheter) to right upper arm." The PICC had been placed at the hospital prior to the resident's admit to the facility. A corresponding PN documented this was done ast 1:43 PM.	F 309	Systemic Changes: Licensed staff have been inserviced in regards to following the physicians' orders including vital sign parameters on hypertensive medications and to not administer blood pressure medications if outside of ordered parameters. The lab monitoring system has been reviewed to ensure that results are received in a timely manner and has double checks in place. Staff will verify that there are no pending labs before d/c'ing a PICC line. Licensed staff have been inserviced on treatment and services for urinary tract infections. Monitors: The Director of Nursing or her designee will audit 25% of the current patients weekly times 4 then monthly times 5 to ensure that: 1. Medications have been administered according to physician orders including parameters including holding blood pressure	

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ASPEN TRANSITIONAL REHABILITATION	2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642

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F 309	Continued From page 21 The fourth laboratory report for the urine culture reported on 8/8/15 at 11:00 AM documented, "Non-lactose fermenter identified as Pseudomonas aeruginosa...This is a completed report." The report also contained the antibiotics which would be susceptible and resistant for the gram negative bacterium. There was no corresponding facility PN or PO noting or responding to this laboratory result. On 8/11/15 4:00 AM, a PN documented, "...patient seems alert and oriented...voiding yellow clear urine w/o [without] urgency..." On 8/11/15 at an unknown time, Resident #9's Physical Therapy note documented, "...Pt [patient] lifted hand to face and started shaking, eyes shut, having difficulty responding. Nsg [nursing] notified...Pt able to report where she was, had difficult time keeping eyes open..." The fourth laboratory report was noted by a LN at the facility on 8/11/15, three days after the facility should have had the report with a note that the NP has also been contacted on 8/11/15. On 8/11/15 11:26 AM, a PN documented, "Final urine culture results received. Called...NP. Order received to send pt for further evaluation to [hospital's name] ER. Pt is growing pseudomonas aeruginosa. Pt presents this AM with convulsions intermittently and states she has a headache. Pt resistant to go to ER but strongly suggested she do so given hx [history] of septic shock..." On 8/11/15, a PO documented, "Send patient to Emergency Room for evaluation." The resident's 8/11/15 Emergency Department	F 309	medications if vital signs were outside of the ordered parameters. 2. Any patients with a UTI (if any) are receiving proper treatment and services for their UTI. 3. If a patient's physician orders a PICC line d/c'd there is documentation that there were no pending labs before the PICC was d/c'd or that if there were pending labs that the order was re-verified with the physician. 4. Lab results were received in a timely manner. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date of Compliance: 10/19/15	

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F 309	Continued From page 22 report documented, "...Chief Complaint...Possible sepsis...Diagnosis UTI...female presents with increasing confusion and tremors...She was there because of the recovering from septic shock. She recently had a urinary tract infection but is currently not on any antibiotics...Medications Administered IV's...Normal Saline IV 500ml bolus...Ordered medication from a 500 ml bag was given via an intravenous route, peripheral catheter, initiated at this time...the differential diagnoses considered were: Urinary tract infection, Sepsis, Pneumonia, Dehydration. Intracranial abnormality..." On 8/12/15 at 8:02 AM, Resident #9 was observed eating breakfast in the dining room. The resident stated she had to go to the ER yesterday and they had determined she had a UTI. The resident said it was frightening because she was worried she was going to become, "Really sick, like the last time." Resident #9 stated the ER had started her on antibiotics and she was feeling so much better today. On 8/12/15 at 11:00 AM, LN #1 was interviewed in regards to Resident #9's laboratory results. The LN said she realized she did not have the resident's final lab results, until the resident had the reported convulsions/tremors. The LN said she called the laboratory in order to find out about the final urine lab results and then proceeded to inform the NP. The LN stated the NP told her to send the resident to the emergency room for further evaluation. On 8/14/15 at 2:04 PM, the laboratory was called by the surveyor that had performed the resident's urine lab tests. The microbiologist stated, urine test results are finalized from 2 to 3 days,	F 309		

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F 309	Continued From page 23 dependent on when the specimen has been collected. Resident #9's final urine lab tests results would have been finalized on 8/8/15 at 11:00 AM. The laboratory's system documented those results were sent to an unkown number on 8/8/15 at 11:00 AM. 2. Resident #4 was admitted to the facility 7/30/15 with multiple diagnoses including congestive heart failure, hypertension, and atrial fibrillation. The July and August 2015 physician recapitulation orders documented hold hypertension medications for systolic blood pressure less than 100 or diastolic blood pressure less than 65. Lopressor 37.5 mg was ordered for atrial fibrillation and hypertension and was to be given twice a day. Spironolactone 12.5 mg was ordered for congestive heart failure and hypertension and was to be given once a day. The resident's August 2015 MAR documented blood pressure (BP) readings: 8/3/15 - BP 126/62 8/9/15 - BP 120/51 8/6/15 - BP 100/57 The Lopressor and the Spironolactone were documented as administered on the above dates, even though the diastolic blood pressure was below the Physician ordered parameters. On 8/12/15 at 8:59 a.m., the DON said the blood pressure parameters were standing orders and the Physician also had blood pressure parameters on each individual medication and this was the orders the LNs followed. The DON stated she would to see if the Physician would discontinue the standing orders, since it had caused some confusion with different	F 309		

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F 309	Continued From page 24 parameters. 3. Resident #2 was admitted to the facility 6/25/15 with multiple diagnoses including chronic pulmonary heart disease and atrial fibrillation. The July and August 2015 physician recapitulation orders documented Diltiazem was to be given once a day for hypertension with instructions to hold the medication for a systolic blood pressure less than 105 or heart rate less than 60. The July 2015 TAR documented one instance in July and one instance in August when the resident's systolic blood pressure was less than 105 and the medication was not held. On 8/13/15 at 10:15 a.m., the DON stated Diltiazem should have been held in these instances.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328		9/14/15

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F 328	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review, it was determined the facility failed to meet residents' oxygen needs for 3 of 11 (#s 3 & 10) sampled residents, and 1 Random Resident #12. This deficient practice created the potential for more than minimal harm should residents have a drop in oxygen saturations causing them to become anxious, confused and experience respiratory distress. Findings included: 1. Resident #3 was admitted to the facility 7/7/15 with multiple diagnoses including obstructive sleep apnea. The resident's August 2015 respiratory care plan documented the resident was to receive oxygen and CPAP per MD order, related to that diagnosis. The August 2015 physician recapitulation orders documented orders for: *Oxygen at 2 liters per nasal cannula; adjust LPM (liters per minute) to keep SaO2 (oxygen saturation) >90% and, *CPAP at night per home settings (discontinued on 7/7/15). On 8/10/15 at 9:00 a.m., Resident #3 stated at times she wore oxygen at night, and did not wear the CPAP. The administration of oxygen for the resident was not observed during the survey from 8/10/15 - 8/13/15. On 8/12/15 at 10:30 a.m., the RUC stated the oxygen order did not clarify the frequency of oxygen treatment for the resident. 2. Resident #10 was admitted to the facility on	F 328	F 328 Patient Specific: Patients' numbers 3 and 11 have been discharged. Patient number 12's oxygen orders have been clarified to include liter flow with parameters, frequency, and duration of oxygen treatment. Other Patients: All current patients with oxygen have been reviewed to ensure that oxygen orders have been clarified	

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F 328	Continued From page 26 7/21/15 with multiple diagnoses including chronic obstructive pulmonary disease. A 7/21/15 Physician Order documented, "Oxygen @ [at] 2 L [liters] via NC [nasal cannula], adjust LPM to keep SaO2 [oxygen saturation] > 90%." On 8/12/15 at 11:15 a.m., the RUC stated the oxygen order was a PRN order and staff adjust the liter flow anywhere from "room air" to 2 liters. She stated the order should have been documented as PRN and the liter flow parameters should have been clarified. 3. Resident #12 was admitted on 8/8/15 with multiple diagnoses including hip joint replacement. A physician order, dated 8/8/15, documented, "Oxygen per NC; adjust LPM to keep SaO2 > 90%." The order did not specify the liter flow rate, frequency, or duration of oxygen treatment. On 8/10/15 at 8:00 a.m., Resident #12 was observed at the breakfast meal service with a portable oxygen canister and nasal cannula in place. The oxygen canister was turned to "0 liters." On 8/10/15 at 8:15 a.m., LPN #6 stated the resident had an order for continuous oxygen at 2 liters to keep oxygen saturation above 90% and stated the canister should have been turned on. On 8/12/15 at 11:15 a.m., the RUC stated the resident's oxygen order should specify the liter flow with parameters, frequency, and duration of oxygen treatment.	F 328	to include liter flow with parameters, frequency, and duration of oxygen treatment. Systemic Changes: Licensed Staff have been inserviced in regards to clarifying oxygen orders which do not have flow with parameters, frequency, and duration of oxygen treatment. Monitors: The Director of Nursing or her designee will perform audits of 25% of the current patients weekly times four then monthly times five to ensure that oxygen orders include flow with parameters, frequency, and duration of oxygen treatment. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date of Compliance: 10/19/2015	

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to post Nurse Staffing Information on a daily basis. This deficient practice had the potential to affect 12 of	F 356	F 356 Patient Specific: Please see systemic changes. Other Patients: Please see systemic changes. Systemic Changes: The nurse manager will be responsible for posting the necessary information daily. Licensed staff have been inserviced in regards to updating the actual hours each shift on the Nurse Staffing Information. Monitors: The Administrator or his designee will audit the nurse staffing information sheets daily times 14 days. If no issues arise then audits will change to weekly times 2 weeks and monthly times five to ensure that actual hours are updated. He will report his findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date of Compliance: 10/19/2015	9/14/15

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F 356	Continued From page 28 12 (#s 1-12) sample residents, all other residents who resided in the facility, and visitors who came to the facility. Findings included: On 8/10/15 at 7:45 AM, the Nurse Staffing Information was observed, posted in a frame on a shelf by the Administrator's office. There were two columns on the page, one side listed "scheduled" nursing hours and the other side had spaces to document the "actual hours." There were no documented "actual hours" provided and this portion was blank upon observation. The date for the posting was documented as 8/7/15. On 8/11/15 at 9:30 AM, the Nurse Staffing Information was discussed with the Administrator and AIT during the Environmental Tour. The Administrator and AIT were made aware of the concerns of the sign not being updated since 8/7/15 and not reflective of the actual hours worked by the nursing staff.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 371	F 371 Patient Specific: Please see systemic changes: Other Patients: Please see systemic changes: Systemic Changes: Dietary staff have been inserviced in regards to: 1. Utilizing towels to turn off faucets after washing hands.	9/14/15

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F 371	Continued From page 29 determined the facility did not ensure food was prepared in a sanitary environment. This had the the potential to affect 11 out of 11 sampled residents (#s 1-11) and any resident who ate their meals in the facility. This created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included: 1. On 8/10/15 at 7:35 AM, the following was observed in the kitchen: a. The morning cook was observed to wash his hands and did not protect them with a towel before turning off the faucet. b. The morning cook was observed in the kitchen with a hair net hanging from his ears underneath his beard which did not cover his beard. c. Underneath the handwashing sink, in close proximity to food preparation, a dirty bucket was found which contained squeegees and other cleaning tools, along with the following chemicals: 1) A large, unlabeled, spray bottle of Multi-Quat Sanitizer; 2) A 19 oz. aerosol can of oven cleaner; 3) A quart bottle of Lime-Out; 4) A gallon container of Kool Clean; 5) A 26 oz. bottle of Bar Keeper's Friend; 6) A 1 gallon container of Eco Suds; and, 7) A 24 oz. bottle of Dawn Dish Detergent. 2. On 8/10/15 at 10:50 AM, the steam table was observed to contain an iced area which held yogurt and garnishes for residents. Included in the iced area was a reused, 32 oz., plastic bottle brought from the cook's home which contained ice tea for his own personal use. The cook stated he drank the ice tea straight from the bottle. 3. On 8/10/15 at 11:00 AM, the steam table was observed to have a leaky pipe with a bucket	F 371	2. Proper utilization of hair nets and beard nets. 3. Proper storage of cleaning materials. 4. Proper storage of personal hydration items. The intermittent leak in the pipe under the steam table has been repaired. Monitors: The Dietary Manager or her designee will perform daily audits times 14. If no issues arise then audits will change to weekly times 2 weeks and monthly times five to ensure that: 1. Proper handwashing techniques are practiced. 2. Hair and beard nets are utilized properly. 3. Cleaning materials are stored properly. 4. Personal hydration items are stored properly. 5. Pipes are not leaking. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date of Compliance:	

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F 371	Continued From page 30 underneath to catch the drips. The DM stated the leaky pipe "comes and goes," but was unable to state how long it had been leaking. 4. On 8/10/15 at 11:15 AM, the DM was observed in the kitchen to wash her hands and did not protect them with a towel before turning off the faucet. The DM stated she knew she should have used a towel to turn off the handles. 5. On 8/11/15 at 11:25 AM, the morning cook was observed in the kitchen to wash his hands and did not protect them with a towel before turning off the faucet. The cook stated, "I'll try to watch that." The RD then spoke with the cook regarding proper handwashing procedure. On 8/10/15 at 11:00 AM, the Dietary Manager (DM) stated the aforementioned chemicals found underneath the handwashing sink were all hazardous and moved them to the Mop/Chemical Storage Room. On 8/11/15 at 9:45 AM, the morning cook stated he should have used a towel to turn off the handles after washing his hands.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425		9/14/15

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F 425	Continued From page 31 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, review of records, and review of medications during the medication pass task, it was determined the facility and pharmacy services failed to monitor and remove 751 expired medications (in units of individual capsules, tablets, vials, etc.) in the pyxis and 2 expired insulin pens in the medication refrigerator. This had the potential to affect any resident in the facility utilizing medications from the pyxis or medication refrigerator. The deficient practice had the potential for a resident to experience adverse medication side effects or decreased therapeutic efficacy should a resident be administered an expired medication. During the medication pass observation on 8/10/15 at 10:40 AM, LN #4 was observed as she was preparing to dispense one tablet of Ondansetron 4 mg for Resident #5's nausea. The LN stated Resident #5 did not have any Ondansetron in a blister pack, so she would need to retrieve the medication from the facility's Pyxis. LN #4 proceeded to the Pyxis, the Pyxis computer screen showed the Ondansetron 4 mg	F 425	10/19/2015 F 425: Patient Specific: Patient number 5 has been discharged. Other Patients: All current patients' medications have been checked by nursing staff and have proper expiration dates. Systemic Changes: Pharmacy has been notified of the expired medications and they immediately checked all medications in the facility to ensure proper expiration dates. They will perform independent weekly-audits to ensure medications are not expired.	

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F 425	Continued From page 32 available and also showed an expiration date of 7/21/15. The LN did not observe the date on the Pyxis screen nor did she observe the expired date of 7/21/15 on the individual packet. LN #5 prepared to administer the expired Ondansetron when the surveyor intervened before the medication could be administered. There were a total of 4 expired Ondansetron tablets in the Pyxis and 2 tablets which had not expired. On 8/10/15 at 11:00 AM, the Pyxis and medication refrigerator were reviewed for expired medications. In the Pyxis, 706 medications (in units of individual capsules, tablets, vials, etc.) had expired on 7/21/15, 34 medications expired on 5/21/15, 6 medications expired 6/29/15, and 5 medications expired 6/21/15. In the medication refrigerator, 2 medications had expired on 6/29/15. On 8/10/15 at 1:45 PM, the Director of Pharmacy Operations (DPO) confirmed these medications were expired. The DPO stated all medications were reviewed monthly for expiration and the pharmacy also performed a quarterly review that would match each medication with the expiration date. The quarterly review was scheduled for the end of July 2015. The DPO said the monthly review had been completed a couple of weeks ago for July 2015, but was not sure why the expired medications were not pulled from the stock at that time. The quarterly review scheduled for the end of July had not taken place because of vacations and employees' illnesses.	F 425	Monitors: The Director of Nursing or her designee will perform weekly rounds times four then monthly times five to ensure that medications are not past their expiration date. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date of Compliance: 10/19/2015 F 441	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	Patient Specific: Patient number 5 has been discharged.	)/14/15

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F 441	Continued From page 33 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was	F 441	Other Patients: All current patients have staff utilizing proper handwashing techniques and have their k-pads stored in an appropriate manner when not in use. Systemic Changes: Licensed and certified staff have been inserviced in regards to: 1. Proper handwashing. 2. Proper storage of K-pads when not in use.	

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F 441	Continued From page 34 determined the facility failed to prevent the spread of infection when a physical therapist did not perform handwashing after direct contact with a resident, and a K-pad (large electric heating pad) was left on the floor. This was true for 1 of 11 (#5)sampled residents. Failure to follow standard infection control measures placed the residents at risk for infections. Findings included: Resident #5 was admitted to the facility on 7/28/15 with diagnoses which included rehabilitation after surgery. On 8/10/15 at 9:50 AM, Physical Therapist (PT) #8 was observed as she assisted Resident #5 to transition from her wheelchair, using a slide board, to her bed. PT #8 stated she was working with the resident in hopes of not using the Hoyer. A heat therapy device and a K-Pad were observed against the wall, on the floor, underneath the resident's window. After PT #8 helped the resident transfer from the WC to her bed, she picked up the heat therapy device and K-Pad off the floor. She then helped the resident lay down on her right side with the help of 2 LNs. The surveyor asked PT #8 if the heat therapy device and K-Pad should have been on floor. She stated she didn't use those devices, that nurses used them. LN #4 stated the K-Pad should not have been on the floor and she would get the resident another bladder (K-Pad). PT #8 was then observed to leave the room and did not wash her hands after working with the resident. On 8/10/15 at 10:05 AM, PT #8 stated she did not wash her hands when she left the room to get a Cold Pak in the Nourishment Room. On 8/12/15 at 5:30 PM, the DON stated the	F 441	Monitors: The Rehab Services Manager or his designee will perform two observations of therapy staff washing their hands weekly times four then monthly times five to ensure that proper handwashing techniques are utilized. The Director of Nursing or designee will perform observations of on hall weekly times four then monthly times five to ensure that K-pads are stored in an appropriate manner when not in use. The Rehab Services Manager and the Director of nursing will report their findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date of Compliance: 10/19/15	

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F 441	Continued From page 35 resident's K-Pad Bladder should have been on the bed.	F 441	F 490	
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, it was determined the management team failed to administer resources which could effectively and efficiently prevent systematic problems. This was true for 9 of 11 sample residents (#s 2, 3, 4, 5, 6, 7, 9, & 10), 1 random resident (#12), and the potential to affect any resident who resided in the facility. This failure resulted in the management team providing insufficient direction and control necessary to ensure residents' Quality of Life and Quality of Care needs were being met. Findings included: The facility failed to provide sufficient implementation, monitoring, evaluation and continued oversight to maintain regulatory compliance in the following areas: A. Refer to F250 - The facility failed to ensure residents with social services needs were being monitored, evaluated, counseled, and assisted in meeting their treatment goals as it related to discharge planning, psychosocial functioning, and	F 490	Patient Specific: Patients 2, 3, 4, 5, 6, 7, 9, 10, & 12 have been discharged. Other Patients: Refer to POC for F-250, F-279, F-280, F-309, F-328, and F-441. Systemic Changes: Refer to POC for F-250, F-279, F-280, F-309, F-328, and F-441. A root cause analysis identified insufficient experience in the survey process as an underlying cause for these citations. Therefore, in addition to systemic changes made for each identified citation a mock survey that includes corporate staff will occur each month. Monitors: Refer to POC for F-250, F-279, F-280, F-309, F-328, and F-441. Results of the mock surveys will be reviewed by QA committee. Date of Compliance: 10/19/15	9/14/15

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F 490	Continued From page 36 well-being. B. Refer to F279 - The facility failed to initiate a discharge care plan and interventions for feelings of anxiety for a resident, which could have resulted in the resident's assessed needs not being met due to the lack of direction in the care plans. C. Refer to F280 - The facility failed to ensure care plans were updated and monitored to reflect the residents' current directive of care as it related to CPAPs, discharges, and safety alarms on wheelchairs and beds. D. Refer to F309 - The facility failed to ensure laboratory reports were received and acted upon promptly, which resulted in a resident's need to go to the emergency room and have an invasive procedure performed (IV line inserted). The facility failed to ensure residents with blood pressure parameters were being followed prior to administration of hypertensive medications. The facility failed to ensure a resident was not receiving another resident's medication and any expired medications. Last, the facility failed to ensure accurate accounting for a large supply of expired medications and to ensure these medications were not available for the residents use. E. Refer to F328 - The facility failed to ensure residents' oxygen needs were being met. F. Refer to F441 - The facility failed to use appropriate handwashing practices and did not provide a safe and sanitary environment to prevent the development and transmission of disease and infection.	F 490		

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F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents' medical records were complete. This was true for 1 of 11 sampled residents (Resident #3) when the resident refused a speech therapy consultation and it was not documented. This failure created the potential for medical decisions based on incomplete information. Findings included: Resident #3 was admitted 7/7/15 with multiple diagnoses including hip joint replacement. On 7/14/15, an order for speech therapy evaluation for Resident #3 was documented, and was communicated on the care plan as well. On 8/12/15 at 1:30 p.m., the DON was asked about the results of the speech therapy evaluation. She said the resident refused the	F 514	F 514 Patient Specific: Patient number 3 has been discharged. Other Patients: All current patients who have refused a therapy evaluation have documentation in place. (if any). Systemic Changes: A root cause analysis determined that lack of knowledge of one staff member was the cause of this deficiency. This staff member and all other therapy staff have been inserviced in regards to proper documentation when a patient refuses an evaluation. Monitors: The Rehab Services Manager will audit 25% of the current patients charts weekly times four then monthly times five to ensure that any patient who refuses an evaluation has proper documentation in place. He will report his findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date of Compliance: 10/19/2015	9/14/15

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F 514	Continued From page 38 evaluation, but this was not documented in the resident's record.	F 514		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff were able to explain the emergency procedures in the event of a power failure. This was true for 1 of 3 (CNA #2) staff interviewed for emergency preparedness. This practice created the potential for more than minimal harm should a power failure occur. Findings included: The facility's Utility and Power Outage policy and procedures documented there was a generator that would power the emergency medical equipment, fire safety equipment, and heating devices through red outlets throughout the facility. The staff were to ensure emergency medical equipment was plugged into the emergency outlets, notify the Administrator, DON, charge nurse, and the Power Company. On 8/11/15 at 10:10 a.m., CNA #2 was interviewed on emergency preparedness procedures. When asked about the procedure during a power outage, the CNA was unsure of what to do and was unsure if the facility had an	F 518	F 518 Patient Specific: Please see systemic changes: Other Patients: Please see systemic changes. Systemic Changes. Licensed and certified staff have been inserviced in regards to referencing the disaster manual at the nurses station if there are any questions at to what to do in an emergency situation. Monitors: The Administrator or his designee will interview five staff members weekly times four then monthly times five to ensure that they know to reference the disaster manual at the nurses station if there are any questions at to what to do in an emergency. Date of Compliance: 10/19/15	9/14/15

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F 518	Continued From page 39	F 518		
	emergency generator.			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		9/14/15
	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.		F 520 Patient Specific: Please see systemic changes.	
	The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.		Other Patients: Please see systemic changes.	
	A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.		Systemic Changes: The Q.A.P.I. policy and procedure has been reviewed with Administrative Staff.	
	Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.		Licensed and certified staff have been inserviced on the ability to bring concerns to the Q.A.P.I. committee.	
	This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and a review of the facility's compliance history, it was determined the facility's Quality Assessment and Assurance (QAA) committee failed to take actions that identified and resolved systematic problems for 9 of 11 sample residents			

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F 520	Continued From page 40 (#s 2-7, 9, & 10) and 1 random resident (#12), with the potential to affect all residents in the facility. This failure resulted in the QAA committee providing insufficient and necessary direction and control over the facility to ensure residents' quality of life, assessments, and quality of care needs were met. Findings included: The QAA committee failed to provide sufficient monitoring and oversight and the ability to sustain regulatory compliance, as evidenced by the following citations for the recertification and complaint survey, dated 8/13/15. a. Refer to F250 as it related to the QAA committee's failure to identify the concerns and ensure the facility provided medically related social services to improve the residents' physical, mental and psychosocial function. b. Refer to F279 and F280 as it related to the QAA committee's failure to ensure care plans were developed and revised to reflect the care needs of the residents. The facility was previously cited at F279 during the recertification survey, dated 4/24/14, as well as for the current recertification and complaint survey, dated 8/13/15. c. Refer to F309 as it related to the QAA committee's failure to ensure the facility provided the necessary care and services to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being when a resident's lab results were not received, reviewed, and acted upon timely. Also, residents were given hypertensive medications when their blood pressures were not within the parameters and the facility could have given expired	F 520	The Q.A.P.I. committee will meet monthly for the next 6 months instead of quarterly to increase monitoring of compliance with F250, F279, F280, F 309, F 328, F425, F371, F441, a well as other areas identified through the policy and procedure. Monitors: Results of the monitoring for each individual tag will be reported on and evaluated at each of the Q.A. meetings and changes to the plan of correction will be evaluated and implemented as needed. Date of Compliance: 10/19/2015	

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F 520	Continued From page 41 medications. d. Refer to F328 as it related to the QAA committee's failure to ensure the facility met the residents' oxygen needs. The facility was previously cited at F328 during the recertification survey, dated 4/24/14, as well as for the current recertification and complaint survey, dated 8/13/15. e. Refer to F425 as it related to the QAA committee's failure to ensure the facility did not have hundreds of expired medications available for administration to the residents. f. Refer to F371 and F441 as it related to the QAA committee's failure to ensure the facility's compliance with the prevention and spread of infection as evidenced by the staffs' inappropriate handwashing techniques, beards not being covered in the kitchen, and staff's personal items not stored separately from the residents' food items in the kitchen. The facility was cited at F371 and F441 for the recertification and complaint survey, dated 8/13/15. On 8/12/15 at 5:25 PM, the Administrator stated their Corporate office had sent out questionnaire forms to residents after they had discharged, so the facility could work on areas where there was an identified need. The questionnaires addressed a scoring area for Admissions, Nursing, Therapy, Dining, General, Discharge, and Home Health. The form also had questions on why the resident chose the facility, improvements needed, what the resident liked best, and a place for other comments. The Administrator stated there was a team approach for the discharge planning and there had been no concerns identified. The	F 520		

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F 520	Continued From page 42 response on the questionnaires was tracked at a 35.85% return rate. The facility was unable to show the QAA process to be effective at sustaining and maintaining compliance as evidenced by the deficiencies cited in 5 areas of quality of life, resident assessment, and quality of care categories and in 7 other areas of facilitys' practices.	F 520		