



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
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

September 11, 2015

Gerald L. Bosen, Administrator
Kindred Nursing & Rehabilitation - Weiser
331 East Park Street
Weiser, ID 83672-2053

Provider #: 135010

Dear Mr. Bosen:

On **August 28, 2015**, a survey was conducted at Kindred Nursing & Rehabilitation - Weiser 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal 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) and on or before the "Opportunity to Correct." **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 24, 2015**. Failure to submit an acceptable PoC by **September 24, 2015**, may result in the imposition of civil monetary penalties by **October 14, 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 2, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 2, 2015**. A change in the seriousness of the deficiencies on **October 2, 2015**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **October 2, 2015** includes the following:

Denial of payment for new admissions effective **November 28, 2015**. [42 CFR §488.417(a)]

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 28, 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 28, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, 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>

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

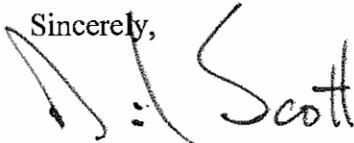
- BFS Letters (06/30/11)

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

This request must be received by **September 24, 2015**. If your request for informal dispute resolution is received after **September 24, 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,

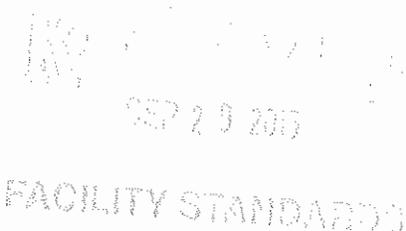
A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "S" for "Scott".

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

DS/dmj
Enclosures

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

PRINTED: 09/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/28/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from August 24, 2015 to August 28, 2015.</p> <p>The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Linda Kelly, RN Angela Morgan, RN, BSN Presie Billington, RN</p> <p>Survey Abbreviations: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide COTA=Certified Occupational Therapy Assistant/Aide CVA=Cerebral Vascular Accident DDCO=District Director of Clinical Operations DNS/DON = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment OT=Occupational Therapy PRN = As Needed SCD=Staff Development Coordinator</p>	F 000	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Weiser does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p style="text-align: center;">  </p>	
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private</p>	F 164	<p>F 164</p> <p>Resident Specific The ID team validated resident #6 current MARs and personal medical information is being protected.</p> <p>Other Residents The ID team reviewed other residents for exposed personal information. No other issues were identified.</p>	

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

TITLE

(X6) DATE

Serald Bose

Executive Director

9/28/15

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

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

TITLE

(X6) DATE

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F 164	<p>Continued From page 1 room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to protect personal medical information for 1 of 9 sample residents (#6). The failure created the potential for a negative effect on the resident's psychosocial well-being. Findings included:</p> <p>On 8/26/15 at 11:49 a.m., before the lunch meal service, LN #7 was observed as she administered one oral medication to Resident #6 in the dining room. The LN then returned to the medication cart in the hallway across from the Administrative offices. A large binder on top of the cart was opened to page 3 of Resident #6's MAR. The exposed page contained the resident's diagnoses, allergies, and listed 4 medications. When asked if the binder was left open with the</p>	F 164		

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F 164	Continued From page 2 resident's personal information exposed, the LN stated, "Yes." The LN then closed the MAR binder.	F 164		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined the facility used physical restraints on a resident without assessment of less restrictive devices/restraints and failed to adequately provide the risks and benefits of a resident's seatbelt and bilateral feet straps. This was true for 1 of 3 (#8) residents sampled for the use of physical restraints and created the potential for harm should residents experience contractures, decreased mobility, and/or skin impairment. Findings included: Resident #8 was admitted to the facility on 7/6/15 with multiple diagnoses, including cerebral palsy (CP), mild intellectual disability, and spastic quadriplegia. The resident's admission MDS assessment, dated 7/13/15, documented: *BIMS score of 13 - Cognition intact; *Total assist of 2 staff for bed mobility, transfers, and dressing; and, *No physical restraints in use.	F 221		

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F 221	Continued From page 3 Resident #8's August 2015 Physician's Orders documented: 7/6/15 - Weekly skin checks. 7/6/15 - OT (Occupational Therapy) evaluate and treat: Motorized wheelchair for safety. 7/6/15 - Occupational and Physical Therapy (PT) evaluation and treatment. 7/6/15 - Resident incapable of making her own health decisions. The resident's PT Plan of Care, dated 7/7/15, documented: * Significant decline in sitting balance, bed mobility, ability to change position and shift weight in wheelchair over last 2-3 years due to cerebral palsy and spastic quadriplegia. * Required skilled therapy to improve self care and functional activities of daily living such as bed mobility, pelvic and trunk stability for safe reaching of upper extremities from the sitting position. * Improve postural alignment and lower extremity strength. * Improve ability to shift weight for repositioning and pressure relief. * Uses adaptive equipment, including motorized wheelchair, mechanical lift, and bilateral ankle braces. The resident's OT Plan of Care, dated 7/8/15, documented: * Requires skilled therapy to improve self care and functional activities of positioning and safety with electric wheelchair. * Positioning precautions related to decreased trunk control and arm function. The resident's Powered Personal Mobility Device	F 221			

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F 221	<p>Continued From page 4</p> <p>Skills Assessment Results completed by PT, dated 7/12/15, did not reflect the resident had a seat belt nor the need for the bilateral ankle braces.</p> <p>Resident #8's Self Care Performance Deficit Care Plan documented: * Limited ROM, limited mobility, quadriplegia, and contractures * Mobility via motorized wheelchair * Non-restrictive wheelchair leg straps to provide secure and safe leg positioning</p> <p>The Care Plan did not include or address a seat belt around the resident's mid section or assessment of the skin under the restrictive devices (seat belt and foot straps).</p> <p>On 8/25/15 at 2:00 PM and 8/27/15 at 9:50 AM, Resident #8 was observed in the Willow Room and the hallway seated in her power wheelchair. The resident had a seat belt clipped around her lower abdominal section and black velcro straps secured around both feet that were secured to each footrest.</p> <p>On 8/27/15 at 10:10 PM, the Physical Therapist stated she asked the resident if she could remove her seat belt, but that the resident was hesitant to release the seat belt as it provided her protection from falling out of the wheelchair. The resident then demonstrated to the PT that she could release the seatbelt by herself. The PT stated the resident could not lean over and remove the foot straps.</p> <p>On 8/27/15 at 10:35 AM, the DNS stated she thought OT had completed assessments for the seat belt and bilateral feet straps, but had not</p>	F 221		

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F 221	Continued From page 5	F 221		
F 246 SS=D	discussed the risks and benefits of the devices with the resident. She stated that discussion would take place immediately by speaking with the resident's authorized representative. 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident's call light was within reach. This was true for 1 of 6 residents reviewed for accommodation of needs and had the potential to cause more than minimal harm if the resident could not summon assistance when needed. Findings included: Resident #3 was admitted to the facility on 7/21/15 with multiple diagnoses including a CVA (Cerebral Vascular Accident) with left sided hemiparesis. The resident's 7/27/15 admission MDS assessment documented the resident required total one to two person assistance for all ADL's. A BIMS was not conducted, the resident was coded as "rarely/never understood" with inattention, disorganized thinking and psychomotor	F 246		

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F 246	Continued From page 6 retardation present continuously without fluctuation. The resident was observed in bed on his side with the call light behind him on 8/24/15 at 2:00 PM, 8/25/15 at 9:50 AM, 8/26/15 at 9:05 AM, and 8/26/15 at 11:50 AM. On 8/27/15 at 9:40 AM, when asked if the residents call light was accessible, the DON said no.	F 246			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, it was determined the facility failed to provide a meaningful activities program designed to meet the interests and needs of 1 of 6 sample residents (#1). The deficient practice had the potential for more than minimal harm if Resident #1 experienced mood changes, boredom, and/or decreased socialization from lack of activities. Findings included: Resident #1 was admitted to the facility in 2012 with multiple diagnoses including Alzheimer's Disease, depression, and history of Cerebrovascular Accident (CVA).	F 248			

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F 248	Continued From page 7 The resident's 8/14/15 annual MDS assessment documented: * Understood others and was understood by others * BIMS score of 6 (severe cognitive impairment) * "Somewhat important" activity preferences included listening to music, news, going outside for fresh, and participating in religious services/practices The resident's care plan identified the need for diversional activities related to dementia, depression, history of working at night, enjoyed independent activities daily, enjoyed group activities 1-2 times per week, outings with family, and being out of his room daily. Each goal was revised 8/28/14. Interventions included, "Depression: ...general loss of interest in things, sad look/ tearfulness, and persistent low mood. Try: 1) toilet 2) redirect 3) offer food and /or fluids 4) activity 5) change position 6) inform nurse of mood changes ... Encourage...group activities: special events, music entertainment, church services in facility ... independent activities: family/friend visits ... plays keyboard in room as desires, reads mail, watches tv as he desires ... comes out of room in afternoons and evenings/nights ..." Resident #1 was observed in his room sitting in his recliner without the TV on at the following times: * 8/25/15 from 10:15 AM to 12:20 PM, 1:30 PM, 4:45 PM, 5:25 PM and 6:00 PM; * 8/26/15 from 9:10 AM to 12:55 PM; and * 8/27/15 at 8:30 AM, 9:30 AM, 10:30 AM, 12:00 PM, 1:15 PM and at 2:20 PM	F 248			

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F 248	Continued From page 8 On 8/25/15 at 10:15 AM, Resident #1 said he would go outside if someone took him, there is "nothing special" to do on weekends, and he "tinkers" with the keyboard in his room. The resident said he does not watch television unless the President of the United States is on. When asked about religious activity, he said he would go if someone took him. A picture of the resident playing chess with a young boy and several VHS (video home system) tapes, but no VHS player, were observed in the resident's room. Review of Resident #1's Daily Activities/Group Activities records for April 2015 through August 2015 revealed there was no documented evidence the resident participated in spiritual activities/church service, outside activities or the "Out and About" activity. Progress Notes for April through August 2015 revealed no documented evidence the facility encouraged or assisted the resident to attend or that the resident refused to attend those activities. On 8/27/15 at 1215, the Activity Director (AD) said the resident watched television and played the keyboard. When asked if she was aware of the resident's chess picture and VHS tapes, the AD replied, "No, I do not know," but the facility had a tape player that could be brought into resident's room. When asked if the resident attended church/spiritual activities on the weekend, the AD said she did not know. She stated, "I am not here on the weekend, I have an assistant who oversees the weekend program."	F 248		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	<p>Continued From page 9</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to revise/update care plans to reflect residents' current status. This was true for 5 of 10 (#'s 2, 4, 5, 6, and 8) sampled residents and had the potential to result in more than minimal harm if residents did not receive appropriate care due to lack of direction in their care plans. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 6/17/14, and readmitted on 1/13/15, with multiple diagnoses, including meningioma.</p> <p>Resident #4's nutritional care plan, revised.</p>	F 280		

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F 280	<p>Continued From page 10</p> <p>4/27/15, documented the need for a nadaptive lip plate for eating; the fall care plan, revised 2/10/2015, documented, "Non skid socks on at all times."</p> <p>a) The resident was observed wearing black shoes and white socks on 8/25/15 and 8/26/15.</p> <p>On 8/27/15, the DON was informed of the observations and asked if the resident should have non-skid socks on at all times. The DON said, "No," but noted the care plan should have been revised when the resident was able to wear sock and shoes.</p> <p>b) On 8/26/15 at 12:15 PM, during the lunch meal service, Resident #4 was observed using a standard plate.</p> <p>During the lunch meal service, the Dietary Manager (DM) was asked if the resident should have a lipped plate. The DM stated the resident had not required a lip plate for two months. The DM said the care plan should have been updated to reflect the change.</p> <p>2. Resident #2 was admitted to the facility on 12/22/14 with multiple diagnoses, including muscle wasting and atrophy, and history of falling.</p> <p>Resident #2's August 2015 Physician's Orders documented she had reached maximum functional potential with Physical Therapy and had been discharged on 6/19/15 to restorative nursing care for ambulation and exercise. There were no Physician's Orders related to bilateral feet splints and a right wrist splint.</p>	F 280		

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F 280	<p>Continued From page 11</p> <p>The resident's current Limited Physical Mobility Care Plan documented:</p> <ul style="list-style-type: none"> *Weakness, at risk for falls, and depression or severe anxiety. *Monitor for complications related to immobility, including contractures, thrombus formation, skin breakdown, and fall related injury. *Provide supportive care/assistance with mobility as needed. Wheelchair for mobility. FWW (front wheel walker) and gaitbelt with therapy. *Bilateral foot splints with schedule. <p>Resident #2's Care Plan did not document the resident was involved in an RNA program or wore a right wrist splint daily.</p> <p>Resident #2's July 2015 & August 2015 Restorative Nurse Aide (RNA) Flow Sheet Record documented she could use the Nu-Step, but that walking was most important. The resident was also to ambulate with the FWW 150 feet and 200 feet.</p> <p>On 8/28/15 at 11:00 AM, OT #5 was interviewed regarding the resident's leg splints and the right hand splint. The OT stated there had been written communication to the nursing staff when therapy discontinued services for the resident. The nursing staff were to apply the right wrist splint daily and the feet splints were to be applied twice a day for an hour. The OT stated this information had been posted, but staff were unable to locate the documentation regarding when the feet splints were to be worn.</p> <p>On 8/28/15 the DNS stated the wrist brace, the feet splints, and the RNA program for Resident #2 should have been addressed on the Care Plan.</p>	F 280			

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F 280	<p>Continued From page 12</p> <p>3. Resident #5 was readmitted to the facility on 8/8/14 with multiple diagnoses, including muscle wasting and atrophy, presence of artificial hip joint, and apraxia.</p> <p>Resident #5's August 2015 Physician's Orders directed staff to walk the resident "more." There was no specific Physician's Order addressing the resident's involvement in the maintenance ADL program instituted after Physical Therapy had been discontinued.</p> <p>The resident's current Fall Risk/ADL Self Care Deficit/Nutrition Deficit Care Plan documented she was to be equipped with an adaptive lip plate for meals. The resident did not have a specific Care Plan related to her placement on an ADL Maintenance Program and was to receive walking assistance to- and from meals, as documented on the August 2015 ADL Flow Sheet Record."</p> <p>On 8/26/15 at 12:00 PM, the resident was observed seated in her wheelchair in the main dining room with a regular plate without lip. The resident said she broke her wrist the previous year and used a lipped plate when she was in a cast.</p> <p>On 8/28/15, the DNS stated the resident's Care Plan should have been revised to include walking to the dining room and removal of the lipped plate.</p> <p>4. Resident #6 was admitted to the facility on 3/13/14 with multiple diagnoses including history of cerebrovascular accident (CVA), left-sided hemiplegia and hemiparesis.</p> <p>Resident #6's August 2015 Physician's Orders</p>	F 280		

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F 280	<p>Continued From page 13</p> <p>documented the resident was to receive a Physical Therapy three times weekly for 12 weeks. There was no specific Physician's Order addressing the RNA program after PT completed their evaluation and treatment.</p> <p>Resident #6's August 2015 RNA Flow Sheet Record documented the use of a Nu-Step and directed staff to walk the resident with a quad cane and increase distances as tolerated.</p> <p>The resident's Nursing Progress Notes contained only one entry detailing the resident's progress in the RNA program from 5/28/15 through 8/25/15.</p> <p>The resident's current Self Care/ADL Deficit and Physical Mobility Impairment Care Plan documented contractures affecting the left upper extremity, CVA with limited hemiparesis, and unsteady gait. Interventions included therapeutic exercises, Nu-Step, and ambulation along hand rails with quad cane. The Care Plan did not address how often the Nu-Step was to be used, how often/distance the resident was to be ambulated, or that the resident required an adaptive lipped plate at meals to enable independent dining.</p> <p>On 8/25/15 at 5:45 PM and 8/26/15 at 12:20 PM, the resident was observed in the dining room eating independently from a white lipped plate. The resident's meal card documented the use of an adaptive lipped plate.</p> <p>On 8/28/15, the DNS said she was aware the resident's Care Plan needed to be updated.</p> <p>5. Resident #8 was admitted to the facility on 7/6/15 with multiple diagnoses, including cerebral</p>	F 280			

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F 280	<p>Continued From page 14</p> <p>palsy (CP) and spastic quadriplegia.</p> <p>Resident #8's August 2015 Physician's Orders documented weekly skin checks, OT evaluation and treatment, use of a motorized wheelchair, and PT/OT evaluations and treatment.</p> <p>The resident's PT Plan of Care, dated 7/7/15, documented:</p> <ul style="list-style-type: none"> * Significant decline in sitting balance, bed mobility, ability to change position and ability to shift weight in wheelchair due to cerebral palsy and spastic quadriplegia. * Required skilled therapy to improve self care and functional activities of daily living, such as bed mobility, and pelvic and trunk stability. * Uses adaptive equipment, including motorized wheelchair, mechanical lift, and bilateral ankle braces. <p>The resident's OT Plan of Care, dated 7/8/15, documented:</p> <ul style="list-style-type: none"> * Required skilled therapy to improve self care and functional activities of positioning and safety with electric wheelchair. * Positioning precautions related to decreased trunk control and arm function. <p>The PT and OT Plans of Care addressed the resident's decreased trunk control, but did not document the resident had a seat belt in place nor the need for bilateral feet/ankle straps.</p> <p>Resident #8's Self Care Performance Deficit and Skin Impairment Care Plan documented:</p> <ul style="list-style-type: none"> * Limited ROM, limited mobility, quadriplegia, and contractures. * Turn/reposition every 2 hours. * Mobility via motorized wheelchair. 	F 280		

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F 280	Continued From page 15 * Non-restrictive wheelchair leg straps to provide secure and safe leg positioning. The Care Plan did not include or address a seatbelt around the resident's midsection or assessment of the skin under the restrictive devices (seatbelt and bilateral foot straps). On 8/25/15 at 2:00 PM and 8/27/15 at 9:50 AM, Resident #8 was observed in the Willow Room and hallway seated in her power wheelchair. The resident had a seatbelt clipped around her lower abdominal section and black velcro straps secured around both feet and secured to each footrest.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure staff adhered to professional standards of practice for 1 of 9 sampled residents (#1) and one random resident (#11). This failure created the potential for harm when Flomax was not administered as ordered and when a LN used incorrect hand washing technique while caring for Resident #11. Findings included: 1. Resident #1 was admitted to the facility in 2012 with multiple diagnosis, including benign prostatic hypertrophy (BPH).	F 281		

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F 281	<p>Continued From page 16</p> <p>On 8/26/15 at 9:15 AM, during the morning med pass, LN #4 said she already provided Resident #1's morning medications. When asked if Flomax 0.4 mg was included on the medications given, LN said, "Yes, all medications were given before his breakfast."</p> <p>Resident's #1 Physician Orders documented the Flomax was to be given to the resident daily 30 minutes following a meal.</p> <p>The 2016 Nursing Drug Handbook documented, "... once daily given 30 minutes after same meal each day."</p> <p>2. On 8/26/15 at 9:20 a.m., LN #7 was observed setting up and then administering a breathing treatment to Resident #11. In the resident's room, the LN washed her hands, turned off the faucet with paper towels then tried her hands with the same paper towels before she set-up the treatment. The LN used the same hand washing technique after the breathing treatment.</p> <p>Immediately afterward, the LN was informed of the 2 observations and asked about the handwashing technique. The LN thought a moment then said she turned off the faucet and dried her hands with the same paper towel.</p> <p>Clinical Nursing Skills & Techniques, 8th edition by Perry and Potter, documented the following steps (and rationale) regarding handwashing, "...Wet hands and wrists...Apply...antiseptic soap...Perform hand hygiene...Rinse hands and wrists...Dry hands thoroughly from fingers to wrists with paper towel, single-use cloth, or warm</p>	F 281			

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F 281	Continued From page 17 air dryer. If used, discard paper towel...(Prevents transfer of microorganisms.) To turn off hand faucet, use clean, dry paper towel...(Wet towel and hands allow transfer of pathogens from faucet by capillary action.)"	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to ensure physicians orders were followed for 5 of 10 sampled residents (#2, 3, 4, 5 and 7). *Resident #3 was at risk for nutritional deficient when his "continuous" tube feeding was stopped repeatedly and for prolonged times; and at risk for eye/skin irritation when his eyes were taped open without physician's orders. *Resident #2 was at risk for skin breakdown when hand/feet splints were in place without a physician's order or monitoring. *Resident #4 was at risk for lower extremity edema when physician-ordered "tubigrips" were not in place. *Resident #5 was at risk for complications related to a fracture when a wrist brace was not in place as ordered. *Resident #7 was at risk for complications related	F 309		

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F 309	<p>Continued From page 18</p> <p>to dialysis when an access device/site was not monitored and post-dialysis care was not provided.</p> <p>These failures created the potential for more than minimal harm for the residents. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 7/21/15 with multiple diagnoses, including dysphagia.</p> <p>The resident's 7/27/15 admission MDS assessment coded the resident was rarely/never understood, total assistance was needed for all ADL's, and all caloric/nutritional intake was via tube feeding.</p> <p>Resident #3's care plan documented altered nutritional status, NPO, and all nutritional needs were to be met through enteral feedings.</p> <p>Resident #3's August 2015 recapitulated Physician's Orders included NPO and continuous tube feeding at 83 ml (milliliters) per hour via percutaneous endoscopic gastrostomy (PEG) tube.</p> <p>The care plan and physician orders did not include holding the tube feeding or taping the resident's eyes open.</p> <p>a) Resident #3's physician ordered continuous tube feeding was observed either disconnected or paused as follows: *8/25/15 from 11:10 AM to 11:20 AM, and from 2:30 PM to 3:15 PM. *8/26/15 from 9:30 AM to 9:45 AM and from 11:50 AM to 11:55 AM.</p> <p>On 8/26//15, LN #1 said the resident's tube</p>	F 309		

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F 309	<p>Continued From page 19</p> <p>feeding was "disconnected for transfers and during therapy, but the tube feeding is continuous 24 hours."</p> <p>On 8/26/15, the Registered Dietician (RD) #8 and DDCO were informed of the observations. When asked if the physician's order for continuous tube feeding was followed when Resident #3's tube feeding was disconnected for 45 minutes and/or paused multiple times, both said, "No." The RD stated that there would be a minimal effect if the feeding was stopped for 45 minutes to an hour.</p> <p>b) On 8/25/15 at 11:10 AM, Resident #3's eyes were observed taped open with adhesive tape during a therapy session with COTA #5. At 11:20 AM, LN #1 said the Physical Therapist (PT) tapes the resident's eyes open during therapy sessions.</p> <p>On 8/26/15, when asked who directed taping Resident #3's eyes open, PT #3 stated, "PT." The PT was asked to provide a physician order to tape Resident#3's eyes open. PT #3 said a physician order was not needed because taping the resident's eyes open was an intervention.</p> <p>On 8/27/15, PT #9 said that taping Resident #3's eyes open was part of "eval and treat." PT #9 added, "It is a modification of body parts just like moving his hand."</p> <p>On 8/28/15, OT #10 was asked if she taped Resident #3's eyes open. The OT said, "No." When asked if she provided direction to her staff to tape the resident's eyes open, the OT said, "Yes." The OT said there were no documented directions, care plan intervention, or physician's order to tape the resident's eyes open.</p>	F 309			

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F 309	<p>Continued From page 20</p> <p>2. Resident #4 was admitted to the facility on 6/17/14, and readmitted on 1/13/15, with multiple diagnoses, including edema.</p> <p>Resident #4's August 2015 recapitulated Physician Order's documented the use of tubigrips to both legs every morning for edema. The tubigrips were to be removed at bedtime.</p> <p>The August 2015 Treatment Record documented tubigrips were in place August 1-5 and August 10; all other spaces were blank during August.</p> <p>Resident #4 was observed without tubigrips on his lower extremities on 8/25/15 at 2:30 PM and 8/26/15 at 9:20 AM.</p> <p>On 8/25/15, when asked about the tubigrips for his legs, the resident said he quit wearing the tubigrip socks because his legs were not improving.</p> <p>On 8/26/15, LN #1 acknowledged the resident's tubigrips were not in place.</p> <p>On 8/28/15 at 8:50 AM, the resident was observed wearing tubigrips on both legs.</p> <p>2. Resident #7 was admitted to the facility on 12/19/13 with multiple diagnoses, including chronic renal insufficiency with dialysis treatment.</p> <p>The August 2015 Physician's Orders documented the resident was not to receive blood pressure medications prior to dialysis every Monday, Wednesday, and Friday.</p> <p>Resident #7's current Hemodialysis Care Plan</p>	F 309		

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F 309	<p>Continued From page 21</p> <p>documented: *End stage renal failure and AV (arteriovenous) fistula in the left lower arm. *Check complete dialysis communication log record on return from dialysis appointments for any reports. *If bleeding occurs at shunt site, apply pressure to site for 15-20 minutes. If bleeding does not stop, transport to the emergency room for assistance.</p> <p>The Dialysis Communication Log was completed for the resident's dialysis appointments in June, July, and August 2015. The Communication Log had a place for the LNs to document the resident's vital signs, weight, and any abnormalities or notes for the dialysis center.</p> <p>The facility's Dialysis Log included spaces to document the resident's vital signs, weight, daily site care, signs and symptoms of infection, the presence of the bruit or thrill, and post-dialysis check of the shunt site for bleeding, pain, redness, swelling every hour for 6 hours. The Dialysis documented: *June 2015 - All information was documented except for the post-dialysis hourly checks for six hours. The Log documented the resident was checked hourly for 3 hours on most of those days he/she received dialysis. The resident did not have documented daily site care or documented assessments of the thrill and bruit. *July and August 2015 - The facility did not provide any documentation the resident received his dialysis treatment or that his site was monitored.</p> <p>On 8/27/15, the DNS and DDCO were interviewed regarding the dialysis daily care and</p>	F 309		

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F 309	<p>Continued From page 22</p> <p>post-dialysis site care for Resident #7. The DDCO stated the facility was unable to provide the Dialysis Log documentation for the months of July and August 2015 to reflect daily site care had been provided, infection assessments had been performed, presence of bruit and thrill had been assessed, or that hourly post-dialysis shunt site checks had taken place for 6 hours after dialysis treatment.</p> <p>3. Resident #2 was admitted to the facility on 12/22/14 with multiple diagnoses including muscle wasting and atrophy.</p> <p>The August 2015 Physician's Orders documented the resident had reached maximum functional potential with Physical Therapy and was to receive Restorative Nursing Care for ambulation and exercise.</p> <p>The OT Plan of Care included a physician's order for bilateral feet splints and a right wrist splint, however the order did not document when the splints were to be worn or how/when they were to be monitored.</p> <p>The resident's current Limited Physical Mobility Care Plan documented a schedule of use for the bilateral foot splints, but did not include direction to staff for the right hand splint.</p> <p>On 8/25/15 at 3:00 PM, the resident was observed on her bed with a brace on her right arm, which she said she wore for support. When asked about leg braces that were observed behind a nightstand, the resident stated she wore the braces when she was out of bed and in her wheelchair, but she could not walk with them on.</p>	F 309		

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F 309	Continued From page 23 On 8/28/15, OT #5 stated written communication to nursing staff when therapy had been discontinued directed nursing staff to apply the right wrist splint daily and the feet splints were twice a day for an hour. OT #5 stated the facility could not now locate that documentation. On 8/28/15, the DNS stated she should have received a physician order for the hand splint and the leg splints, and implemented the monitoring of those devices, when nursing staff took over that care from OT. 4. Resident #5 was readmitted to the facility on 8/8/14 with multiple diagnoses including muscle wasting and atrophy, presence of artificial hip joint, and apraxia. The August 2015 Physician's Orders documented Resident #5's right wrist brace was to be kept in place and could be removed only for washing. On 8/26/15 at 12:00 PM, the resident was observed seated in her wheelchair in the main dining room without a brace on her right wrist. The resident stated she had broken her wrist the previous year and the arm had been in a cast, but it was now healed and she did not need to wear it now. On 8/28/15, the DNS stated the facility should have asked the resident's physician to discontinue the brace.	F 309			
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	F 311			

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F 311	<p>Continued From page 24 specified in paragraph (a)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure 3 of 9 sampled residents (#s 2, 5, & 6) were provided restorative or maintenance services to prevent decline and to restore and/or maintain their current levels of functional ability. This deficient practice had the potential for harm if residents experienced a decline in their ability to perform activities of daily living. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 12/22/14 with multiple diagnoses including muscle wasting and atrophy, major depression, and history of falling.</p> <p>The resident's quarterly MDS assessment, dated 7/7/15, documented: *Intact cognition; *Extensive assist of 1 staff for dressing, toileting, and bathing; and, *Frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>August 2015 Physician's Orders discharged Resident #2 on 6/19/15 to Restorative Nursing care for ambulation and exercise as the resident had reached "maximum functional potential with Physical Therapy."</p> <p>The resident's current Care Plan documented limited physical mobility related to weakness, at risk for falls, and depression or severe anxiety. The Care Plan directed staff to monitor for</p>	F 311		

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F 311	<p>Continued From page 25</p> <p>complications related to immobility, including contractures, thrombus formation, skin breakdown, and fall related injury; provide supportive care and assistance with mobility as needed; wheelchair for mobility; and FWW (front wheel walker) and gaitbelt with therapy. Resident #2's Care Plan did not document the resident was involved in the RNA program. (Refer to F280 as it relates to Care Plans).</p> <p>Resident #2's Restorative Nurse Aide (RNA) Flow Sheet Record documented: * Ambulate ... with front wheel walker (FWW) 150 feet and 200 feet. In July 2015, staff documented the resident did this 18 times out of 31 opportunities and refused on 3 occasions. * Ambulate with contact guard with FWW 150 feet and 200 feet. In August 2015, staff documented the resident ambulated with FWW 6 times out of 28 opportunities. The resident refused on 1 occasion in August.</p> <p>On 8/24/15 at 2:20 PM and 4:00 PM, 8/25/15 at 10:20 AM, 3:00 PM, and 5:45 PM, and on 8/26/15 at 10:05 AM and 12:05 PM, the resident was observed in her wheelchair or her bed. The resident was not observed participating in RNA ambulation services on any of those three days. When asked, Resident #2 stated she used her FWW to go to the bathroom in her room.</p> <p>2. Resident #6 was admitted to the facility on 3/13/14 with multiple diagnoses including history of cerebrovascular accident (CVA), hemiplegia and hemiparesis, and depression.</p> <p>The resident's quarterly MDS assessment, dated 6/30/15, documented: *Intact Cognition;</p>	F 311		

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F 311	<p>Continued From page 26</p> <p>*Extensive assist of 1 staff for dressing, transferring, toileting, and bathing; and, *Always incontinent of bladder and bowel.</p> <p>Resident #6's August 2015 Physician's Orders documented on 3/19/14 that PT (Physical Therapy) was to evaluate and treat 3 times a week for 12 weeks. Treatment option included gait training, therapeutic exercise and activities, modalities, neuromuscular re-education, and patient/family/staff instruction.</p> <p>There was no specific Physician's Order addressing the RNA program for Resident #6.</p> <p>The resident's current Care Plan documented impaired physical mobility related to contractures of the left upper extremity, CVA with limited hemiparesis, and unsteady gait. Interventions included Restorative Nursing programs to maintain physical function, therapeutic exercises and Nu-Step, and ambulation along hand rails with a quad cane. Additionally, RNA was to ambulate the resident using an assistive device.</p> <p>Resident #6's Restorative Nurse Aide (RNA) Flow Sheet Record documented in July 2015 that the resident completed the Nu-Step 20 times out of 31 opportunities, and ambulated with a quad cane 18 times out of 31 opportunities. The resident refused RNA services on 1 occasion.</p> <p>In August 2015, nursing staff documented the resident completed the Nu-Step 9 times out of 28 opportunities, ambulated with a quad cane 8 times out of 25 opportunities, and did not refuse any RNA services.</p>	F 311		

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F 311	<p>Continued From page 27</p> <p>The resident's Nursing Progress Notes documented on 7/20/15, "This resident is doing well with his restorative programs. His first program is the Nu-Step. He is also on a restorative ambulation program ... walks 150 ft along the hand rails in the halls with the quad cane. He is maintaining his functional status." This Nursing Progress Note was the only documentation from 5/28/15 through 8/25/15 that mentioned the restorative program.</p> <p>On 8/24/15 at 2:05 PM, 8/25/15 at 10:35 AM, 11:40 AM, 1:30 PM, 3:15 PM, and 5:45 PM, 8/26/15 at 11:45 AM and 12:20 PM, the resident was observed in his wheelchair. The resident was not observed on the Nu-Step or being ambulated with his FWW during these three days.</p> <p>On 8/27/15, the DNS stated she had recently taken charge of the RNA and nursing maintenance programs. She said the facility had some staffing challenges in August and some nursing functions were not provided. The DNS stated RNA and Maintenance Flow Sheet Records documenting tasks were not performed were accurate.</p> <p>3. Resident #5 was readmitted to the facility on 8/8/14 with multiple diagnoses, including muscle wasting and atrophy, presence of artificial hip joint, depression, and apraxia.</p> <p>The resident's quarterly MDS assessment, dated 7/13/15, documented: *Intact Cognition; *Extensive assist of 1 staff for locomotion on- and off the unit and bathing; *Limited assist of 1 staff for dressing, walking in room, and personal hygiene; and,</p>	F 311		

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F 311	<p>Continued From page 28</p> <p>*Frequently incontinent of bladder and always continent of bowel.</p> <p>Resident #5's August 2015 Physician's Orders documented the resident was to be walked "more," PT was to evaluate and treat for gait instability. There was no specific Physician's Order addressing the maintenance ADL program for Resident #6.</p> <p>The current Care Plan documented Resident #5 was at moderate risk for falls related to gait/balance problems, incontinent, had a history of falls, and received psychoactive medications. The resident also had an ADL self care performance deficit related to left hip replacement and arthritis. Interventions included the provision of activities promoting movement and increasing strength, staff assistance with ADLs, and encouraging the resident to use a call light for assistance. The resident did not have a specific Care Plan addressing her placement on a Maintenance Program.</p> <p>Resident #5's ADL Flow Sheet Record documented in August 2015 that the resident self-propelled in a wheelchair and was to walk to the dining room with one staff assist to and from meals using FWW. Nursing staff documented the resident did this 25 times out of 25 opportunities and the resident had no refusals.</p> <p>On 8/24/15 at 2:25 PM and 4:00 PM, 8/26/15 at 9:20 AM, 11:45 AM, and 12:00 PM, and 8/27/15 at 11:50 AM, the resident was observed in her wheelchair or bed. The resident was not observed to be walked to the dining room for her meals. On 8/26/15 at 12:00 PM and 8/27/15 at 11:50 AM, Resident #5 stated she likes to walk,</p>	F 311		

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F 311	Continued From page 29 but she had become "tired of fighting them over it." The resident stated on 8/26/15 at 12:00 PM that she had waited for staff to walk her to the dining room until a physical therapist instead wheeled her to the dining room in her wheelchair. The resident stated it was the therapist who told her to walk more, but then did not offer the necessary assistance. Resident #5 stated her walking times were very brief and she did not want to "bother" staff since they were "so busy." On 8/28/15, CNA #2 stated she signed the ADL Flow Sheet Record at the end of shift if the resident propelled herself and/or if the CNA walked or wheeled the resident in her wheelchair. CNA #2 said the resident was often already in the dining room or hallway propelling herself in her wheelchair, so the CNA often would not document she had been walked.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure showers and/or baths were consistently provided for 3 of 7 residents (#s 1, 2, & 6) reviewed for ADL assistance. This deficient practice had the potential for more than minimal harm if residents experienced rashes, skin issues and/or	F 312		

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F 312	<p>Continued From page 30</p> <p>unpleasant odors due to not being bathed regularly. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 12/22/14 with multiple diagnoses, including muscle wasting and atrophy, major depression, and history of falling.</p> <p>The resident's quarterly MDS assessment, dated 7/7/15, documented: *Intact cognition; *Extensive assistance of 1 staff for dressing, toileting, and bathing; and, *Frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>The facility's Shower List documented the resident was to be showered on Mondays and Thursdays on the evening shift. The bath aides were to document any refusals and the LNs were to review baths that were being done in the morning and evening.</p> <p>The ADL Flow Sheet Record documented the resident was to be showered/bathed with shampoo twice weekly, and her fingernails and toenails were to be checked and cleaned.</p> <p>Resident #2's shower/bath Flow Sheet Record documented: *June 2015 - The resident was not bathed for 10 days, from 6/8/15 until 6/18/15. The resident refused a bath/shower on 8/11/15, but was not offered or given another bath/shower for 7 days. The resident did not bathe for 7 days, from 6/22/15 until 6/29/15. The resident did not refuse any baths/showers during this period. *July 2015 - The resident was not bathed for 11 days, from 7/23/15 until 8/3/15. The resident did</p>	F 312			

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F 312	<p>Continued From page 31</p> <p>not refuse a bath/shower during this time.</p> <p>*August 2015 - The resident was not bathed for 11 days, from 8/6/15 until 8/17/15. The resident refused a bath/shower on 8/10/15, but was not offered or given another bath/shower for 7 days.</p> <p>Nursing Progress Notes did not address whether the LNs discussed the refusals or lack of bathing with the resident.</p> <p>On 8/27/15, the DNS said the resident missed showers on her scheduled days. She stated she expected CNAs to document resident refusals and reapproach at a later time or another day when the resident refused, which she could see was not being done.</p> <p>2. Resident #6 was admitted to the facility on 3/13/14 with multiple diagnoses including hemiplegia and hemiparesis, and depression.</p> <p>The resident's quarterly MDS assessment, dated 6/30/15, documented: *Intact Cognition; *Extensive assistance of 1 staff for dressing, transferring, toileting, and bathing; and, *Always incontinent of bladder and bowel.</p> <p>The facility's Shower List documented the resident was to be showered on Tuesdays and Saturdays on the evening shift. The bath aides were to document any refusals and the LNs were to review baths that were being done during day and evening shifts.</p> <p>Resident #6's shower/bath Flow Sheet Record documented: *June 2015 - The resident did not bathe for 9 days, from 6/1/15 until 6/9/15. The resident did</p>	F 312		

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F 312	<p>Continued From page 32</p> <p>not refuse a bath/shower during this time. The resident also was not bathed for 11 days, from 6/13/15 until 6/20/15. The resident refused a bath/shower on 6/16/15, but was not offered or given another bath/shower for 4 days.</p> <p>*July 2015 - The resident was not bathed for 7 days, from 7/4/15 until 7/11/15. The resident did not refuse a bath/shower during this time. The resident did not bathe for an additional 7 days, from 7/11/15 until 7/18/15. The resident refused a bath/shower on 7/14/15 and 7/16/15, but was not reapproached at a different time or asked why he had refused.</p> <p>*August 2015 - The resident was not bathed for 14 days, from 8/11/15 until 8/26/15. The resident did not refuse a bath/shower during this time period.</p> <p>There were no Nursing Progress Notes to address whether the LNs had addressed the lack of bathing or refusals.</p> <p>On 8/27/15 at 10:35 AM, the DNS said she was aware there was an issue with bathing and that the Performance Improvement Team was investigating the refusals and re-evaluating the bath/shower schedule to resolve the concerns.</p> <p>3. Resident #1 was admitted to the facility in 2012 with multiple diagnoses, including Alzheimer's Disease, depression, and history of cerebrovascular accident (CVA).</p> <p>The resident's most recent quarterly MDS assessment, dated 5/22/15, documented severe cognitive impairment, no rejection of cares, and</p>	F 312		

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F 312	<p>Continued From page 33 extensive assistance of 1 staff for bathing.</p> <p>Resident #1's annual MDS assessment, dated 8/14/15, documented severe cognitive impairment, rejection of cares occurred 1-3 days, and bathing did not occur during the previous two weeks.</p> <p>The current Care Plan documented, "Resident will take at least 1 bath a week." Interventions included set-up assistance with bathing.</p> <p>The Resident's ADL Flow Sheet for June, July, and August 2015 recorded the resident was to receive a shower or bath twice a week and documented::</p> <p>*June 2015 -1 bath and 3 refusals: The resident was not bathed for 12 days (6/1-6/12) and 17 days (6/14-6/30). There was no documented indication the resident was reapproached or offered to bathe at a different time or day for 2 of the 3 refusals.</p> <p>*July 2015- 2 baths and 4 refusals: The resident was not bathed for 9 days (7/2-7/10). Per Nursing Progress Notes, dated 7/8/15, the resident stated, "I just don't feel like it tonight, I will tomorrow." There was no documentation the resident was offered or encouraged to bathe the next day. The resident was not bathed for 13 days (7/12-7/24), and no refusals were documented.</p> <p>*August 2015- 2 baths and 4 refusals: The resident was not bathed for 17 days (8/1- 8/17). There was no documented evidence the resident was reapproached to bathe at different time or day for 3 of the 4 refusals.</p> <p>On 8/27/15, the DON said she was aware the resident frequently refused to bathe and noted the resident's family indicated on 8/18/15 that a</p>	F 312			

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F 312	Continued From page 34	F 312		
F 329 SS=D	<p>specific family member should be called whenever the resident refused bathing.</p> <p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility fauled to ensure residents were free from unnecessary medications. This was true for 1 of 6 sample residents (#1). Failure to follow pharmacist</p>	F 329		

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F 329	<p>Continued From page 35</p> <p>recommendation for orthostatic blood pressure checks had the potential to cause declines if residents experienced negative effects from receiving a medication for which there was no clear clinical indication. Findings included:</p> <p>Resident #1 was admitted to the facility in 2012 with multiple diagnoses, including hypertension.</p> <p>An Incident and Accident report, dated 5/7/15, documented the resident complained of right hip and right lower back pain, and thought he fell the previous day, but did not tell anyone. Vital Signs documented on the Incident and Accident report were dated 5/4/15, three days before the reported unwitnessed fall. The facility's Incident Investigation policy directed staff to complete neurological checks for unwitnessed falls. The 5/4/15 report did not include documentation of the resident's vital signs.</p> <p>Nursing Notes dated 5/8/15 documented "...this [morning] resident without complaints of pain in his hip area. Will do 15 minute checks [for] 72 hours to watch for any other concerns."</p> <p>Recapitulated Physician 's Orders for August 2015 documented Resident #1 received Norvasc for hypertension; Coreg, which was to be given with food to minimize potential orthostasis; Cozaar; and Lasix.</p> <p>A pharmacy report, dated 6/11/15, documented, "No medication changes are recommended because of this fall. If you think they can be done safely, please consider doing two sets of orthostatic blood pressure/pulse, one an hour or two after he receives his morning medications and the other between supper and bedtime."</p>	F 329		

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F 329	Continued From page 36	F 329		
F 334 SS=D	<p>When asked on 8/27/15 whether the pharmacist's recommendation of Orthostatic BPs and pulse (PR) were completed, the DON replied, "None that I know of."</p> <p>On 8/27/15, the DON, said she could not find the neurocheck and vital signs documentation for the resident. When asked what the facility's policy required related to the unwitnessed fall, the DON stated, "Neurochecks! Yes, that is an issue."</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the</p>	F 334		

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F 334	<p>Continued From page 37</p> <p>influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p>	F 334		

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F 334	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to offer the influenza vaccine during the flu season (October 1 to March 31). This was true for 1 of 5 sample residents (#1) reviewed for influenza vaccination. This failure created the potential risk the development and spread of infections in the facility. Findings include: Resident #1 was admitted to the facility in 2012 with multiple diagnoses, including hypertension, Alzheimer's Disease, depression and history of Cerebrovascular Disease (CVA). On 8/27/15, the facility was asked to provide documentation that Resident #1 was offered- received- or refused an influenza immunization in 2014. On 8/28/15, the DON stated documentation regarding the 2014 influenza immunization for Resident #1 could not be found.	F 334		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

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F 441	<p>Continued From page 39 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to ensure contact precautions were implemented as ordered; TB (tuberculosis) screenings were completed; tube feeding syringes and measuring cups were changed daily; and that staff performed hand hygiene before and after injections and following resident contact. This was true for 3 of 9 sample residents (#s 3, 4 & 9) and 1 random resident (#13). The failures created</p>	F 441		

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F 441	<p>Continued From page 40</p> <p>the potential for infections to develop and spread in the facility. Findings include:</p> <p>1. Resident #9 was admitted to the facility on 8/21/15 with multiple diagnoses, including urinary tract infection (UTI).</p> <p>The resident's 8/21/15 Admission Orders included, "Contact Precautions: MRSA [Methicillin-resistant Staphylococcus aureus]."</p> <p>On 8/24/15, a rack with personal protective equipment (PPE) was observed on the wall in the hallway next to Resident #9's door. There was no signage on or near the resident's door for visitors and staff to check with the nurse before entering the room.</p> <p>On 8/25/15, a sign which read, "STOP," and instructed visitors and staff to check with the nurse before entering the room was observed on the resident's door.</p> <p>On 8/28/15, the RN Supervisor (RNS) confirmed the resident was in isolation and that contact precautions were initiated on 8/24/15. The RNS said it was not initially clear if MRSA was in the resident's urine or nare (nostril), but on 8/24/15 she received a hospital laboratory report, dated 8/15/15, which documented MSRA was positive in the resident's left nare; and on 8/25/15, she received a final urine culture report, dated 8/18/15, that was negative for infection. The RNS said she was not on duty on 8/21/15 when the DON admitted the resident.</p> <p>On 8/28/15 at 2:15 p.m., the DON said contact precautions were not started on 8/21/15 because the physician thought the MRSA was "colonized"</p>	F 441		

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F 441	<p>Continued From page 41</p> <p>in the residents nare. When asked if the order for contact precautions was discontinued, the DON stated, "No."</p> <p>The contact precautions were not implemented for 3 days after they were ordered.</p> <p>2. During a medication pass on 8/25/15 at 4:00 p.m., an LN was observed placing the cap off a bottle of artificial tears right side up on top of Resident #12's dresser before administering artificial tears into the resident's eyes. The LN did not sanitize the top of the dresser or utilize a barrier under the cap.</p> <p>Immediately afterward, the LN was asked what she did with the cap when she administered the resident's eye drops. The LN stated, "Oh, I sat it on the dresser. Yes I did."</p> <p>3. On 8/25/15, LN #1 was observed as she sanitized her hands, donned gloves, and prepared an insulin medication for subcutaneous injection for Resident #9. The LN then removed her gloves and took the insulin flex pen into the resident's room. In the resident's room, the LN did not perform hand hygiene before she applied new gloves and administered the insulin by injection. After the medication administration, the LN removed her gloves, left the resident's room and returned to the medication cart. The LN did not wash or sanitize her hands before or after she gave the insulin injection.</p> <p>When informed of the observation regarding the insulin administration for Resident #9, LN #1 stated she had sanitized her hands and wore gloves when she set-up the insulin pen.</p>	F 441		

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F 441	Continued From page 42 4. Resident #3 was admitted to the facility on 7/21/15 with multiple diagnoses including CVA. On 7/21/15, Resident #3's Admission Orders documented the resident was to receive a TB (tuberculosis) screening upon admission and continuous tube feedings via the percutaneous endoscopic gastrostomy (PEG) tube. a) The resident's July and August 2015 Medication Records documented the first step of the TB screening was administered 7/23/15 and was negative when read five days later on 7/28/15. The PPD 2nd step scheduled for 8/12/15 was not completed. On 8/28/15, the Staff Development Coordinator (SDC) said the second step of the resident's TB screening was not performed within 30 days after admission per standard practice or the facility's policy. b) On 8/26/16 at 11:50 AM, PT #3 was observed as she applied Resident #3's shoes and then transferred the resident to his wheelchair. The PT did not perform any type of hand hygiene before she opened the door, left the room, and walked to the speech therapy (ST) office. Immediately afterward, the PT was asked about hand hygiene. The PT said she would do it right then. 5. Resident #4 was admitted to the facility on 6/17/14, and readmitted on 1/13/15, with multiple diagnoses including meningioma.	F 441		

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F 441	Continued From page 43 The resident's August 2015 Physician's Orders included a 1/14/15 order for a TB screening. Review of the resident's clinical records revealed there was no evidence the resident had been screened for TB. On 8/28/15, when asked whether the resident received his physician-ordered TB screening, the DON stated, "No, he might not have. We are still looking for it."	F 441		
F 490 SS=E	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, resident and staff interviews, and medical record review, it was determined the facility failed to administer resources effectively and efficiently to prevent systematic problems for 9 of 10 sampled residents (#s 1-9) and 3 random residents (#s 11-13). This failure had the potential to affect all residents in the facility and resulted in the management team providing insufficient direction and control necessary to ensure residents' Quality of Life and Quality of Care needs were met. Findings included: The facility failed to provide sufficient	F 490		

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F 490	<p>Continued From page 44 implementation, monitoring, evaluation, and continued oversight to maintain regulatory compliance in the following areas:</p> <p>A. Refer to F221 - The facility failed to ensure residents with restrictive devices were assessed for the safety of these devices and the resident or resident's representative were informed of the risks and benefits of a seatbelt and bilateral feet straps.</p> <p>B. Refer to F246 - The facility failed to ensure a resident's call light was within reach and the resident assessed for ability to activate a call light.</p> <p>C. Refer to F248 - The facility failed to ensure activities were meaningful and individualized for a resident.</p> <p>D. Refer to F309 - The facility failed to ensure Physicians' orders were followed, assessment of a dialysis access site was monitored, and medications clarified for a resident who was NPO (nothing orally by mouth).</p> <p>E. Refer to F310 - The facility failed to ensure residents received consistent restorative and maintenance nursing services to maintain or improve their ADL functioning.</p> <p>F. Refer to F312 - The facility failed to ensure residents were bathed on a consistent basis.</p> <p>G. Refer to F329 - The facility failed to ensure residents were not administered medications without proper monitoring.</p> <p>H. Refer to F441 - The facility failed to ensure</p>	F 490		

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F 490 F 514 SS=E	<p>Continued From page 45 residents were provided the necessary care and treatment to minimize the risks and prevent the spread of infectious diseases.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to maintain clinical records for each resident that were complete and accurate. This was true for 4 of 10 sample residents (#s 1, 2, 7, & 8) and created the potential for medical decisions to be based on incomplete or inaccurate information, which increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 12/22/14 with multiple diagnoses, including muscle wasting and atrophy, major depression, and diabetes.</p>	F 490 F 514		

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F 514	<p>Continued From page 46</p> <p>The resident's current Care Plan documented potential for nutritional deficits related to depression, diabetes, variable intake, and bouts of nausea, and directed staff to encourage oral intake and fluids, as well as offer and document bedtime (HS) snacks.</p> <p>Resident #2's ADL Flow Sheet documented: * July 2015 - The resident accepted an HS snack 18 times and refused 10 times out of 31 opportunities. * August 2015 - The resident accepted a snack 5 times and refused 8 times out of 25 opportunities.</p> <p>On 8/25/15, Resident #2 stated she has never been a big eater and does not have much of an appetite. The resident said she always has snacks available in her room and staff frequently encouraged her to eat something.</p> <p>On 8/28/15, evening shift LN #4 stated the HS snack/hydration cart is sent out nightly at approximately 7:30 PM. She said CNAs are responsible for passing HS snacks and drinks, but if they are busy then she will ensure residents are offered something from the cart. LN #4 stated Resident #2 is offered a Boost drink every night, which she routinely accepts, and another snack, which she often declines.</p> <p>2. Resident #7 was admitted to the facility on 12/19/13 with multiple diagnoses including chronic renal insufficiency and diabetes.</p> <p>The resident's August 2015 Physician's Orders documented the resident could not leave the facility on "pass."</p>	F 514		

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F 514	<p>Continued From page 47</p> <p>Resident #7's Care Plan documented a need for diversional activities related to a history of depression and directed staff to encourage participation in out-of-facility opportunities with friends, family, or as part of a group.</p> <p>On 8/24/15, Resident #7 stated he was very active at the facility and had gone fishing with other residents, as well as on numerous outings with friends and family.</p> <p>On 8/27/15, the DNS stated the resident was able and safe to leave the facility on pass.</p> <p>3. Resident #8 was admitted to the facility on 7/6/15 with multiple diagnoses including cerebral palsy and severe dysphagia.</p> <p>The resident's August 2015 Physician's Orders and MAR documented nine medications for which there was no clinical explanation for use provided. These medications included Levothyroxine, Sodium, Baclofen, Gentamin, Prevacid, Artificial Tears, Ear Drops, Reclast Infusion, Promod, and Jevity 1.2.</p> <p>On 8/27/15, the DNS stated the lack of diagnoses had been an oversight which would be corrected right away.</p> <p>4. Resident #1 was admitted to the facility in 2012 with multiple diagnoses, including hypertension, Alzheimer's Disease, depression, and history of Cerebrovascular Disease (CVA).</p> <p>The Resident's #1 August 2015 Physician's Orders documented; "03/03/12: May go out on</p>	F 514		

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F 514	Continued From page 48 pass: NO. Resident #1's current Care Plan documented, "Resident will go on outings as desires with family." An 8/8/15 Social Services Notes documented, "Much family support. Goes on outings with them when he chooses ..." On 8/27/15, when asked about the conflicting 8/8/15 Social Services Note, August 2015 Physician's Orders, the Activities Director said, "I don't know, but I will find out." On 8/27/15, the DNS stated the resident was able to go out of the facility on pass.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		

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F 520	<p>Continued From page 49</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, 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 concerning quality of care and quality of life issues for 9 of 10 sampled residents (#s 1-9) and 4 random residents (#s 11-13). This deficient practice also had the potential to affect all residents in the facility. Findings included:</p> <p>The QAA committee failed to provide sufficient monitoring and oversight, or sustain regulatory compliance, as evidenced by the re-citation of the following deficient practice as determined by the recertification survey of 8/24/15 through 8/28/15.</p> <p>Refer to F309 as related to the facility's failure to ensure provision of the necessary care and services to attain or maintain residents' highest practicable physical, mental, and psychosocial well-being. The facility was previously cited at F309 during its 2014 recertification survey, as well as for the current 2015 recertification survey.</p>	F 520			

Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual State licensure survey of your facility.</p> <p>The surveyors who conducted the survey were: Linda Hukill-Neil, RN, Team Coordinator Linda Kelly, RN Angela Morgan, RN, BSN Presie Billington, RN</p> <p>The survey team entered the facility on August 24, 2015 and exited on Friday August 28, 2015.</p>	C 000		
C 422	<p>02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility did not have at least one bathing facility for every 12 licensed beds.</p> <p>The facility was licensed for 76 beds, which required 7 bathing facilities. The facility had only 3 permanent bathing facilities, and 3 temporary bathing facilities in a storage unit in the back of the building. The temporary bathing units could easily be transported into the building for resident use.</p>	C 422		

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

TITLE

(X6) DATE

Bureau of Facility Standards

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C 422	Continued From page 1 On 8/27/15 at 8:00 AM, the Administrator stated there were currently 34 residents, and the 3 temporary bathing units were portable and could easily be rolled into the facility. The facility was cited at F312 for bathing/shower concerns not related to the lack of bathing facilities.	C 422		

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F 164	<p>Continued From page 1 room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to protect personal medical information for 1 of 9 sample residents (#6). The failure created the potential for a negative effect on the resident's psychosocial well-being. Findings included: On 8/26/15 at 11:49 a.m., before the lunch meal service, LN #7 was observed as she administered one oral medication to Resident #6 in the dining room. The LN then returned to the medication cart in the hallway across from the Administrative offices. A large binder on top of the cart was opened to page 3 of Resident #6's MAR. The exposed page contained the resident's diagnoses, allergies, and listed 4 medications. When asked if the binder was left open with the</p>	F 164	<p>Facility Systems Licensed nurses are educated to protect personal information on hire and annually. Re-education was provided by the SDC/DNS to include but not limited to, covering/protecting personal information on the Medication Administration Record when the nurse is not in direct attendance. Monitoring for protection of personal information is added to daily clinical manager rounds. Licensed nurses are educated to peer accountability and supervised by the RN supervisor for engagement.</p> <p>Monitor The Director of Nursing Services and/or designee will audit two medication passes a week for four weeks for protection of personal information and then audit one time a week for 8 weeks. Starting the week of Sept 28, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p> <p>Date of Compliance: October 5, 2015</p>	

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation - Weiser does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.

10/21/15
SEP 29 2015
FACILITY STANDARDS

F 164

Resident Specific

The ID team validated resident #6 current MARs and personal medical information is being protected.

Other Residents

The ID team reviewed other residents for exposed personal information. No other issues were identified.

Facility Systems

Licensed nurses are educated to protect personal information on hire and annually. Re-education was provided by the SDC/DNS to include but not limited to, covering/protecting personal information on the Medication Administration Record when the nurse is not in direct attendance. Monitoring for protection of personal information is added to daily clinical manager rounds. Licensed nurses are educated to peer accountability and supervised by the RN supervisor for engagement.

Monitor

The Director of Nursing Services and/or designee will audit two medication passes a week for four weeks for protection of personal information and then audit one time a week for 8 weeks. Starting the week of Sept 28, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

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F 164	Continued From page 2 resident's personal information exposed, the LN stated, "Yes." The LN then closed the MAR binder.	F 164			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined the facility used physical restraints on a resident without assessment of less restrictive devices/restraints and failed to adequately provide the risks and benefits of a resident's seatbelt and bilateral feet straps. This was true for 1 of 3 (#8) residents sampled for the use of physical restraints and created the potential for harm should residents experience contractures, decreased mobility, and/or skin impairment. Findings included: Resident #8 was admitted to the facility on 7/6/15 with multiple diagnoses, including cerebral palsy (CP), mild intellectual disability, and spastic quadriplegia. The resident's admission MDS assessment, dated 7/13/15, documented: *BIMS score of 13 - Cognition intact; *Total assist of 2 staff for bed mobility, transfers, and dressing; and, *No physical restraints in use.	F 221	F 221 Resident Specific The ID team updated resident # 8 restraint assessment, physician orders, care plans and monitors. The consent was received after explanation of risks and benefits. The seat belt and foot straps are appropriate for the resident. Other Residents The ID team reviewed other residents for least restrictive devices being used. Adjustments have been made as indicated. Facility Systems Nursing staff are educated on the resident's right to be free from any physical restraints on hire and annually. Re-education was provided by the SDC/DNS to include but not limited to, not using a physical restraint without assessment, physician orders, care plans, and monitors, and providing risks and benefits prior to consent. During morning clinical meeting devices will be reviewed, by therapy and the ID team, on initiation, with change of condition, and at least quarterly during completion of the MDS.		

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F 221	Continued From page 3 Resident #8's August 2015 Physician's Orders documented: 7/6/15 - Weekly skin checks. 7/6/15 - OT (Occupational Therapy) evaluate and treat: Motorized wheelchair for safety. 7/6/15 - Occupational and Physical Therapy (PT) evaluation and treatment. 7/6/15 - Resident incapable of making her own health decisions. The resident's PT Plan of Care, dated 7/7/15, documented: * Significant decline in sitting balance, bed mobility, ability to change position and shift weight in wheelchair over last 2-3 years due to cerebral palsy and spastic quadriplegia. * Required skilled therapy to improve self care and functional activities of daily living such as bed mobility, pelvic and trunk stability for safe reaching of upper extremities from the sitting position. * Improve postural alignment and lower extremity strength. * Improve ability to shift weight for repositioning and pressure relief. * Uses adaptive equipment, including motorized wheelchair, mechanical lift, and bilateral ankle braces. The resident's OT Plan of Care, dated 7/8/15, documented: * Requires skilled therapy to improve self care and functional activities of positioning and safety with electric wheelchair. * Positioning precautions related to decreased trunk control and arm function. The resident's Powered Personal Mobility Device	F 221	Monitor The Director of Nursing Services and/or designee will audit each new device and those for quarterly review for restrictive measures and implementation of protocols weekly for 12 weeks. Starting the week of September 28 th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate. Date of Compliance: October 5, 2015		

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F 221	<p>Continued From page 4</p> <p>Skills Assessment Results completed by PT, dated 7/12/15, did not reflect the resident had a seat belt nor the need for the bilateral ankle braces.</p> <p>Resident #8's Self Care Performance Deficit Care Plan documented: * Limited ROM, limited mobility, quadriplegia, and contractures * Mobility via motorized wheelchair * Non-restrictive wheelchair leg straps to provide secure and safe leg positioning</p> <p>The Care Plan did not include or address a seat belt around the resident's mid section or assessment of the skin under the restrictive devices (seat belt and foot straps).</p> <p>On 8/25/15 at 2:00 PM and 8/27/15 at 9:50 AM, Resident #8 was observed in the Willow Room and the hallway seated in her power wheelchair. The resident had a seat belt clipped around her lower abdominal section and black velcro straps secured around both feet that were secured to each footrest.</p> <p>On 8/27/15 at 10:10 PM, the Physical Therapist stated she asked the resident if she could remove her seat belt, but that the resident was hesitant to release the seat belt as it provided her protection from falling out of the wheelchair. The resident then demonstrated to the PT that she could release the seatbelt by herself. The PT stated the resident could not lean over and remove the foot straps.</p> <p>On 8/27/15 at 10:35 AM, the DNS stated she thought OT had completed assessments for the seat belt and bilateral feet straps, but had not</p>	F 221			

F 221

Resident Specific

The ID team updated resident # 8 restraint assessment, physician orders, care plans and monitors. The consent was received after explanation of risks and benefits. The seat belt and foot straps are appropriate for the resident.

Other Residents

The ID team reviewed other residents for least restrictive devices being used. Adjustments have been made as indicated.

Facility Systems

Nursing staff are educated on the resident's right to be free from any physical restraints on hire and annually. Re-education was provided by the SDC/DNS to include but not limited to, not using a physical restraint without assessment, physician orders, care plans, and monitors, and providing risks and benefits prior to consent. During morning clinical meeting devices will be reviewed, by therapy and the ID team, on initiation, with change of condition, and at least quarterly during completion of the MDS.

Monitor

The Director of Nursing Services and/or designee will audit each new device and those for quarterly review for restrictive measures and implementation of protocols weekly for 12 weeks. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

Date of Compliance: October 5, 2015

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F 221	Continued From page 5 discussed the risks and benefits of the devices with the resident. She stated that discussion would take place immediately by speaking with the resident's authorized representative.	F 221			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident's call light was within reach. This was true for 1 of 6 residents reviewed for accommodation of needs and had the potential to cause more than minimal harm if the resident could not summon assistance when needed. Findings included: Resident #3 was admitted to the facility on 7/21/15 with multiple diagnoses including a CVA (Cerebral Vascular Accident) with left sided hemiparesis. The resident's 7/27/15 admission MDS assessment documented the resident required total one to two person assistance for all ADL's. A BIMS was not conducted, the resident was coded as "rarely/never understood" with inattention, disorganized thinking and psychomotor	F 246	F 246 Resident Specific The ID team validated resident #3 call light is regularly within reach. Other Residents The ID team reviewed other residents for call light accessibility. Adjustments have been made as indicated. Facility Systems Nursing staff are educated on reasonable accommodation of resident needs. Re-education was provided by the SDC/DNS to include but not limited to, call lights must be within reach. LN will include monitoring during rounds and medication pass. SDC and clinical management team will monitor during observation rounds. In addition, center management staff are "Angels" for each resident at the center. "Angels" will monitor for call light accessibility during their visits. If a concern arises, the "Angel" will resolve the call light accessibility and notify the RN supervisor. Monitor The Director of Nursing Services and/or designee will audit call lights for being within resident's reach three times per week for 4 weeks, then twice a week for 8 weeks. Starting the week of September 28, the		

F 246**Resident Specific**

The ID team validated resident #3 call light is regularly within reach.

Other Residents

The ID team reviewed other residents for call light accessibility. Adjustments have been made as indicated.

Facility Systems

Nursing staff are educated on reasonable accommodation of resident needs. Re-education was provided by the SDC/DNS to include but not limited to, call lights must be within reach. LN will include monitoring during rounds and medication pass. SDC and clinical management team will monitor during observation rounds. In addition, center management staff are "Angels" for each resident at the center. "Angels" will monitor for call light accessibility during their visits. If a concern arises, the "Angel" will resolve the call light accessibility and notify the RN supervisor.

Monitor

The Director of Nursing Services and/or designee will audit call lights for being within resident's reach three times per week for 4 weeks, then twice a week for 8 weeks. Starting the week of September 28, the

review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

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F 248

Resident Specific

The ID team reviewed resident #1, and his activity care plan has been re-assessed and updated to meet his needs and interests.

Other Residents

The ID team reviewed other residents for updated activity care plans and programs that meet resident's needs and interests. Adjustments have been made as indicated.

Facility Systems

Activity staff are educated to update care plans. Re-education was provided by SDC and DNS to include but not limited to, addressing accommodation of life interests,

coordination to address depression, and individualize interventions to meet residents' needs. Social services will review initial care plan development, concerns with change of condition, and during quarterly MDS review to validate activity plan enhances the psychosocial plan for the resident.

Monitor

The Executive Director and/or designee will audit activity care plans for updates pertaining to resident's needs and interests, weekly for 12 weeks. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

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F 246	Continued From page 6 retardation present continuously without fluctuation. The resident was observed in bed on his side with the call light behind him on 8/24/15 at 2:00 PM, 8/25/15 at 9:50 AM, 8/26/15 at 9:05 AM, and 8/26/15 at 11:50 AM. On 8/27/15 at 9:40 AM, when asked if the residents call light was accessible, the DON said no.	F 246	review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate. Date of Compliance: October 5, 2015		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, it was determined the facility failed to provide a meaningful activities program designed to meet the interests and needs of 1 of 6 sample residents (#1). The deficient practice had the potential for more than minimal harm if Resident #1 experienced mood changes, boredom, and/or decreased socialization from lack of activities. Findings included: Resident #1 was admitted to the facility in 2012 with multiple diagnoses including Alzheimer's Disease, depression, and history of Cerebrovascular Accident (CVA).	F 248	F 248 Resident Specific The ID team reviewed resident #1, and his activity care plan has been re-assessed and updated to meet his needs and interests. Other Residents The ID team reviewed other residents for updated activity care plans and programs that meet resident's needs and interests. Adjustments have been made as indicated. Facility Systems Activity staff are educated to update care plans. Re-education was provided by SDC and DNS to include but not limited to, addressing accommodation of life interests,		

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F 248	<p>Continued From page 7</p> <p>The resident's 8/14/15 annual MDS assessment documented: * Understood others and was understood by others * BIMS score of 6 (severe cognitive impairment) * "Somewhat important" activity preferences included listening to music, news, going outside for fresh, and participating in religious services/practices</p> <p>The resident's care plan identified the need for diversional activities related to dementia, depression, history of working at night, enjoyed independent activities daily, enjoyed group activities 1-2 times per week, outings with family, and being out of his room daily. Each goal was revised 8/28/14. Interventions included, "Depression: ...general loss of interest in things, sad look/ tearfulness, and persistent low mood. Try: 1) toilet 2) redirect 3) offer food and /or fluids 4) activity 5) change position 6) inform nurse of mood changes ... Encourage...group activities: special events, music entertainment, church services in facility ... independent activities: family/friend visits ... plays keyboard in room as desires, reads mail, watches tv as he desires ... comes out of room in afternoons and evenings/nights ..."</p> <p>Resident #1 was observed in his room sitting in his recliner without the TV on at the following times: * 8/25/15 from 10:15 AM to 12:20 PM, 1:30 PM, 4:45 PM, 5:25 PM and 6:00 PM; * 8/26/15 from 9:10 AM to 12:55 PM; and * 8/27/15 at 8:30 AM, 9:30 AM, 10:30 AM, 12:00 PM, 1:15 PM and at 2:20 PM</p>	F 248	<p>coordination to address depression, and individualize interventions to meet residents' needs. Social services will review initial care plan development, concerns with change of condition, and during quarterly MDS review to validate activity plan enhances the psychosocial plan for the resident.</p> <p>Monitor The Executive Director and/or designee will audit activity care plans for updates pertaining to resident's needs and interests, weekly for 12 weeks. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p> <p>Date of Compliance: October 5, 2015</p>	

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F 248	Continued From page 8 On 8/25/15 at 10:15 AM, Resident #1 said he would go outside if someone took him, there is "nothing special" to do on weekends, and he "tinkers" with the keyboard in his room. The resident said he does not watch television unless the President of the United States is on. When asked about religious activity, he said he would go if someone took him. A picture of the resident playing chess with a young boy and several VHS (video home system) tapes, but no VHS player, were observed in the resident's room. Review of Resident #1's Daily Activities/Group Activities records for April 2015 through August 2015 revealed there was no documented evidence the resident participated in spiritual activities/church service, outside activities or the "Out and About" activity. Progress Notes for April through August 2015 revealed no documented evidence the facility encouraged or assisted the resident to attend or that the resident refused to attend those activities. On 8/27/15 at 1215, the Activity Director (AD) said the resident watched television and played the keyboard. When asked if she was aware of the resident's chess picture and VHS tapes, the AD replied, "No, I do not know," but the facility had a tape player that could be brought into resident's room. When asked if the resident attended church/spiritual activities on the weekend, the AD said she did not know. She stated, "I am not here on the weekend, I have an assistant who oversees the weekend program."	F 248		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	<p>Continued From page 9</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to revise/update care plans to reflect residents' current status. This was true for 5 of 10 (#'s 2, 4, 5, 6, and 8) sampled residents and had the potential to result in more than minimal harm if residents did not receive appropriate care due to lack of direction in their care plans. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 6/17/14, and readmitted on 1/13/15, with multiple diagnoses, including meningioma.</p> <p>Resident #4's nutritional care plan, revised.</p>	F 280	<p>F 280</p> <p>Resident Specific The ID team reviewed residents #2, 5, 6 and 8 and revised/updated the care plans to reflect the resident's current status. Resident #4 has discharged from the center.</p> <p>Other Residents The ID team reviewed other residents for revised/updated care plans reflecting their current status with adapted eating equipment, non-skid socks wear schedule, splint use directives, RNA and functional monitoring programs, and positioning devices. Adjustments have been made as indicated.</p> <p>Facility Systems ID Team are educated to revise care plans with change of condition, order changes, transitions from therapy, splints, or other positioning devices. Recommendations will be reviewed in morning clinical meeting where care plans will be updated as indicated. Re-education was provided to include but not limited to, ensuring the care plan reflects the resident's current status for adaptive eating equipment, non-skid sock wear schedule, splint use directives, RNA/functional maintenance programs, and positioning devices.</p>	
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F 280	<p>Continued From page 10</p> <p>4/27/15, documented the need for a nadaptive lip plate for eating; the fall care plan, revised 2/10/2015, documented, "Non skid socks on at all times."</p> <p>a) The resident was observed wearing black shoes and white socks on 8/25/15 and 8/26/15.</p> <p>On 8/27/15, the DON was informed of the observations and asked if the resident should have non-skid socks on at all times. The DON said, "No," but noted the care plan should have been revised when the resident was able to wear sock and shoes.</p> <p>b) On 8/26/15 at 12:15 PM, during the lunch meal service, Resident #4 was observed using a standard plate.</p> <p>During the lunch meal service, the Dietary Manager (DM) was asked if the resident should have a lipped plate. The DM stated the resident had not required a lip plate for two months. The DM said the care plan should have been updated to reflect the change.</p> <p>2. Resident #2 was admitted to the facility on 12/22/14 with multiple diagnoses, including muscle wasting and atrophy, and history of falling.</p> <p>Resident #2's August 2015 Physician's Orders documented she had reached maximum functional potential with Physical Therapy and had been discharged on 6/19/15 to restorative nursing care for ambulation and exercise. There were no Physician's Orders related to bilateral feet splints and a right wrist splint.</p>	F 280	<p>Monitor</p> <p>The Director of Nursing Services and/or designee will audit three care plans for reflecting current status, weekly for 4 weeks then two care plans per week for 8 weeks. Starting the week of September 28, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p> <p>Date of Compliance: October 5, 2015</p>		

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F 280	<p>Continued From page 11</p> <p>The resident's current Limited Physical Mobility Care Plan documented:</p> <ul style="list-style-type: none"> *Weakness, at risk for falls, and depression or severe anxiety. *Monitor for complications related to immobility, including contractures, thrombus formation, skin breakdown, and fall related injury. *Provide supportive care/assistance with mobility as needed. Wheelchair for mobility. FWW (front wheel walker) and gaitbelt with therapy. *Bilateral foot splints with schedule. <p>Resident #2's Care Plan did not document the resident was involved in an RNA program or wore a right wrist splint daily.</p> <p>Resident #2's July 2015 & August 2015 Restorative Nurse Aide (RNA) Flow Sheet Record documented she could use the Nu-Step, but that walking was most important. The resident was also to ambulate with the FWW 150 feet and 200 feet.</p> <p>On 8/28/15 at 11:00 AM, OT #5 was interviewed regarding the resident's leg splints and the right hand splint. The OT stated there had been written communication to the nursing staff when therapy discontinued services for the resident. The nursing staff were to apply the right wrist splint daily and the feet splints were to be applied twice a day for an hour. The OT stated this information had been posted, but staff were unable to locate the documentation regarding when the feet splints were to be worn.</p> <p>On 8/28/15 the DNS stated the wrist brace, the feet splints, and the RNA program for Resident #2 should have been addressed on the Care Plan.</p>	F 280			

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F 280	<p>Continued From page 12</p> <p>3. Resident #5 was readmitted to the facility on 8/8/14 with multiple diagnoses, including muscle wasting and atrophy, presence of artificial hip joint, and apraxia.</p> <p>Resident #5's August 2015 Physician's Orders directed staff to walk the resident "more." There was no specific Physician's Order addressing the resident's involvement in the maintenance ADL program instituted after Physical Therapy had been discontinued.</p> <p>The resident's current Fall Risk/ADL Self Care Deficit/Nutrition Deficit Care Plan documented she was to be equipped with an adaptive lip plate for meals. The resident did not have a specific Care Plan related to her placement on an ADL Maintenance Program and was to receive walking assistance to- and from meals, as documented on the August 2015 ADL Flow Sheet Record."</p> <p>On 8/26/15 at 12:00 PM, the resident was observed seated in her wheelchair in the main dining room with a regular plate without lip. The resident said she broke her wrist the previous year and used a lipped plate when she was in a cast.</p> <p>On 8/28/15, the DNS stated the resident's Care Plan should have been revised to include walking to the dining room and removal of the lipped plate.</p> <p>4. Resident #6 was admitted to the facility on 3/13/14 with multiple diagnoses including history of cerebrovascular accident (CVA), left-sided hemiplegia and hemiparesis.</p> <p>Resident #6's August 2015 Physician's Orders</p>	F 280			

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F 280	<p>Continued From page 13</p> <p>documented the resident was to receive a Physical Therapy three times weekly for 12 weeks. There was no specific Physician's Order addressing the RNA program after PT completed their evaluation and treatment.</p> <p>Resident #6's August 2015 RNA Flow Sheet Record documented the use of a Nu-Step and directed staff to walk the resident with a quad cane and increase distances as tolerated.</p> <p>The resident's Nursing Progress Notes contained only one entry detailing the resident's progress in the RNA program from 5/28/15 through 8/25/15.</p> <p>The resident's current Self Care/ADL Deficit and Physical Mobility Impairment Care Plan documented contractures affecting the left upper extremity, CVA with limited hemiparesis, and unsteady gait. Interventions included therapeutic exercises, Nu-Step, and ambulation along hand rails with quad cane. The Care Plan did not address how often the Nu-Step was to be used, how often/distance the resident was to be ambulated, or that the resident required an adaptive lipped plate at meals to enable independent dining.</p> <p>On 8/25/15 at 5:45 PM and 8/26/15 at 12:20 PM, the resident was observed in the dining room eating independently from a white lipped plate. The resident's meal card documented the use of an adaptive lipped plate.</p> <p>On 8/28/15, the DNS said she was aware the resident's Care Plan needed to be updated.</p> <p>5. Resident #8 was admitted to the facility on 7/6/15 with multiple diagnoses, including cerebral</p>	F 280			

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F 280	<p>Continued From page 14 palsy (CP) and spastic quadriplegia.</p> <p>Resident #8's August 2015 Physician's Orders documented weekly skin checks, OT evaluation and treatment, use of a motorized wheelchair, and PT/OT evaluations and treatment.</p> <p>The resident's PT Plan of Care, dated 7/7/15, documented: * Significant decline in sitting balance, bed mobility, ability to change position and ability to shift weight in wheelchair due to cerebral palsy and spastic quadriplegia. * Required skilled therapy to improve self care and functional activities of daily living, such as bed mobility, and pelvic and trunk stability. * Uses adaptive equipment, including motorized wheelchair, mechanical lift, and bilateral ankle braces.</p> <p>The resident's OT Plan of Care, dated 7/8/15, documented: * Required skilled therapy to improve self care and functional activities of positioning and safety with electric wheelchair. * Positioning precautions related to decreased trunk control and arm function.</p> <p>The PT and OT Plans of Care addressed the resident's decreased trunk control, but did not document the resident had a seat belt in place nor the need for bilateral feet/ankle straps.</p> <p>Resident #8's Self Care Performance Deficit and Skin Impairment Care Plan documented: * Limited ROM, limited mobility, quadriplegia, and contractures. * Turn/reposition every 2 hours. * Mobility via motorized wheelchair.</p>	F 280			

F 280

Resident Specific

The ID team reviewed residents #2, 5, 6 and 8 and revised/updated the care plans to reflect the resident's current status. Resident #4 has discharged from the center.

Other Residents

The ID team reviewed other residents for revised/updated care plans reflecting their current status with adapted eating equipment, non-skid socks wear schedule, splint use directives, RNA and functional monitoring programs, and positioning devices. Adjustments have been made as indicated.

Facility Systems

ID Team are educated to revise care plans with change of condition, order changes, transitions from therapy, splints, or other positioning devices. Recommendations will be reviewed in morning clinical meeting where care plans will be updated as

indicated. Re-education was provided to include but not limited to, ensuring the care plan reflects the resident's current status for adaptive eating equipment, non-skid sock wear schedule, splint use directives, RNA/functional maintenance programs, and positioning devices.

Monitor

The Director of Nursing Services and/or designee will audit three care plans for reflecting current status, weekly for 4 weeks then two care plans per week for 8 weeks. Starting the week of September 28, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

Date of Compliance: October 5, 2015

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F 280	Continued From page 15 * Non-restrictive wheelchair leg straps to provide secure and safe leg positioning. The Care Plan did not include or address a seatbelt around the resident's midsection or assessment of the skin under the restrictive devices (seatbelt and bilateral foot straps). On 8/25/15 at 2:00 PM and 8/27/15 at 9:50 AM, Resident #8 was observed in the Willow Room and hallway seated in her power wheelchair. The resident had a seatbelt clipped around her lower abdominal section and black velcro straps secured around both feet and secured to each footrest.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure staff adhered to professional standards of practice for 1 of 9 sampled residents (#1) and one random resident (#11). This failure created the potential for harm when Flomax was not administered as ordered and when a LN used incorrect hand washing technique while caring for Resident #11. Findings included: 1. Resident #1 was admitted to the facility in 2012 with multiple diagnosis, including benign prostatic hypertrophy (BPH).	F 281	F 281 Resident Specific The ID team validated resident #1 is provided Flomax 30 minutes post meal. See F441 for hand washing plan. Other Residents The ID team reviewed other residents for pre and post meal directives. MARs directives and times are adjusted to meet professional standards.		

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F 281	<p>Continued From page 16</p> <p>On 8/26/15 at 9:15 AM, during the morning med pass, LN #4 said she already provided Resident #1's morning medications. When asked if Flomax 0.4 mg was included on the medications given, LN said, "Yes, all medications were given before his breakfast."</p> <p>Resident's #1 Physician Orders documented the Flomax was to be given to the resident daily 30 minutes following a meal.</p> <p>The 2016 Nursing Drug Handbook documented, "... once daily given 30 minutes after same meal each day."</p> <p>2. On 8/26/15 at 9:20 a.m., LN #7 was observed setting up and then administering a breathing treatment to Resident #11. In the resident's room, the LN washed her hands, turned off the faucet with paper towels then tried her hands with the same paper towels before she set-up the treatment. The LN used the same hand washing technique after the breathing treatment.</p> <p>Immediately afterward, the LN was informed of the 2 observations and asked about the handwashing technique. The LN thought a moment then said she turned off the faucet and dried her hands with the same paper towel.</p> <p>Clinical Nursing Skills & Techniques, 8th edition by Perry and Potter, documented the following steps (and rationale) regarding handwashing, "...Wet hands and wrists...Apply...antiseptic soap...Perform hand hygiene...Rinse hands and wrists...Dry hands thoroughly from fingers to wrists with paper towel, single-use cloth, or warm</p>	F 281	<p>Facility Systems</p> <p>Licensed nurses are educated to administer medication as ordered and to utilize appropriate hand washing technique. Re-education was provided by SDC and DNS to include but not limited to, administering medication with ordered mealtime parameters, and immediately disposing of the paper towel used to turn off the faucet. SDC will perform skills checks within 30 days of hire and annually to observe medication pass of the nurses. Hand washing surveillance is completed by the SDC/Infection Control Coordinator twice a month and documented for at least 10 staff to validate the standard of practice is being met. Staff is corrected immediately as needed with counseling as indicated for repeat non-compliance. The results are reviewed in the infection control committee monthly.</p> <p>Monitor</p> <p>The Director of Nursing Services and/or designee will audit two medication passes per week for medications administered as ordered with mealtime parameters and hand washing for appropriate technique weekly for 4 weeks, then audit on pass per week for 8 weeks. Starting the week of September 28, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p> <p>Date of Compliance: October 5, 2015</p>		

F 281

Resident Specific

The ID team validated resident #1 is provided Flomax 30 minutes post meal. See F441 for hand washing plan.

Other Residents

The ID team reviewed other residents for pre and post meal directives. MARs directives and times are adjusted to meet professional standards.

Facility Systems

Licensed nurses are educated to administer medication as ordered and to utilize appropriate hand washing technique. Re-education was provided by SDC and DNS to include but not limited to, administering medication with ordered mealtime parameters, and immediately disposing of the paper towel used to turn off the faucet. SDC will perform skills checks within 30 days of hire and annually to observe medication pass of the nurses. Hand washing surveillance is completed by the SDC/Infection Control Coordinator twice a month and documented for at least 10 staff to validate the standard of practice is being met. Staff is corrected immediately as needed with counseling as indicated for repeat non-compliance. The results are reviewed in the infection control committee monthly.

Monitor

The Director of Nursing Services and/or designee will audit two medication passes per week for medications administered as ordered with mealtime parameters and hand washing for appropriate technique weekly for 4 weeks, then audit on pass per week for 8 weeks. Starting the week of September 28, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

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F 281	Continued From page 17 air dryer. If used, discard paper towel...(Prevents transfer of microorganisms.) To turn off hand faucet, use clean, dry paper towel...(Wet towel and hands allow transfer of pathogens from faucet by capillary action.)"	F 281			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to ensure physicians orders were followed for 5 of 10 sampled residents (#2, 3, 4, 5 and 7). *Resident #3 was at risk for nutritional deficient when his "continuous" tube feeding was stopped repeatedly and for prolonged times; and at risk for eye/skin irritation when his eyes were taped open without physician's orders. *Resident #2 was at risk for skin breakdown when hand/feet splints were in place without a physician's order or monitoring. *Resident #4 was at risk for lower extremity edema when physician-ordered "tubigrips" were not in place. *Resident #5 was at risk for complications related to a fracture when a wrist brace was not in place as ordered. *Resident #7 was at risk for complications related	F 309	F 309 Resident Specific The ID team validated residents #2, 3, 5, and 7 have orders updated /clarified and documentation of assessment as indicated. Resident #4 has discharged from the center. Other Residents The ID team reviewed other residents for physician's orders requiring updates/clarifications for continuous tube feeding adjustments without infusion, splint use and monitoring, edema management and implantation, and dialysis. No other residents are currently receiving dialysis. Adjustments have been made as indicated. Facility Systems Therapists and Licensed nurses are educated to seek MD orders updates and clarifications. SDC and DNS provided re-education to include but not limited to, nutritional risk of stopping a continuous tube feeding, risk of taping a resident's eyes open, skin risk of wearing/not monitoring splints, edema risk of not wearing/		

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F 309	<p>Continued From page 18</p> <p>to dialysis when an access device/site was not monitored and post-dialysis care was not provided. These failures created the potential for more than minimal harm for the residents. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 7/21/15 with multiple diagnoses, including dysphagia.</p> <p>The resident's 7/27/15 admission MDS assessment coded the resident was rarely/never understood, total assistance was needed for all ADL's, and all caloric/nutritional intake was via tube feeding.</p> <p>Resident #3's care plan documented altered nutritional status, NPO, and all nutritional needs were to be met through enteral feedings.</p> <p>Resident #3's August 2015 recapitulated Physician's Orders included NPO and continuous tube feeding at 83 ml (milliliters) per hour via percutaneous endoscopic gastrostomy (PEG) tube.</p> <p>The care plan and physician orders did not include holding the tube feeding or taping the resident's eyes open.</p> <p>a) Resident #3's physician ordered continuous tube feeding was observed either disconnected or paused as follows: *8/25/15 from 11:10 AM to 11:20 AM, and from 2:30 PM to 3:15 PM. *8/26/15 from 9:30 AM to 9:45 AM and from 11:50 AM to 11:55 AM.</p> <p>On 8/26//15, LN #1 said the resident's tube</p>	F 309	<p>monitoring tubi-grips, risk for complications of not wearing/monitoring wrist brace, risk for complications of not monitoring dialysis site, and not providing post dialysis care. Order changes, continuous tube feeding, transitions from therapy, non-traditional therapy standards/interventions, edema management, and residents on dialysis will be reviewed in morning clinical meeting, and order clarifications will be requested as indicated. Care plan will be updated as indicated. RN snpervisor will review care implementations at the bedside to validate resident needs are met for high risk clinical areas. The clinical management team will review dialysis logs and monitors daily in clinical morning meeting.</p> <p>Monitor The Director of Nursing Services and/or designee will audit residents who receive continuous tube feedings non-transitional therapy interventions, residents with splints residents with tubigrips or edema management devices, dialysis patients for completed post dialysis care, and daily site monitoring weekly for 12 weeks. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p> <p>Date of Compliance: October 5, 2015</p>	
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F 309	<p>Continued From page 19</p> <p>feeding was "disconnected for transfers and during therapy, but the tube feeding is continuous 24 hours."</p> <p>On 8/26/15, the Registered Dietician (RD) #8 and DDCO were informed of the observations. When asked if the physician's order for continuous tube feeding was followed when Resident #3's tube feeding was disconnected for 45 minutes and/or paused multiple times, both said, "No." The RD stated that there would be a minimal effect if the feeding was stopped for 45 minutes to an hour.</p> <p>b) On 8/25/15 at 11:10 AM, Resident #3's eyes were observed taped open with adhesive tape during a therapy session with COTA #5. At 11:20 AM, LN #1 said the Physical Therapist (PT) tapes the resident's eyes open during therapy sessions.</p> <p>On 8/26/15, when asked who directed taping Resident #3's eyes open, PT #3 stated, "PT." The PT was asked to provide a physician order to tape Resident#3's eyes open. PT #3 said a physician order was not needed because taping the resident's eyes open was an intervention.</p> <p>On 8/27/15, PT #9 said that taping Resident #3's eyes open was part of "eval and treat." PT #9 added, "It is a modification of body parts just like moving his hand."</p> <p>On 8/28/15, OT #10 was asked if she taped Resident #3's eyes open. The OT said, "No." When asked if she provided direction to her staff to tape the resident's eyes open, the OT said, "Yes." The OT said there were no documented directions, care plan intervention, or physician's order to tape the resident's eyes open.</p>	F 309		

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F 309	<p>Continued From page 20</p> <p>2. Resident #4 was admitted to the facility on 6/17/14, and readmitted on 1/13/15, with multiple diagnoses, including edema.</p> <p>Resident #4's August 2015 recapitulated Physician Order's documented the use of tubigrips to both legs every morning for edema. The tubigrips were to be removed at bedtime.</p> <p>The August 2015 Treatment Record documented tubigrips were in place August 1-5 and August 10; all other spaces were blank during August.</p> <p>Resident #4 was observed without tubigrips on his lower extremities on 8/25/15 at 2:30 PM and 8/26/15 at 9:20 AM.</p> <p>On 8/25/15, when asked about the tubigrips for his legs, the resident said he quit wearing the tubigrip socks because his legs were not improving.</p> <p>On 8/26/15, LN #1 acknowledged the resident's tubigrips were not in place.</p> <p>On 8/28/15 at 8:50 AM, the resident was observed wearing tubigrips on both legs.</p> <p>2. Resident #7 was admitted to the facility on 12/19/13 with multiple diagnoses, including chronic renal insufficiency with dialysis treatment.</p> <p>The August 2015 Physician's Orders documented the resident was not to receive blood pressure medications prior to dialysis every Monday, Wednesday, and Friday.</p> <p>Resident #7's current Hemodialysis Care Plan</p>	F 309			

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F 309	<p>Continued From page 21</p> <p>documented:</p> <ul style="list-style-type: none"> *End stage renal failure and AV (arteriovenous) fistula in the left lower arm. *Check complete dialysis communication log record on return from dialysis appointments for any reports. *If bleeding occurs at shunt site, apply pressure to site for 15-20 minutes. If bleeding does not stop, transport to the emergency room for assistance. <p>The Dialysis Communication Log was completed for the resident's dialysis appointments in June, July, and August 2015. The Communication Log had a place for the LNs to document the resident's vital signs, weight, and any abnormalities or notes for the dialysis center.</p> <p>The facility's Dialysis Log included spaces to document the resident's vital signs, weight, daily site care, signs and symptoms of infection, the presence of the bruit or thrill, and post-dialysis check of the shunt site for bleeding, pain, redness, swelling every hour for 6 hours. The Dialysis documented:</p> <ul style="list-style-type: none"> *June 2015 - All information was documented except for the post-dialysis hourly checks for six hours. The Log documented the resident was checked hourly for 3 hours on most of those days he/she received dialysis. The resident did not have documented daily site care or documented assessments of the thrill and bruit. *July and August 2015 - The facility did not provide any documentation the resident received his dialysis treatment or that his site was monitored. <p>On 8/27/15, the DNS and DDCO were interviewed regarding the dialysis daily care and</p>	F 309		

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F 309	<p>Continued From page 22</p> <p>post-dialysis site care for Resident #7. The DDCO stated the facility was unable to provide the Dialysis Log documentation for the months of July and August 2015 to reflect daily site care had been provided, infection assessments had been performed, presence of bruit and thrill had been assessed, or that hourly post-dialysis shunt site checks had taken place for 6 hours after dialysis treatment.</p> <p>3. Resident #2 was admitted to the facility on 12/22/14 with multiple diagnoses including muscle wasting and atrophy.</p> <p>The August 2015 Physician's Orders documented the resident had reached maximum functional potential with Physical Therapy and was to receive Restorative Nursing Care for ambulation and exercise.</p> <p>The OT Plan of Care included a physician's order for bilateral feet splints and a right wrist splint, however the order did not document when the splints were to be worn or how/when they were to be monitored.</p> <p>The resident's current Limited Physical Mobility Care Plan documented a schedule of use for the bilateral foot splints, but did not include direction to staff for the right hand splint.</p> <p>On 8/25/15 at 3:00 PM, the resident was observed on her bed with a brace on her right arm, which she said she wore for support. When asked about leg braces that were observed behind a nightstand, the resident stated she wore the braces when she was out of bed and in her wheelchair, but she could not walk with them on.</p>	F 309			

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F 309	<p>Continued From page 23</p> <p>On 8/28/15, OT #5 stated written communication to nursing staff when therapy had been discontinued directed nursing staff to apply the right wrist splint daily and the feet splints were twice a day for an hour. OT #5 stated the facility could not now locate that documentation.</p> <p>On 8/28/15, the DNS stated she should have received a physician order for the hand splint and the leg splints, and implemented the monitoring of those devices, when nursing staff took over that care from OT.</p> <p>4. Resident #5 was readmitted to the facility on 8/8/14 with multiple diagnoses including muscle wasting and atrophy, presence of artificial hip joint, and apraxia.</p> <p>The August 2015 Physician's Orders documented Resident #5's right wrist brace was to be kept in place and could be removed only for washing.</p> <p>On 8/26/15 at 12:00 PM, the resident was observed seated in her wheelchair in the main dining room without a brace on her right wrist. The resident stated she had broken her wrist the previous year and the arm had been in a cast, but it was now healed and she did not need to wear it now.</p> <p>On 8/28/15, the DNS stated the facility should have asked the resident's physician to discontinue the brace.</p>	F 309		
F 311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities</p>	F 311		

F 309

Resident Specific

The ID team validated residents #2, 3, 5, and 7 have orders updated /clarified and documentation of assessment as indicated. Resident #4 has discharged from the center.

Other Residents

The ID team reviewed other residents for physician's orders requiring updates/clarifications for continuous tube feeding adjustments without infusion, splint use and monitoring, edema management and implantation, and dialysis. No other residents are currently receiving dialysis. Adjustments have been made as indicated.

Facility Systems

Therapists and Licensed nurses are educated to seek MD orders updates and clarifications. SDC and DNS provided re-education to include but not limited to, nutritional risk of stopping a continuous tube feeding, risk of taping a resident's eyes open, skin risk of wearing/not monitoring splints, edema risk of not wearing/

monitoring tubi-grips, risk for complications of not wearing/monitoring wrist brace, risk for complications of not monitoring dialysis site, and not providing post dialysis care. Order changes, continuous tube feeding, transitions from therapy, non-traditional therapy standards/interventions, edema management, and residents on dialysis will be reviewed in morning clinical meeting, and order clarifications will be requested as indicated. Care plan will be updated as indicated. RN supervisor will review care implementations at the bedside to validate resident needs are met for high risk clinical areas. The clinical management team will review dialysis logs and monitors daily in clinical morning meeting.

Monitor

The Director of Nursing Services and/or designee will audit residents who receive continuous tube feedings non-transitional therapy interventions, residents with splints residents with tubigrips or edema management devices, dialysis patients for completed post dialysis care, and daily site monitoring weekly for 12 weeks. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

Date of Compliance: October 5, 2015

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

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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - WEISER	STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672
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F 311	<p>Continued From page 24 specified in paragraph (a)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure 3 of 9 sampled residents (#s 2, 5, & 6) were provided restorative or maintenance services to prevent decline and to restore and/or maintain their current levels of functional ability. This deficient practice had the potential for harm if residents experienced a decline in their ability to perform activities of daily living. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 12/22/14 with multiple diagnoses including muscle wasting and atrophy, major depression, and history of falling.</p> <p>The resident's quarterly MDS assessment, dated 7/7/15, documented: *Intact cognition; *Extensive assist of 1 staff for dressing, toileting, and bathing; and, *Frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>August 2015 Physician's Orders discharged Resident #2 on 6/19/15 to Restorative Nursing care for ambulation and exercise as the resident had reached "maximum functional potential with Physical Therapy."</p> <p>The resident's current Care Plan documented limited physical mobility related to weakness, at risk for falls, and depression or severe anxiety. The Care Plan directed staff to monitor for</p>	F 311	<p>F 311</p> <p>Resident Specific The ID team reviewed residents #2, 5, and 6 and reassessed their needs for restorative/functional maintenance services. Each plan was updated and services implemented according to their needs.</p> <p>Other Residents The ID team reviewed other residents converting from skilled therapy to restorative/functional maintenance services. Adjustments have been made as indicated.</p> <p>Facility Systems Therapists, Licensed nurses, and C.N.A. staff are educated on the process to transfer from skilled therapy services to Restorative/functional maintenance services. The SDC and DNS provided education to include but not limited to, preventing resident decline, ambulatory programs, and strengthening programs. These programs require that specific directives and documentation of services be provided. Daily validation of residents transitioning from skilled therapy to restorative/functional maintenance programs will occur by the IDT during morning clinical meeting. The ED/DNS will validate adequate weekly staffing to provide opportunity for RNA/functional management programs, and staff documentation of programs is implemented.</p>	
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F 311	<p>Continued From page 25</p> <p>complications related to immobility, including contractures, thrombus formation, skin breakdown, and fall related injury; provide supportive care and assistance with mobility as needed; wheelchair for mobility; and FWW (front wheel walker) and gaitbelt with therapy. Resident #2's Care Plan did not document the resident was involved in the RNA program. (Refer to F280 as it relates to Care Plans).</p> <p>Resident #2's Restorative Nurse Aide (RNA) Flow Sheet Record documented: * Ambulate ... with front wheel walker (FWW) 150 feet and 200 feet. In July 2015, staff documented the resident did this 18 times out of 31 opportunities and refused on 3 occasions. * Ambulate with contact guard with FWW 150 feet and 200 feet. In August 2015, staff documented the resident ambulated with FWW 6 times out of 28 opportunities. The resident refused on 1 occasion in August.</p> <p>On 8/24/15 at 2:20 PM and 4:00 PM, 8/25/15 at 10:20 AM, 3:00 PM, and 5:45 PM, and on 8/26/15 at 10:05 AM and 12:05 PM, the resident was observed in her wheelchair or her bed. The resident was not observed participating in RNA ambulation services on any of those three days. When asked, Resident #2 stated she used her FWW to go to the bathroom in her room.</p> <p>2. Resident #6 was admitted to the facility on 3/13/14 with multiple diagnoses including history of cerebrovascular accident (CVA), hemiplegia and hemiparesis, and depression.</p> <p>The resident's quarterly MDS assessment, dated 6/30/15, documented: *Intact Cognition;</p>	F 311	<p>Monitor The Director of Nursing Services and/or designee will audit Restorative and maintenance services for program updates and implementation daily (M-F) during morning clinical meeting, weekly for 12 weeks. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p> <p>Date of Compliance: October 5, 2015</p>	

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F 311	<p>Continued From page 26</p> <p>*Extensive assist of 1 staff for dressing, transferring, toileting, and bathing; and, *Always incontinent of bladder and bowel.</p> <p>Resident #6's August 2015 Physician's Orders documented on 3/19/14 that PT (Physical Therapy) was to evaluate and treat 3 times a week for 12 weeks. Treatment option included gait training, therapeutic exercise and activities, modalities, neuromuscular re-education, and patient/family/staff instruction.</p> <p>There was no specific Physician's Order addressing the RNA program for Resident #6.</p> <p>The resident's current Care Plan documented impaired physical mobility related to contractures of the left upper extremity, CVA with limited hemiparesis, and unsteady gait. Interventions included Restorative Nursing programs to maintain physical function, therapeutic exercises and Nu-Step, and ambulation along hand rails with a quad cane. Additionally, RNA was to ambulate the resident using an assistive device.</p> <p>Resident #6's Restorative Nurse Aide (RNA) Flow Sheet Record documented in July 2015 that the resident completed the Nu-Step 20 times out of 31 opportunities, and ambulated with a quad cane 18 times out of 31 opportunities. The resident refused RNA services on 1 occasion.</p> <p>In August 2015, nursing staff documented the resident completed the Nu-Step 9 times out of 28 opportunities, ambulated with a quad cane 8 times out of 25 opportunities, and did not refuse any RNA services.</p>	F 311			

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F 311	<p>Continued From page 27</p> <p>The resident's Nursing Progress Notes documented on 7/20/15, "This resident is doing well with his restorative programs. His first program is the Nu-Step. He is also on a restorative ambulation program ... walks 150 ft along the hand rails in the halls with the quad cane. He is maintaining his functional status." This Nursing Progress Note was the only documentation from 5/28/15 through 8/25/15 that mentioned the restorative program.</p> <p>On 8/24/15 at 2:05 PM, 8/25/15 at 10:35 AM, 11:40 AM, 1:30 PM, 3:15 PM, and 5:45 PM, 8/26/15 at 11:45 AM and 12:20 PM, the resident was observed in his wheelchair. The resident was not observed on the Nu-Step or being ambulated with his FWW during these three days.</p> <p>On 8/27/15, the DNS stated she had recently taken charge of the RNA and nursing maintenance programs. She said the facility had some staffing challenges in August and some nursing functions were not provided. The DNS stated RNA and Maintenance Flow Sheet Records documenting tasks were not performed were accurate.</p> <p>3. Resident #5 was readmitted to the facility on 8/8/14 with multiple diagnoses, including muscle wasting and atrophy, presence of artificial hip joint, depression, and apraxia.</p> <p>The resident's quarterly MDS assessment, dated 7/13/15, documented: *Intact Cognition; *Extensive assist of 1 staff for locomotion on- and off the unit and bathing; *Limited assist of 1 staff for dressing, walking in room, and personal hygiene; and,</p>	F 311		
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F 311	<p>Continued From page 28</p> <p>*Frequently incontinent of bladder and always continent of bowel.</p> <p>Resident #5's August 2015 Physician's Orders documented the resident was to be walked "more," PT was to evaluate and treat for gait instability. There was no specific Physician's Order addressing the maintenance ADL program for Resident #6.</p> <p>The current Care Plan documented Resident #5 was at moderate risk for falls related to gait/balance problems, incontinent, had a history of falls, and received psychoactive medications. The resident also had an ADL self care performance deficit related to left hip replacement and arthritis. Interventions included the provision of activities promoting movement and increasing strength, staff assistance with ADLs, and encouraging the resident to use a call light for assistance. The resident did not have a specific Care Plan addressing her placement on a Maintenance Program.</p> <p>Resident #5's ADL Flow Sheet Record documented in August 2015 that the resident self-propelled in a wheelchair and was to walk to the dining room with one staff assist to and from meals using FWW. Nursing staff documented the resident did this 25 times out of 25 opportunities and the resident had no refusals.</p> <p>On 8/24/15 at 2:25 PM and 4:00 PM, 8/26/15 at 9:20 AM, 11:45 AM, and 12:00 PM, and 8/27/15 at 11:50 AM, the resident was observed in her wheelchair or bed. The resident was not observed to be walked to the dining room for her meals. On 8/26/15 at 12:00 PM and 8/27/15 at 11:50 AM, Resident #5 stated she likes to walk,</p>	F 311			

F 311

Resident Specific

The ID team reviewed residents #2, 5, and 6 and reassessed their needs for restorative/functional maintenance services. Each plan was updated and services implemented according to their needs.

Other Residents

The ID team reviewed other residents converting from skilled therapy to restorative/functional maintenance services. Adjustments have been made as indicated.

Facility Systems

Therapists, Licensed nurses, and C.N.A. staff are educated on the process to transfer from skilled therapy services to Restorative/functional maintenance services. The SDC and DNS provided education to include but not limited to, preventing resident decline, ambulatory programs, and strengthening programs. These programs require that specific

directives and documentation of services be provided. Daily validation of residents transitioning from skilled therapy to restorative/functional maintenance programs will occur by the IDT during morning clinical meeting. The ED/DNS will validate adequate weekly staffing to provide opportunity for RNA/functional management programs, and staff documentation of programs is implemented.

Monitor

The Director of Nursing Services and/or designee will audit Restorative and maintenance services for program updates and implementation daily (M-F) during morning clinical meeting, weekly for 12 weeks. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

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F 311	Continued From page 29 but she had become "tired of fighting them over it." The resident stated on 8/26/15 at 12:00 PM that she had waited for staff to walk her to the dining room until a physical therapist instead wheeled her to the dining room in her wheelchair. The resident stated it was the therapist who told her to walk more, but then did not offer the necessary assistance. Resident #5 stated her walking times were very brief and she did not want to "bother" staff since they were "so busy." On 8/28/15, CNA #2 stated she signed the ADL Flow Sheet Record at the end of shift if the resident propelled herself and/or if the CNA walked or wheeled the resident in her wheelchair. CNA #2 said the resident was often already in the dining room or hallway propelling herself in her wheelchair, so the CNA often would not document she had been walked.	F 311			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure showers and/or baths were consistently provided for 3 of 7 residents (#s 1, 2, & 6) reviewed for ADL assistance. This deficient practice had the potential for more than minimal harm if residents experienced rashes, skin issues and/or	F 312	F 312 Resident Specific The ID team validated residents #1, 2, and 6 have their bathing needs provided. Medical records were not adjusted as legally no retroactive changes can be made. Other Residents The ID team reviewed other residents for their bathing needs being met. Adjustments have been made as indicated.		

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F 312	<p>Continued From page 30</p> <p>unpleasant odors due to not being bathed regularly. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 12/22/14 with multiple diagnoses, including muscle wasting and atrophy, major depression, and history of falling.</p> <p>The resident's quarterly MDS assessment, dated 7/7/15, documented: *Intact cognition; *Extensive assistance of 1 staff for dressing, toileting, and bathing; and, *Frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>The facility's Shower List documented the resident was to be showered on Mondays and Thursdays on the evening shift. The bath aides were to document any refusals and the LNs were to review baths that were being done in the morning and evening.</p> <p>The ADL Flow Sheet Record documented the resident was to be showered/bathed with shampoo twice weekly, and her fingernails and toenails were to be checked and cleaned.</p> <p>Resident #2's shower/bath Flow Sheet Record documented: *June 2015 - The resident was not bathed for 10 days, from 6/8/15 until 6/18/15. The resident refused a bath/shower on 8/11/15, but was not offered or given another bath/shower for 7 days. The resident did not bathe for 7 days, from 6/22/15 until 6/29/15. The resident did not refuse any baths/showers during this period. *July 2015 - The resident was not bathed for 11 days, from 7/23/15 until 8/3/15. The resident did</p>	F 312	<p>Facility Systems Licensed nurses and C.N.A.'s are educated to provide good personal hygiene through bathing. Re-education was provided by the SDC and DNS to include but not limited to, addressing lack of bathing documentation and management of resident refusals with plans for re-approach. Clinical management team reviews bathing documentation and stop-n-watch communication tools daily in clinical morning meeting. Resident plans are adjustments as indicated. The nursing supervisor will validate resident bathing needs are met through observation.</p> <p>Monitor The Director of Nursing Services and/or designee will audit resident's bathing records for consistent bathing and documentation of refusals and re-approach as indicated three times a week for 4 weeks then weekly for 8 weeks. Starting the week of September 28, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p> <p>Date of Compliance: October 5, 2015</p>		

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F 312	<p>Continued From page 31</p> <p>not refuse a bath/shower during this time. *August 2015 - The resident was not bathed for 11 days, from 8/6/15 until 8/17/15. The resident refused a bath/shower on 8/10/15, but was not offered or given another bath/shower for 7 days.</p> <p>Nursing Progress Notes did not address whether the LNs discussed the refusals or lack of bathing with the resident.</p> <p>On 8/27/15, the DNS said the resident missed showers on her scheduled days. She stated she expected CNAs to document resident refusals and reapproach at a later time or another day when the resident refused, which she could see was not being done.</p> <p>2. Resident #6 was admitted to the facility on 3/13/14 with multiple diagnoses including hemiplegia and hemiparesis, and depression.</p> <p>The resident's quarterly MDS assessment, dated 6/30/15, documented: *Intact Cognition; *Extensive assistance of 1 staff for dressing, transferring, toileting, and bathing; and, *Always incontinent of bladder and bowel.</p> <p>The facility's Shower List documented the resident was to be showered on Tuesdays and Saturdays on the evening shift. The bath aides were to document any refusals and the LNs were to review baths that were being done during day and evening shifts.</p> <p>Resident #6's shower/bath Flow Sheet Record documented: *June 2015 - The resident did not bathe for 9 days, from 6/1/15 until 6/9/15. The resident did</p>	F 312			

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F 312	<p>Continued From page 32</p> <p>not refuse a bath/shower during this time. The resident also was not bathed for 11 days, from 6/13/15 until 6/20/15. The resident refused a bath/shower on 6/16/15, but was not offered or given another bath/shower for 4 days.</p> <p>*July 2015 - The resident was not bathed for 7 days, from 7/4/15 until 7/11/15. The resident did not refuse a bath/shower during this time. The resident did not bathe for an additional 7 days, from 7/11/15 until 7/18/15. The resident refused a bath/shower on 7/14/15 and 7/16/15, but was not reapproached at a different time or asked why he had refused.</p> <p>*August 2015 - The resident was not bathed for 14 days, from 8/11/15 until 8/26/15. The resident did not refuse a bath/shower during this time period.</p> <p>There were no Nursing Progress Notes to address whether the LNs had addressed the lack of bathing or refusals.</p> <p>On 8/27/15 at 10:35 AM, the DNS said she was aware there was an issue with bathing and that the Performance Improvement Team was investigating the refusals and re-evaluating the bath/shower schedule to resolve the concerns.</p> <p>3. Resident #1 was admitted to the facility in 2012 with multiple diagnoses, including Alzheimer's Disease, depression, and history of cerebrovascular accident (CVA).</p> <p>The resident's most recent quarterly MDS assessment, dated 5/22/15, documented severe cognitive impairment, no rejection of cares, and</p>	F 312			

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

PRINTED: 09/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 312	<p>Continued From page 33 extensive assistance of 1 staff for bathing.</p> <p>Resident #1's annual MDS assessment, dated 8/14/15, documented severe cognitive impairment, rejection of cares occurred 1-3 days, and bathing did not occur during the previous two weeks.</p> <p>The current Care Plan documented, "Resident will take at least 1 bath a week." Interventions included set-up assistance with bathing.</p> <p>The Resident's ADL Flow Sheet for June, July, and August 2015 recorded the resident was to receive a shower or bath twice a week and documented::</p> <p>*June 2015 -1 bath and 3 refusals: The resident was not bathed for 12 days (6/1-6/12) and 17 days (6/14-6/30). There was no documented indication the resident was reapproached or offered to bathe at a different time or day for 2 of the 3 refusals.</p> <p>*July 2015- 2 baths and 4 refusals: The resident was not bathed for 9 days (7/2-7/10). Per Nursing Progress Notes, dated 7/8/15, the resident stated, "I just don't feel like it tonight, I will tomorrow." There was no documentation the resident was offered or encouraged to bathe the next day. The resident was not bathed for 13 days (7/12-7/24), and no refusals were documented.</p> <p>*August 2015- 2 baths and 4 refusals: The resident was not bathed for 17 days (8/1- 8/17). There was no documented evidence the resident was reapproached to bathe at different time or day for 3 of the 4 refusals.</p> <p>On 8/27/15, the DON said she was aware the resident frequently refused to bathe and noted the resident's family indicated on 8/18/15 that a</p>	F 312			

F 312

Resident Specific

The ID team validated residents #1, 2, and 6 have their bathing needs provided. Medical records were not adjusted as legally no retroactive changes can be made.

Other Residents

The ID team reviewed other residents for their bathing needs being met. Adjustments have been made as indicated.

Facility Systems

Licensed nurses and C.N.A.'s are educated to provide good personal hygiene through bathing. Re-education was provided by the SDC and DNS to include but not limited to, addressing lack of bathing documentation and management of resident refusals with plans for re-approach . Clinical management team reviews bathing documentation and stop-n-watch communication tools daily in clinical morning meeting. Resident plans are adjustments as indicated. The nursing supervisor will validate resident bathing needs are met through observation.

Monitor

The Director of Nursing Services and/or designee will audit resident's bathing records for consistent bathing and documentation of refusals and re-approach as indicated three times a week for 4 weeks then weekly for 8 weeks. Starting the week of September 28, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

Date of Compliance: October 5 2015

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F 312	Continued From page 34 specific family member should be called whenever the resident refused bathing.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents were free from unnecessary medications. This was true for 1 of 6 sample residents (#1). Failure to follow pharmacist	F 329	F 329 Resident Specific The ID team validated resident #1 had pharmacist recommendations implemented with subsequent MD follow up. Medical records were not adjusted as legally no retroactive changes can be made. Other Residents The ID team reviewed other residents for a drug regimen free of unnecessary drugs and treatments to ensure highest well being. Adjustments have been made as indicated. Facility Systems Licensed nurses are educated to validate residents are free of unnecessary drugs and have quality assessment post fall. Re-education was provided by SDC and DNS to include but not limited to, following pharmacist's recommendations, completing neurochecks on unwitnessed falls, and reviewing medications for possible adverse side effects.	

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F 329	<p>Continued From page 35</p> <p>recommendation for orthostatic blood pressure checks had the potential to cause declines if residents experienced negative effects from receiving a medication for which there was no clear clinical indication. Findings included:</p> <p>Resident #1 was admitted to the facility in 2012 with multiple diagnoses, including hypertension.</p> <p>An Incident and Accident report, dated 5/7/15, documented the resident complained of right hip and right lower back pain, and thought he fell the previous day, but did not tell anyone. Vital Signs documented on the Incident and Accident report were dated 5/4/15, three days before the reported unwitnessed fall. The facility's Incident Investigation policy directed staff to complete neurological checks for unwitnessed falls. The 5/4/15 report did not include documentation of the resident's vital signs.</p> <p>Nursing Notes dated 5/8/15 documented "...this [morning] resident without complaints of pain in his hip area. Will do 15 minute checks [for] 72 hours to watch for any other concerns."</p> <p>Recapitulated Physician 's Orders for August 2015 documented Resident #1 received Norvasc for hypertension; Coreg, which was to be given with food to minimize potential orthostasis; Cozaar; and Lasix.</p> <p>A pharmacy report, dated 6/11/15, documented, "No medication changes are recommended because of this fall. If you think they can be done safely, please consider doing two sets of orthostatic blood pressure/pulse, one an hour or two after he receives his morning medications and the other between supper and bedtime."</p>	F 329	<p>The ID team will review falls/events in the morning clinical meeting for quality assessment and review. DNS will continue to request pharmacist review of medications post fall. The ID team will validate that pharmacist review occurs and that recommendations are implemented by the clinical team as noted in follow-up documentation placed in the clinical record reflecting the outcomes.</p> <p>Monitor The Director of Nursing Services and/or designee will audit pharmacist's recommendations for follow up with in 7 days of report for 3 months. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p> <p>Date of Compliance: October 5, 2015</p>		

F 329

Resident Specific

The ID team validated resident #1 had pharmacist recommendations implemented with subsequent MD follow up. Medical records were not adjusted as legally no retroactive changes can be made.

Other Residents

The ID team reviewed other residents for a drug regimen free of unnecessary drugs and treatments to ensure highest well being. Adjustments have been made as indicated.

Facility Systems

Licensed nurses are educated to validate residents are free of unnecessary drugs and have quality assessment post fall. Re-education was provided by SDC and DNS to include but not limited to, following pharmacist's recommendations, completing neurochecks on unwitnessed falls, and reviewing medications for possible adverse side effects.

The ID team will review falls/events in the morning clinical meeting for quality assessment and review. DNS will continue to request pharmacist review of medications post fall. The ID team will validate that pharmacist review occurs and that recommendations are implemented by the clinical team as noted in follow-up documentation placed in the clinical record reflecting the outcomes.

Monitor

The Director of Nursing Services and/or designee will audit pharmacist's recommendations for follow up with in 7 days of report for 3 months. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

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F 329	Continued From page 36 When asked on 8/27/15 whether the pharmacist's recommendation of Orthostatic BPs and pulse (PR) were completed, the DON replied, "None that I know of." On 8/27/15, the DON, said she could not find the neurocheck and vital signs documentation for the resident. When asked what the facility's policy required related to the unwitnessed fall, the DON stated, "Neurochecks! Yes, that is an issue."	F 329			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the	F 334	F 334 Resident Specific The ID team reviewed resident #1 and resident has been offered the flu vaccine with documentation noted in the record. Other Residents The ID team reviewed other residents to validate flu vaccines are ordered. Adjustments have been made as indicated.		

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F 334	Continued From page 37 influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	Facility Systems Licensed nurses are educated to offer flu vaccines to existing residents and new admissions though the health department determined flu season. Re-education was provided by Infection Control Coordinator to include but not limited to, documenting resident refusals with evidence of risk and benefits explained. The Infection Control Coordinator will present the monthly electronic audit to the infection control team for validation that documentation is present for immunization or refusal with evidence that education is provided. Monitor The Infection Control Coordinator and/or designee will audit new residents for being offered flu vaccine and documenting of refusals, weekly for 12 weeks. Starting the week of September 28 th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate. Date of Compliance: October 5, 2015		

F 334

Resident Specific

The ID team reviewed resident #1 and resident has been offered the flu vaccine with documentation noted in the record.

Other Residents

The ID team reviewed other residents to validate flu vaccines are ordered. Adjustments have been made as indicated.

Facility Systems

Licensed nurses are educated to offer flu vaccines to existing residents and new admissions through the health department determined flu season. Re-education was provided by Infection Control Coordinator to include but not limited to, documenting resident refusals with evidence of risk and benefits explained. The Infection Control Coordinator will present the monthly electronic audit to the infection control team for validation that documentation is present for immunization or refusal with evidence that education is provided.

Monitor

The Infection Control Coordinator and/or designee will audit new residents for being offered flu vaccine and documenting of refusals, weekly for 12 weeks. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

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F 334	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to offer the influenza vaccine during the flu season (October 1 to March 31). This was true for 1 of 5 sample residents (#1) reviewed for influenza vaccination. This failure created the potential risk the development and spread of infections in the facility. Findings include: Resident #1 was admitted to the facility in 2012 with multiple diagnoses, including hypertension, Alzheimer's Disease, depression and history of Cerebrovascular Disease (CVA). On 8/27/15, the facility was asked to provide documentation that Resident #1 was offered- received- or refused an influenza immunization in 2014. On 8/28/15, the DON stated documentation regarding the 2014 influenza immunization for Resident #1 could not be found.	F 334			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F 441 Resident Specific The ID team reviewed residents, <ul style="list-style-type: none"> # 9 contact precautions were implemented as noted in the CMS-2567. #3 has completed his TB screening. #4 has been discharged from the center. There are no examples noted for failure to change tube feeding syringes and measuring cups; however, the center 		

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F 441	<p>Continued From page 39 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to ensure contact precautions were implemented as ordered; TB (tuberculosis) screenings were completed; tube feeding syringes and measuring cups were changed daily; and that staff performed hand hygiene before and after injections and following resident contact. This was true for 3 of 9 sample residents (#s 3, 4 & 9) and 1 random resident (#13). The failures created</p>	F 441	<p>has changed to a disposable system which can be dated for all tube feeding residents.</p> <p>Other Residents The ID team reviewed other residents for two-step TB screening and orders for contact precautions. Adjustments have been made as indicated. Hand hygiene skills lab is completed for staff. Residents with tube feedings have transitioned to disposable supplies and have evidence of daily change. Also see F281.</p> <p>Facility Systems Licensed nurses and Therapy staff are educated in infection control standards. Re-education was provided by SDC and Infection control Coordinator to include but not limited to, ensuring contact precautions are implemented as ordered. TB Screenings are completed within 30 days of admission. TF feeding syringes and measuring cups are changed to a disposable product. They will be disposed, dated and changed daily by the licensed nurse. Hand hygiene is completed before and after injections and following resident contact. The Infection Control Coordinator will present the monthly electronic audit to the infection control team for validation that documentation is present for TB screening on new residents. Infection control coordinator and clinical management team will monitor TF resident equipment and staff hand hygiene during observation rounds. See F281.</p>		

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F 441	<p>Continued From page 40</p> <p>the potential for infections to develop and spread in the facility. Findings include:</p> <p>1. Resident #9 was admitted to the facility on 8/21/15 with multiple diagnoses, including urinary tract infection (UTI).</p> <p>The resident's 8/21/15 Admission Orders included, "Contact Precautions: MRSA [Methicillin-resistant Staphylococcus aureus]."</p> <p>On 8/24/15, a rack with personal protective equipment (PPE) was observed on the wall in the hallway next to Resident #9's door. There was no signage on or near the resident's door for visitors and staff to check with the nurse before entering the room.</p> <p>On 8/25/15, a sign which read, "STOP," and instructed visitors and staff to check with the nurse before entering the room was observed on the resident's door.</p> <p>On 8/28/15, the RN Supervisor (RNS) confirmed the resident was in isolation and that contact precautions were initiated on 8/24/15. The RNS said it was not initially clear if MRSA was in the resident's urine or nare (nostril), but on 8/24/15 she received a hospital laboratory report, dated 8/15/15, which documented MSRA was positive in the resident's left nare; and on 8/25/15, she received a final urine culture report, dated 8/18/15, that was negative for infection. The RNS said she was not on duty on 8/21/15 when the DON admitted the resident.</p> <p>On 8/28/15 at 2:15 p.m., the DON said contact precautions were not started on 8/21/15 because the physician thought the MRSA was "colonized"</p>	F 441	<p>Monitor</p> <p>The Infection Control Coordinator and/or designee will audit tube feeding syringes and measuring cups for dating, TB Screenings for completion, and general hand washing for compliance on rounds 3 times a week for 4 weeks then two times a week for 8 weeks. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p> <p>Date of Compliance: October 5, 2015</p>		

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F 441	<p>Continued From page 41</p> <p>in the residents nare. When asked if the order for contact precautions was discontinued, the DON stated, "No."</p> <p>The contact precautions were not implemented for 3 days after they were ordered.</p> <p>2. During a medication pass on 8/25/15 at 4:00 p.m., an LN was observed placing the cap off a bottle of artificial tears right side up on top of Resident #12's dresser before administering artificial tears into the resident's eyes. The LN did not sanitize the top of the dresser or utilize a barrier under the cap.</p> <p>Immediately afterward, the LN was asked what she did with the cap when she administered the resident's eye drops. The LN stated, "Oh, I sat it on the dresser. Yes I did."</p> <p>3. On 8/25/15, LN #1 was observed as she sanitized her hands, donned gloves, and prepared an insulin medication for subcutaneous injection for Resident #9. The LN then removed her gloves and took the insulin flex pen into the resident's room. In the resident's room, the LN did not perform hand hygiene before she applied new gloves and administered the insulin by injection. After the medication administration, the LN removed her gloves, left the resident's room and returned to the medication cart. The LN did not wash or sanitize her hands before or after she gave the insulin injection.</p> <p>When informed of the observation regarding the insulin administration for Resident #9, LN #1 stated she had sanitized her hands and wore gloves when she set-up the insulin pen.</p>	F 441			

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F 441	Continued From page 42 4. Resident #3 was admitted to the facility on 7/21/15 with multiple diagnoses including CVA. On 7/21/15, Resident #3's Admission Orders documented the resident was to receive a TB (tuberculosis) screening upon admission and continuous tube feedings via the percutaneous endoscopic gastrostomy (PEG) tube. a) The resident's July and August 2015 Medication Records documented the first step of the TB screening was administered 7/23/15 and was negative when read five days later on 7/28/15. The PPD 2nd step scheduled for 8/12/15 was not completed. On 8/28/15, the Staff Development Coordinator (SDC) said the second step of the resident's TB screening was not performed within 30 days after admission per standard practice or the facility's policy. b) On 8/26/16 at 11:50 AM, PT #3 was observed as she applied Resident #3's shoes and then transferred the resident to his wheelchair. The PT did not perform any type of hand hygiene before she opened the door, left the room, and walked to the speech therapy (ST) office. Immediately afterward, the PT was asked about hand hygiene. The PT said she would do it right then. 5. Resident #4 was admitted to the facility on 6/17/14, and readmitted on 1/13/15, with multiple diagnoses including meningioma.	F 441			

F 441

Resident Specific

The ID team reviewed residents,

- # 9 contact precautions were implemented as noted in the CMS-2567.
- #3 has completed his TB screening.
- #4 has been discharged from the center.
- There are no examples noted for failure to change tube feeding syringes and measuring cups; however, the center

has changed to a disposable system which can be dated for all tube feeding residents.

Other Residents

The ID team reviewed other residents for two-step TB screening and orders for contact precautions. Adjustments have been made as indicated. Hand hygiene skills lab is completed for staff. Residents with tube feedings have transitioned to disposable supplies and have evidence of daily change. Also see F281.

Facility Systems

Licensed nurses and Therapy staff are educated in infection control standards. Re-education was provided by SDC and Infection control Coordinator to include but not limited to, ensuring contact precautions are implemented as ordered. TB Screenings are completed within 30 days of admission. TF feeding syringes and measuring cups are changed to a disposable product. They will be ~~disposed~~, dated and changed daily by the licensed nurse. Hand hygiene is completed before and after injections and following resident contact. The Infection Control Coordinator will present the monthly electronic audit to the infection control team for validation that documentation is present for TB screening on new residents. Infection control coordinator and clinical management team will monitor TF resident equipment and staff hand hygiene during observation rounds. See F281.

Monitor

The Infection Control Coordinator and/or designee will audit tube feeding syringes and measuring cups for dating, TB Screenings for completion, and general hand washing for compliance on rounds 3 times a week for 4 weeks then two times a week for 8 weeks. Starting the week of September 28th the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

Date of Compliance: October 5, 2015

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

PRINTED: 09/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 43	F 441			
F 490 SS=E	<p>The resident's August 2015 Physician's Orders included a 1/14/15 order for a TB screening.</p> <p>Review of the resident's clinical records revealed there was no evidence the resident had been screened for TB.</p> <p>On 8/28/15, when asked whether the resident received his physician-ordered TB screening, the DON stated, "No, he might not have. We are still looking for it."</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and medical record review, it was determined the facility failed to administer resources effectively and efficiently to prevent systematic problems for 9 of 10 sampled residents (#s 1-9) and 3 random residents (#s 11-13). This failure had the potential to affect all residents in the facility and resulted in the management team providing insufficient direction and control necessary to ensure residents' Quality of Life and Quality of Care needs were met. Findings included:</p> <p>The facility failed to provide sufficient</p>	F 490	<p>F 490</p> <p>Resident Specific See F221, 246, 248, 309, 310, 312, 329, and 441</p> <p>Other Residents See F221, 246, 248, 309, 310, 312, 329, and 441</p> <p>Facility Systems See facility systems for F221, 246, 248, 309, 310, 312, 329, 441, and 520.</p> <p>Monitor See facility monitoring for F221, 246, 248, 309, 310, 312, 329, 441, and 520</p>		

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F 490	<p>Continued From page 44 implementation, monitoring, evaluation, and continued oversight to maintain regulatory compliance in the following areas:</p> <p>A. Refer to F221 - The facility failed to ensure residents with restrictive devices were assessed for the safety of these devices and the resident or resident's representative were informed of the risks and benefits of a seatbelt and bilateral feet straps.</p> <p>B. Refer to F246 - The facility failed to ensure a resident's call light was within reach and the resident assessed for ability to activate a call light.</p> <p>C. Refer to F248 - The facility failed to ensure activities were meaningful and individualized for a resident.</p> <p>D. Refer to F309 - The facility failed to ensure Physicians' orders were followed, assessment of a dialysis access site was monitored, and medications clarified for a resident who was NPO (nothing orally by mouth).</p> <p>E. Refer to F310 - The facility failed to ensure residents received consistent restorative and maintenance nursing services to maintain or improve their ADL functioning.</p> <p>F. Refer to F312 - The facility failed to ensure residents were bathed on a consistent basis.</p> <p>G. Refer to F329 - The facility failed to ensure residents were not administered medications without proper monitoring.</p> <p>H. Refer to F441 - The facility failed to ensure</p>	F 490		
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F 490

Resident Specific

See F221, 246, 248, 309, 310, 312, 329, and 441

Other Residents

See F221, 246, 248, 309, 310, 312, 329, and 441

Facility Systems

See facility systems for F221, 246, 248, 309, 310, 312, 329, 441, and 520.

Monitor

See facility monitoring for F221, 246, 248, 309, 310, 312, 329, 441, and 520

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F 490	Continued From page 45 residents were provided the necessary care and treatment to minimize the risks and prevent the spread of infectious diseases.	F 490			
F 514 SS=E	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 record review and resident and staff interview, it was determined the facility failed to maintain clinical records for each resident that were complete and accurate. This was true for 4 of 10 sample residents (#s 1, 2, 7, & 8) and created the potential for medical decisions to be based on incomplete or inaccurate information, which increased the risk for complications due to inappropriate care or interventions. Findings included: 1. Resident #2 was admitted to the facility on 12/22/14 with multiple diagnoses, including muscle wasting and atrophy, major depression, and diabetes.	F 514	F 514 Resident Specific The ID team reviewed residents: #2 medical records were not adjusted as legally no retroactive changes can be made. #1 and #7 orders have been clarified for their current facility pass status. #7 clarification orders have been requested and received for diagnosis to indicate use. Other Residents The ID team reviewed other residents for facility pass orders and diagnosis for medication use. Adjustments have been made as indicated. Facility Systems Nursing staff and medical records are educated to maintain clinical records in accordance with accepted professional standards. Re-education was provided by SDC and DNS to include, but not limited to, records that are complete and accurate r/t HS Snacks, Out on Pass, and diagnoses listed to support medication use. Orders are reviewed on admission, with change of condition, with monthly recapitulation, and at least quarterly by clinical management team.		

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F 514	<p>Continued From page 46</p> <p>The resident's current Care Plan documented potential for nutritional deficits related to depression, diabetes, variable intake, and bouts of nausea, and directed staff to encourage oral intake and fluids, as well as offer and document bedtime (HS) snacks.</p> <p>Resident #2's ADL Flow Sheet documented: * July 2015 - The resident accepted an HS snack 18 times and refused 10 times out of 31 opportunities. * August 2015 - The resident accepted a snack 5 times and refused 8 times out of 25 opportunities.</p> <p>On 8/25/15, Resident #2 stated she has never been a big eater and does not have much of an appetite. The resident said she always has snacks available in her room and staff frequently encouraged her to eat something.</p> <p>On 8/28/15, evening shift LN #4 stated the HS snack/hydration cart is sent out nightly at approximately 7:30 PM. She said CNAs are responsible for passing HS snacks and drinks, but if they are busy then she will ensure residents are offered something from the cart. LN #4 stated Resident #2 is offered a Boost drink every night, which she routinely accepts, and another snack, which she often declines.</p> <p>2. Resident #7 was admitted to the facility on 12/19/13 with multiple diagnoses including chronic renal insufficiency and diabetes.</p> <p>The resident's August 2015 Physician's Orders documented the resident could not leave the facility on "pass."</p>	F 514	<p>Monitor The Director of Nursing Services and/or designee will audit clinical records on admissions and for HS snack flowsheet completion three times a week for 4 weeks and then two times a week for 8 weeks. Starting the week of September 28, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p> <p>Date of Completion: October 5, 2015</p>		

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F 514	<p>Continued From page 47</p> <p>Resident #7's Care Plan documented a need for diversional activities related to a history of depression and directed staff to encourage participation in out-of-facility opportunities with friends, family, or as part of a group.</p> <p>On 8/24/15, Resident #7 stated he was very active at the facility and had gone fishing with other residents, as well as on numerous outings with friends and family.</p> <p>On 8/27/15, the DNS stated the resident was able and safe to leave the facility on pass.</p> <p>3. Resident #8 was admitted to the facility on 7/6/15 with multiple diagnoses including cerebral palsy and severe dysphagia.</p> <p>The resident's August 2015 Physician's Orders and MAR documented nine medications for which there was no clinical explanation for use provided. These medications included Levothyroxine, Sodium, Baclofen, Gentamin, Prevacid, Artificial Tears, Ear Drops, Reclast Infusion, Promod, and Jevity 1.2.</p> <p>On 8/27/15, the DNS stated the lack of diagnoses had been an oversight which would be corrected right away.</p> <p>4. Resident #1 was admitted to the facility in 2012 with multiple diagnoses, including hypertension, Alzheimer's Disease, depression, and history of Cerebrovascular Disease (CVA).</p> <p>The Resident's #1 August 2015 Physician's Orders documented; "03/03/12: May go out on</p>	F 514			

F 514

Resident Specific

The ID team reviewed residents: #2 medical records were not adjusted as legally no retroactive changes can be made. #1 and #7 orders have been clarified for their current facility pass status. #7 clarification orders have been requested and received for diagnosis to indicate use.

Other Residents

The ID team reviewed other residents for facility pass orders and diagnosis for medication use. Adjustments have been made as indicated.

Facility Systems

Nursing staff and medical records are educated to maintain clinical records in accordance with accepted professional standards. Re-education was provided by SDC and DNS to include, but not limited to, records that are complete and accurate r/t HS Snacks, Out on Pass, and diagnoses listed to support medication use. Orders are reviewed on admission, with change of condition, with monthly recapitulation, and at least quarterly by clinical management team.

Monitor

The Director of Nursing Services and/or designee will audit clinical records on admissions and for HS snack flowsheet completion three times a week for 4 weeks and then two times a week for 8 weeks. Starting the week of September 28, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.

Date of Completion: October 5, 2015

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F 514	Continued From page 48 pass: NO. Resident #1's current Care Plan documented, "Resident will go on outings as desires with family." An 8/8/15 Social Services Notes documented, "Much family support. Goes on outings with them when he chooses ..." On 8/27/15, when asked about the conflicting 8/8/15 Social Services Note, August 2015 Physician's Orders, the Activities Director said, "I don't know, but I will find out." On 8/27/15, the DNS stated the resident was able to go out of the facility on pass.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520	F520 Resident Specific See F309 Other Residents See F309 Facility Systems The DNS completes clinical review for the QAPI meeting each month. QI scoring is reviewed and previous survey issues are assessed. The PI team will trend data, develop action plans, provide education, and monitor the areas indicated for effectiveness. Systems will be implemented to correct issues based upon a root cause analysis.	

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F 520	<p>Continued From page 49</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, 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 concerning quality of care and quality of life issues for 9 of 10 sampled residents (#s 1-9) and 4 random residents (#s 11-13). This deficient practice also had the potential to affect all residents in the facility. Findings included:</p> <p>The QAA committee failed to provide sufficient monitoring and oversight, or sustain regulatory compliance, as evidenced by the re-citation of the following deficient practice as determined by the recertification survey of 8/24/15 through 8/28/15.</p> <p>Refer to F309 as related to the facility's failure to ensure provision of the necessary care and services to attain or maintain residents' highest practicable physical, mental, and psychosocial well-being. The facility was previously cited at F309 during its 2014 recertification survey, as well as for the current 2015 recertification survey.</p>	F 520	<p>Monitor</p> <p>The Executive Director and/or designee will audit for plan effectiveness. Trends and plans will be documented in the PI minutes. Reviews will occur monthly for 3 months. The PI committee may adjust the frequency of the monitoring as it deems appropriate.</p> <p>Date of Compliance: October 5, 2015</p>		

F520

Resident Specific
See F309

Other Residents
See F309

Facility Systems

The DNS completes clinical review for the QAPI meeting each month. QI scoring is reviewed and previous survey issues are assessed. The PI team will trend data, develop action plans, provide education, and monitor the areas indicated for effectiveness. Systems will be implemented to correct issues based upon a root cause analysis.

Monitor

The Executive Director and/or designee will audit for plan effectiveness. Trends and plans will be documented in the PI minutes. Reviews will occur monthly for 3 months. The PI committee may adjust the frequency of the monitoring as it deems appropriate.

Date of Compliance: October 5, 2015

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001830	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - WEI	STREET ADDRESS, CITY, STATE, ZIP CODE 331 EAST PARK STREET WEISER, ID 83672
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual State licensure survey of your facility.</p> <p>The surveyors who conducted the survey were: Linda Hukill-Neil, RN, Team Coordinator Linda Kelly, RN Angela Morgan, RN, BSN Presie Billington, RN</p> <p>The survey team entered the facility on August 24, 2015 and exited on Friday August 28, 2015.</p>	C 000		
C 422	<p>02.120.05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility did not have at least one bathing facility for every 12 licensed beds.</p> <p>The facility was licensed for 76 beds, which required 7 bathing facilities. The facility had only 3 permanent bathing facilities, and 3 temporary bathing facilities in a storage unit in the back of the building. The temporary bathing units could easily be transported into the building for resident use.</p>	C 422	<p>C 422</p> <p>Resident Specific The facility has adequate shower and bathing units to meet the needs of our current resident census. No specific residents were identified.</p> <p>Other Residents If our census increases to a level higher then our current need we have portable shower units on site that can be used to meet the needs.</p> <p>Facility Systems The portable bathing units are requested as a waiver. This unit can be taken to resident rooms for those who do not want to and/or are unable to leave their rooms.</p> <p>Monitor Executive Director is responsible to oversee that the facility has adequate shower units to meet the needs of the residents who live in the facility. There are adequate shower units to meet our current census. Furthermore if our census does increase we have the portable units for use. Any issues or concerns will be addressed immediately and reported at our Performance Improvement committee Meeting for further recommendations.</p> <p>Date of Compliance: October 5, 2015</p>	

FACILITY SCAN
SEP 29 2015

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Herald B...</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>9/28/15</i>
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Bureau of Facility Standards

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C 422	Continued From page 1 On 8/27/15 at 8:00 AM, the Administrator stated there were currently 34 residents, and the 3 temporary bathing units were portable and could easily be rolled into the facility. The facility was cited at F312 for bathing/shower concerns not related to the lack of bathing facilities.	C 422		
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C 422

Resident Specific

The facility has adequate shower and bathing units to meet the needs of our current resident census. No specific residents were identified.

Other Residents

If our census increases to a level higher than our current need we have portable shower units on site that can be used to meet the needs.

Facility Systems

The portable bathing units are requested as a waiver. This unit can be taken to resident rooms for those who do not want to and/or are unable to leave their rooms.

Monitor

Executive Director is responsible to oversee that the facility has adequate shower units to meet the needs of the residents who live in the facility. There are adequate shower units to meet our current census. Furthermore if our census does increase we have the portable units for use. Any issues or concerns will be addressed immediately and reported at our Performance Improvement committee Meeting for further recommendations.

Date of Compliance: October 5, 2015