



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

October 28, 2015

Shelly Henderson, Administrator
Payette Center
1019 Third Avenue South,
Payette, ID 83661-2832

Provider #: 135015

Dear Ms. Henderson:

On **October 9, 2015**, a survey was conducted at Payette Center 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 in your facility to be **ISOLATED** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) in writing on **October 9, 2015**.

On **October 15, 2015**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction and an on-site review on October 26, 2015, it was determined that the immediate jeopardy to the residents had been removed on October 19, 2015. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided

listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by November 9, 2015. Failure to submit an acceptable PoC by , may result in the imposition of additional civil monetary penalties by November 12, 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.
- 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*.

Shelly Henderson, Administrator
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Based on the immediate jeopardy cited during this survey:

F0281 -- S/S: J -- 483.20(k)(3)(i) -- Services Provided Meet Professional Standards

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

A 'per instance' civil money penalty of \$5,000 per each "IJ" citation and \$750 for each "G" level citation.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 9, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe the 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, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

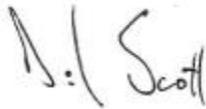
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by November 9, 2015. If your request for informal dispute resolution is received after , 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 "D. Scott". The signature is written in a cursive style.

David Scott, Supervisor
Long Term Care

DJS/lj
Enclosures

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

PRINTED: 12/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2015
NAME OF PROVIDER OR SUPPLIER PAYETTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility October 5-9, 2015. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Kendra Deines, RN, BSN Abbreviations included: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters mg/dl = milligrams per deciliter CNA = Certified Nurse Aide CP = Care Plan CVA = Cardiovascular Accident H&P = History and Physical I & A = Incident and Accident LN = Licensed Nurse LPM = Liters per Minute MAR = Medication Administration Record MD/md = Medical Doctor MDS = Minimum Data Set assessment O.T. = Occupational Therapy PRN = As Needed P.T. = Physical Therapy TAR = Treatment Administration Record DNS = Director of Nursing Services ADL = Activities of Daily Living CCHO = Consistent Carbohydrate CHO = Carbohydrate RCM = Regional Clinical Manager DMT = Dietary Manager in Training	F 000			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with	F 248		12/16/15	

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

TITLE

(X6) DATE

Electronically Signed

11/10/2015

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

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F 248	<p>Continued From page 1</p> <p>the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident group interview and staff interview, it was determined the facility failed to provide activities that met the interest of each resident. This was true for 10 of 10 residents who attended the resident group interview and had the potential to negatively impact the residents' psychosocial status due to a lack of offered activities that met their mental, physical, and emotional needs.</p> <p>The October 2015 Activity Calendar documented the latest activity in the month starting at 6:00 p.m. No "outing" type activity was offered for the month. All Sundays in the month documented a church "Message & Song" with no other activity on Sundays.</p> <p>On 10/6/15, residents were interviewed during the resident group interview. When asked about activities in the facility, the residents stated it was "boring for a lot of people" and they did not have many chances to get out of the facility on outings. They stated they would like to go on scenic rides or shopping, but that there was no bus to take them. They also stated they would like more to do on the weekends, particularly Saturdays, and evenings.</p> <p>On 10/9/15 at 2:05 p.m., the Recreation Director stated that until recently the facility did not have activities on the evenings or weekends. She stated evenings weren't "a big hit" and that</p>	F 248	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Payette Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F 248</p> <p>Affected On or before 12/16/15 center residents will be re-interviewed/re-assessed, by the Activities Director or designee, for activities preferences.</p> <p>Potential Effective on or before 12/16/15 the Activities Director or designee will review current resident's activities preferences. The calendar of events will be updated to reflect the resident's current activities/leisure interest needs. Care plans for residents whose activities needs have</p>		

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F 248	Continued From page 2 residents were in bed by 6:00 p.m. She stated the facility does not use the van for activities.	F 248	<p>changed will be updated by the Activities Director on or before 12/16/15 to reflect the resident's current activities/leisure interests.</p> <p>On 11/05/15, the Activities Director or designee conducted a group interview to determine residents' current activities desires, including preferences for weekend, evening, and outing activities.</p> <p>On or before 11/19/15 an activities calendar will be developed, by the Activities Director or designee, to reflect the current activities/leisure needs/interest of residents including weekend, evening, and outing activities.</p> <p>Systemic On or before 11/12/15 the Activities Director will receive education provided by the divisional quality of life regarding identification of leisure interests and developing a program of events to meet the mental, physical and emotional needs of residents, including evening and weekend opportunities.</p> <p>Beginning 11/19/15 the calendar of events will be reviewed by the Administrator and provided to the resident council for review and approval.</p> <p>Monitor Effective 11/19/2015, the Administrator or designee will audit the calendar of events to ensure that it reflects the current needs/interests of the residents including weekend, evening, and outing activities.</p>		

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F 248	Continued From page 3	F 248	Effective 12/16/15, the Administrator or designee will interview three residents related to their satisfaction with activities programming. Audits/ Interview results will be completed weekly X 4 then Monthly X 2. The results of these audits will be compiled by the Administrator and reported to the QAPI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The Administrator is responsible for monitoring and follow-up.		
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services 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 staff interview and record review, it was determined the facility failed to implement social service interventions to meet residents' emotional needs, identify resident centered treatment goals, and provide ways to maintain or enhance residents' choices in full recognition of their individuality. This was true for 1 of 4 (#4) residents sampled for social services and had the potential for psychosocial harm.</p> <p>1. Resident #4 was admitted to the facility with multiple diagnoses, including major depressive disorder and history of CVA.</p>	F 250	<p>F250</p> <p>Affected Resident #4 was assessed/ interviewed by the Licensed Social Worker on 10/20/15 related to psychosocial well-being, current medication regimen (including risk vs benefits of current treatment plan), sexual well-being, and privacy needs. With the resident's consent, the resident's guardian, primary physician, and the geropsychiatrist were notified of assessment results as</p>	12/16/15	

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F 250	<p>Continued From page 4</p> <p>Review of MDS assessments dated 2/9/15, 5/12/15, 7/15/15, and 9/29/15 documented the resident did not display behavioral symptoms that were distressing or potentially harmful to the resident, or distressing or disruptive to facility residents and/or staff members. Additionally, the 2/9/15, 5/12/15, and 9/29/15 MDS assessments documented the resident was cognitively intact.</p> <p>The current care plan, dated 7/30/15, documented the resident "enjoys self stimulation" and had a history of increased libido. Interventions directed staff to avoid types of conversation that could encourage or initiate "inappropriate behavior;" display an accepting "non-judgmental" manner to encourage Resident #4 to discuss staff-identified concerns about the resident's sexuality; provide counseling services; and "as a means of distraction" offer puzzles, newspapers, and magazines.</p> <p>A psychiatric progress note, dated 9/14/15, documented, "The patient has history of using vibrator excessively," had on one occasion touched one staff member inappropriately, and made inappropriate sexual comments about female staff members' breast sizes.</p> <p>On 9/14/15, the resident's Zolofit was increased and the following interventions were implemented: * Set firm limits; * Explain to the resident that what she is saying and doing is disrespectful; and * Do not say anything that might inadvertently reinforce behaviors.</p> <p>On 10/7/15 at 8:15 PM, CNA #1 and CNA #2</p>	F 250	<p>indicated. Physician orders were implemented as needed. The resident's plan of care was reviewed and updated by the Licensed Social Worker and the Director of Nursing or designee on 11/10/15.</p> <p>Resident #4 was assessed by the Geropsychiatrist on 11/2/15 and resident's treatment plan was reviewed with the resident, including a review of resident's current psychotropic medications and the risk vs benefits of their use. Follow-up was completed by the Licensed Social Worker on or before 11/10/15.</p> <p>On or before 12/16/15, CNA #1 and #2 were educated on resident #4's plan of care including how to approach the resident, and not engaging resident in conversation that is sexual in nature.</p> <p>Potential On or before 12/16/15, a review of residents on psychotropic medications was completed by the Licensed Social Worker to ensure that residents and or residents' responsible parties were involved and aware of current treatment plan, and risk vs benefit of psychotropic medications. Follow-up care conferences were completed and the residents' treatment plans and plan of care were updated to meet residents' emotional needs, resident centered treatment goals, and resident choice on or before 12/16/15.</p>		

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F 250	<p>Continued From page 5</p> <p>were observed getting the resident ready for bed. When CNA #2 removed the resident's shirt, the resident remarked about the size and position of her own breasts. CNA #2 gestured and lifted up her own breasts and stated to the resident, "That's what happens when we get old." CNA #1 and CNA #2 continued to discuss breast size and position of womens' breasts with the resident. CNA #1 stated in a joking manner that she would give the resident some of her breasts because she had more than enough to share. The resident did not make any additional comments regarding breasts during or after this conversation.</p> <p>From 10/5/15 to 10/9/15, the resident was observed multiple times during various shifts interacting with staff. During these interactions, the resident was not observed making inappropriate statements or gestures to staff.</p> <p>On 10/9/15, the MSW was asked if the resident told staff that she felt she was using the vibrator in excess. The MSW stated it was not the resident who felt the vibrator was used excessively, but staff who made the report. The MSW stated she requested a psychiatric consult for the resident due to the resident's increased use of the vibrator, depression, anxiety, and to assess the resident for other activities she could participate in instead of "masturbation." When asked if the resident had requested her libido to be suppressed, the MSW stated the resident had not, nor had the resident requested medication to suppress her sexual urges. Additionally, the MSW stated she could not recall if the risks and benefits related to increasing the dosage of antidepressant medication had been discussed with the resident. When asked if she and/or the facility provided direct training to staff in how to</p>	F 250	<p>Systemic</p> <p>On or before 12/16/15, the Nurse Practice Educator or designee will provide education to nursing staff and the IDT regarding the need to provide services that meet each resident's emotional needs, identify resident centered treatment goals, and maintain or enhance resident choices in recognition of their individuality.</p> <p>On or before 12/16/15, the nursing staff will be educated by the Licensed Social Worker or designee on being sensitive to residents' sexuality and providing privacy/ dignity for sexual expression.</p> <p>The Licensed Social Worker was educated by the Divisional quality of life specialist on 11/6/15 regarding the need to provide medically related social services that meet the residents emotional needs, identify resident centered treatment goals, and enhance or maintain resident choices in full recognition of their individuality.</p> <p>Nurses and CNA's were re-educated by the Nurse Practice Educator or designee on or before 12/16/15 on providing services per the residents' plan of care, and professional standards when communicating with residents.</p> <p>Beginning the week of 11/16/15 any resident with new orders for psychotropic medication will be reviewed by the Licensed Social Worker or designee in morning clinical meeting to ensure that</p>		

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F 250	Continued From page 6 respond to the resident's sexual "behaviors," she stated no formal education/training was given. When asked if she had spoken with the resident to assist in her processing feelings of sexual tension, the MSW stated she had not.	F 250	the resident/ responsible party are aware and have been provided choice regarding current treatment plan and goals, and medication therapy risk vs benefit. Beginning the week of 11/16/15 residents with psychotropic medications and behaviors will be reviewed in the IDT Customer at Risk meeting per Genesis Policy. Monitor Effective 12/16/15, the Director of Nursing or designee will conduct an audit of 3 residents with psychotropic medications, to ensure that resident/ responsible party agree with the current treatment plan and goals including risk vs benefit of medication therapy, and that resident psychosocial needs are met. Audits will be completed weekly X 4 then Monthly X 2. The results of these audits will be compiled by the Director of Nursing and reported to the QAPI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and follow-up.		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252		12/16/15	

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F 252	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to provide a clean and homelike environment for any resident ambulating in the hallway between rooms 301-306, rooms 214-216, and at the 300 hall nurse's station when the hallway surrounding these rooms smelled of urine.</p> <p>On 10/7/15 at 8:00 p.m., a strong urine smell was present around the 300 hall utility closet, nurse's station, room 303, and shower room. The area of the urine smell was approximately 30 feet by 9 inches and was detected repeatedly through 10/9/15.</p> <p>On 10/7/15 at 8:00 p.m. LN #8 stated the odor was very strong and stronger than usual.</p>	F 252	<p>F 252</p> <p>Affected On or before 12/16/15, Resident rooms 301 through 306 and 214 through 216 were deep cleaned by housekeeping services.</p> <p>On or before 12/16/15, Residents residing in rooms on the 200-300 unit were re-assessed by the Director of Nursing or designee for strong urine odor or additional intervention. Individual resident plans for odor control were developed for identified residents by the Director of Nursing or designee on or before 12/16/15.</p> <p>Potential On or before 11/5/15 the Administrator or designee will conduct facility rounds to assess for odors, to identify additional resident rooms with odor problems. Follow-up was completed as indicated.</p> <p>A Resident Council meeting was held on 11/5/15 by the administrator. Residents were interviewed related to odors in the facility. Follow-up assessment and intervention will be completed by the Administrator or designee related to any odors identified by the resident group.</p> <p>Systemic On or before 12/16/15, staff were educated by the Nurse Practice Educator or Designee regarding appropriate</p>		

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F 252	Continued From page 8	F 252	<p>follow-up for residents/ rooms with smell of urine including individualized toileting plans and increase frequency of peri-care. Staff was also re-educated to report any persistent odors to the center Administrator for follow-up.</p> <p>On or before 12/16/15, housekeeping staff were educated by the Nurse Practice Educator or designee regarding cleanliness of resident rooms and resident room odors.</p> <p>Beginning 11/16/15 the Director of Housekeeping will report in the morning stand-up meeting any odors that do not resolve with cleaning intervention.</p> <p>Monitor Effective 12/16/15 a rounding audit will be conducted by the Administrator or designee to ensure resident rooms are free from persistent odor. Audits will be completed weekly X 4 then Monthly X 2. The results of these audits will be compiled by the Administrator and reported to the QAPI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The Administrator is responsible for monitoring and follow-up.</p>		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>	F 279		12/16/15	

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F 279	<p>Continued From page 9</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to develop a comprehensive diabetic care plan for 2 of 6 residents (#4 and #11) sampled for diabetes. This failed practice placed diabetic residents at risk for serious injury or death if the care plan did not provide clear direction related to the management of a hyperglycemic events.</p> <p>1. Resident #4 was admitted to the facility on 4/13/12 with multiple diagnoses, including Type 2 diabetes mellitus.</p> <p>The current diabetic care plan documented staff were to assess and record blood glucose levels twice a day; monitor for signs and symptoms of hyper/hypoglycemia; and report abnormal findings to the physician. The care plan did not document what signs and symptoms and/or</p>	F 279	<p>F279</p> <p>Affected On 10/14/15 Resident #4 and #11 care plan was reviewed and updated, by the Director of Nursing or designee, to reflect the resident's current diabetic management and parameters.</p> <p>Potential On or before 12/16/15, the Director of Nursing or designee will review and identify residents with diabetes. Each resident's care plans will be reviewed and updated as needed to reflect the resident's current plan of care, including blood glucose management and related parameters.</p>		

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F 279	Continued From page 10 abnormal findings should be reported. Additionally, the care plan did not document high and low parameters for hyper- or hypoglycemia. On 10/8/15, the RCM stated she was unsure why hyperglycemic interventions or policy and procedure was not reflected on the care plans. 2. Resident #11 was admitted to the facility on 2/23/15 with multiple diagnoses, including Type 2 diabetes mellitus. The current diabetic care plan documented staff were to assess and record blood glucose levels twice a day; monitor for signs and symptoms of hyper/hypoglycemia; and report abnormal findings to the physician. The care plan did not document what signs and symptoms and/or abnormal findings should be reported. Additionally, the care plan did not document high and low parameters for hyper- or hypoglycemia. On 10/8/15, the RCM stated she was unsure why hyperglycemic interventions or policy and procedure was not reflected on the care plans. Please refer to F 281 as it relates to inadequate diabetic management.	F 279	Systemic On 10/13/15 the Nurse Practice Educator or designee will educate licensed nurses on the need to update resident care plans with changes to reflect the resident's current status including diabetic management and parameters. Beginning 11/16/15 newly admitted residents and those residents with diabetes without physician orders related to the monitoring and management of their diabetes will be reviewed in morning clinical meeting by the Director of Nursing or designee to ensure that care plans related to diabetes include instructions for managing blood glucose levels including monitoring and reporting parameters . Monitor Effective 12/16/15, the Director of Nursing or designee will audit the care plans of 3 residents with diabetes, to ensure the care plans include managing blood glucose levels including monitoring and reporting parameters. Audits will be completed weekly X 4 then Monthly X 2 months. The Director of Nursing will compile and report the results of these audits to the QAPI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and follow-up.		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		12/16/15	

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F 281	<p>Continued From page 11</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview, review of the facility's hyperglycemic policy procedure, and review of diabetic menus, it was determined the health and safety of two of six residents sampled for management of diabetes mellitus (#s 4 and 11) were in Immediate Jeopardy and at risk for serious harm, impairment, or death when the facility: *Failed to follow its policy and procedures related to physician notification of blood sugars in excess of 300 mg/dl [milligrams per decaliter]; *Failed to clarify physician-ordered hyperglycemic parameters and ensure those parameters were consistent with recognized professional standards of practice; *Failed to provide appropriate diabetic meals; *Failed to provide risks and benefits education related to non-compliance with dietary restrictions; and *Failed to assess residents for signs and symptoms of acute hyperglycemia, such as diabetic ketoacidosis (DKA).</p> <p>The American Diabetes Association (ADA), in an article entitled "Hyperglycemia," (last edited 9/16/14), defined hyperglycemia as "...high blood glucose (blood sugar that) ... happens when the body has too little insulin or when the body can't use insulin properly ... Hyperglycemia can be a serious problem...fail[ure] to treat hyperglycemia, [may result in] a condition called ketoacidosis ... Ketoacidosis is life-threatening and needs immediate treatment ..."</p>	F 281	<p>F281</p> <p>Affected Residents # 4 and #11 were assessed by the Unit Manager on 10/9/15 for signs or symptoms of hypo/hyperglycemia with none noted.</p> <p>The Unit Manager contacted the residents #4 and #11's physician on 10/9/15 and reviewed residents blood sugars, laboratory values, condition, diet and current notification parameters. New orders for physician notification parameters were received and implemented by the unit manager on 10/9/15.</p> <p>Residents #4 and #11 were assessed by the Registered Dietician and the Licensed Social Worker on 10/15/15 related to dietary interventions and compliance. Residents were educated on dietary interventions and risks associated with hyperglycemia, and resident goals related to diabetic management were reviewed.</p> <p>Residents #4 and Resident #11 were reviewed by the IDT on 10/15/15 and resident care plans were updated to include parameters for physician notification, management of hyperglycemia, and resident specific</p>		

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F 281	<p>Continued From page 12</p> <p>ADA Standards of Medical Care in Diabetes (2015), documented, "Patients with poorly controlled diabetes may be subject to acute complications...including dehydration, poor wound healing, and hyperglycemic hyperosmolar coma." The ADA identified the following treatment goals for glycemia in older adults with intermediate remaining life expectancy and three or more chronic illnesses.</p> <p>*Hemoglobin A1C goal of less than 8.0%; *Fasting (no caloric intake for 8 hours) or preprandial (before meals) blood sugar goal of 90-150 mg/dl; and *Bed time glucose goal of 100-180 mg/dl.</p> <p>On 10/9/15 at 3:30 p.m., the Administrator, DNS, and the Regional Nurse Consultant were notified verbally and in writing of the Immediate Jeopardy involving the facility's failure to: *Ensure, diabetic residents had parameters for high blood sugars which required physician notification; *Educate licensed nurses to the facility's hyperglycemic protocol; and, *Assess diabetic residents for signs and symptoms of hyperglycemia.</p> <p>On 10/15/15, the facility was informed in writing the Immediate Jeopardy also encompassed the facility's failure to: *Provide ongoing dietary assessments; *Provide consistent carbohydrate meals per the facility's Diet Manual; *Provide residents with risks and benefits education related to non-compliance with dietary restrictions.</p> <p>The facility submitted an acceptable Abatement Plan to the Bureau of Facility Standards on</p>	F 281	<p>approaches and goals.</p> <p>Residents #4 and #11 diets were reviewed by the Registered Dietician with resident and Licensed Social Worker input on or before 10/15/15. Dietary changes and or education was completed by the Registered dietician as indicated.</p> <p>Potential Residents with diabetes were reviewed by their attending physician on or before 10/15/15 current blood glucose levels, other pertinent laboratory values, diet compliance, and other factors affecting their diabetes. New orders, including parameters for physician notification were implemented at time of receipt and the plan of care will be updated by the Director of Nursing or designee on or before 10/15/15.</p> <p>Residents with diabetes were reviewed by the IDT including a Registered Dietician and Licensed Social Worker on or before 10/13/15 related to factors affecting diabetes including diet, dietary compliance, medication regimen, laboratory values, and history of blood glucose levels. Follow-up was completed as indicated.</p> <p>Residents with diabetes were reviewed by the Director of Nursing or designee on or before 10/15/15 to ensure that physician notification parameters for hypo/hyperglycemia are in place and meet the clinical needs of the resident. Physicians were contacted and resident</p>		

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F 281	<p>Continued From page 13</p> <p>10/19/15 and an on-site survey on 10/26/15 confirmed the conditions of the IJ had been abated.</p> <p>The abatement plan included a review of diabetic residents' blood glucose levels, medication regimen, and physician-set hyperglycemic parameters for individual residents that would require physician notification. The hyperglycemia protocol was revised and nursing staff were educated on the new protocol. Diabetic residents' care plans were also individualized to reflect physician notification parameters, as well as specific preferences regarding a diabetic diet.</p> <p>Findings included:</p> <p>The facility's Diabetic Care Protocol in effect at the time Immediate Jeopardy was determined documented the following parameters for physician notification for a resident without individualized parameters: *Immediate physician notification of blood glucose levels greater than 400 mg/dl; *Physician notification "as soon as possible during normal business hours" of blood glucose levels greater than 350 mg/dl or greater than 300 mg/dl on two consecutive readings.</p> <p>The protocol did not define "consecutive" and it was unclear whether it would apply to two blood glucose checks in a 24 hour period, two blood glucose checks minutes apart, and/or bedtime and morning blood glucose assessments.</p> <p>1. Resident #4 was admitted to the facility on 4/13/12 with multiple diagnoses including Type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, and acute kidney failure.</p>	F 281	<p>specific parameters were implemented on or before 10/15/15 per MD order.</p> <p>Systemic Nursing and dietary staff were re-educated on diabetes, diabetes management, hypo/hyperglycemia, insulin, and other topics related to diabetes by the Nurse Practice Educator or designee on or before 10/13/15.</p> <p>The Center's protocol for physician notification will be updated by Nurse Practice Educator or designee on or before 12/16/15 to include physician notification parameters for hyperglycemia for those residents who do not have individualized physician orders for notification: Unless the physician provides other monitoring parameters, physicians will be notified for any two blood glucose readings greater than 250mg/dl with an associated change in condition during all or part of two consecutive days, or any two blood glucose readings greater than 300 during all or part of two consecutive days, or any one blood glucose reading greater than 400 mg/dl.</p> <p>For hypoglycemia, the physician will be immediately notified for any blood glucose level less than 70mg/dl.</p> <p>Residents will be assessed for signs and symptoms of hypo/hyperglycemia by the licensed nurse at time of blood glucose check with follow-up as indicated.</p>		

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F 281	<p>Continued From page 14</p> <p>The resident's July 2015 MAR documented 6 occurrences of blood glucose over 300 mg/dl for which physician notification was warranted based on facility protocol, and one blood glucose check greater than 400 mg/dl. The August 2015 MAR documented 21 occurrences that warranted physician notification for blood glucose levels in excess of 300 mg/dl and 3 blood glucose checks of more than 400 mg/dl. The September 2015 MAR documented 10 occurrences of blood glucose levels in excess of 300 mg/dl. The facility failed to notify Resident #4's physician of any of the 41 hyperglycemic episodes during this three month period and the resident's medical record did not include evidence she was assessed for signs/symptoms of hyperglycemia.</p> <p>On 10/8/15 at 3:45 p.m., the DNS and RCM stated there was no evidence Resident #4's physician was notified when the resident's blood glucose levels exceeded either 300 mg/dl or 400 mg/dl.</p> <p>The resident's October 2015 recapitulated physician orders documented the resident was to receive blood glucose monitoring twice daily, the results of which were to be faxed to the medical director each Thursday night. No further individualized blood glucose parameters with physician notification were documented.</p> <p>It could not be determined from the resident's medical record whether any monitoring of the resident's blood glucose level was faxed to the physician who, on 10/9/15, stated he did not know whether blood glucose monitoring results had been faxed to him as he had ordered.</p>	F 281	<p>New admissions with diabetes will be reviewed by the Director of Nursing or designee beginning 11/16/15 to ensure that diabetic management plans are in place including parameters for physician notification for hypo/hyperglycemia.</p> <p>The Regional Dietitian Consultant reeducated the Registered Dietitian on or before 12/16/15 regarding nutritional interventions for diabetics including having discussions with diabetic residents about choices and goals.</p> <p>A competency validation with post-test was given to licensed nurses related to diabetic management, including but not limited to insulin administration, signs and symptoms of hypo/hyperglycemia, dietary interventions and approaches. The competency with post-test will be administered by the Director of Nursing or designee for licensed staff on or before 10/13/15.</p> <p>On or before 12/16/15 the Director of Nursing implemented the Stop and Watch assessment tool for center staff to communicate changes in condition, including to the licensed nurse.</p> <p>Monitor Effective 12/16/15, the Director of Nursing or designee will audit 3 residents with diabetes for effectiveness of diabetes management, including parameters for physician notification for hypo/hyperglycemia. These audits will be completed weekly X4 weeks and then</p>		

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F 281	<p>Continued From page 15</p> <p>A 10/21/14 physician visit/progress note documented Resident #4's blood glucose was "running in the 300's" with no new interventions initiated after the physician's visit.</p> <p>A 1/15/15 physician progress note documented the resident was "shaky" with a blood sugar of 306 mg/dl during an on-site visit. No new interventions were initiated at this time.</p> <p>A 4/6/15 physician's note documented the resident's diabetes was poorly controlled. No further interventions for diabetic management were initiated during the physician's 4/6/15 visit.</p> <p>A 6/30/15 physician's note documented the resident's blood glucose was assessed in the "200-300 range;" no new interventions were initiated after the June physician visit.</p> <p>Resident #4's diabetic care plan, initiated 7/30/15, documented staff were to provide and encourage consumption of a consistent carbohydrate diet.</p> <p>On 10/9/15 at 9:30 a.m., the resident's physician stated he "let her eat what she wanted to eat ... and just gave up" and that he was "ignoring high blood glucose to keep her quality of life ... let her eat what she wants." The physician also stated he would wait until Resident #4's blood glucose levels were in the "600-700 [mg/dl]" range before "doing something more about it ... [it's a] judgment thing." The resident's physician added that it was a "waste of time and energy for the facility to send me [weekly] blood sugars on [Resident #4] because I'm not going to do anything about them."</p> <p>Resident #4's medical record did not document</p>	F 281	<p>monthly X2 months. The Director of Nursing will compile the results of these audits and report them to the QAPI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and follow-up.</p>		

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F 281	<p>Continued From page 16</p> <p>the resident received continuing education and/or risk vs. benefit discussion regarding her diabetic diet. It could not be determined from the resident's medical record whether she was asked for nutritional preferences, needs, or goals.</p> <p>Additionally, physician progress notes did not document any discussion regarding the risks of continued hyperglycemia or the resident's diabetic management goals.</p> <p>On 10/9/15 at 12:50 p.m., the RD stated the facility's diabetic education wasn't "intensive," but did include notification that residents could make food choices as well as information on snacks that were consistent with diabetic restrictions. She stated diabetic nutritional approaches were tailored to diabetic residents' quarterly HgA1c labs and reviewed when any problems arose. The RD noted that Resident #4's HgA1c labs had been reviewed.</p> <p>2. Resident #11 was admitted to the facility on 12/02/14, and readmitted on 2/23/15, with multiple diagnoses, including Type 2 diabetes mellitus with unspecified complications, pulmonary hypertension, heart failure, and hypertension.</p> <p>On 2/22/15 the resident was sent to the Emergency Room and diagnosed with acute hyperglycemia with a blood glucose level in the "500 range" and exacerbation of COPD [Chronic Obstructive Pulmonary Disease]. While in the Emergency Room (ER), the resident received insulin intravenously for elevated blood glucose levels. The following blood sugars were documented in the Emergency Room from 2/22/15 to 2/23/15: 387 mg/dl, 459 mg/dl, 436</p>	F 281			

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F 281	<p>Continued From page 17 mg/dl, and 262 mg/dl.</p> <p>A physician visit dated 2/25/15 documented concerns related to fasting glucose levels over 200 mg/dl (often greater than 300 mg/dl or more). The Assessment/Plan after the 2/25/15 physician's visit did not include any changes to the resident's diabetic medications or management plan.</p> <p>Resident #11's medial record from 4/15/15 to 8/19/15 did not document individualized parameters had been established for the resident's blood sugars. On 8/20/15, five months after the resident was treated in the Emergency Room for hyperglycemia, the facility requested hyperglycemic parameters from the physician. The physician documented he wanted to be notified only when the resident's blood glucose levels were greater than 500 mg/dl. The physician did not document a rationale for that notification requirement given that the resident had required emergent treatment in February 2015 for a blood glucose "in the 500 range."</p> <p>The June, July, and August 2015 recapitulated physician orders documented staff were to check Resident #11's blood glucose every morning and at bedtime, however individualized parameters were not specified at this time. An 8/20/15 order directed staff to assess the resident's blood glucose every morning and at bedtime, and to notify the physician for blood glucose levels greater than 500 mg/dl.</p> <p>Resident #11's July 2015 MAR documented 12 occurrences of blood glucose over 300 mg/dl in which physician notification was required per facility protocol. The August 2015 MAR</p>	F 281			

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F 281	<p>Continued From page 18</p> <p>documented 4 occurrences of blood glucose levels greater than 300 mg/dl (before 8/20/15). The physician was not notified of the identified occurrences, and signs and symptoms of hyperglycemia were not assessed per the medical record when the resident's blood glucose was elevated.</p> <p>The resident's October 2015 recapitulated physician orders documented Resident #11 recieved a "regular, liberalized" diet. A Medical Nutrition Therapy Assessment note documented upon admission the resident did not want to be on a diabetic diet, but rather followed a "limited sugar" diet. It could not be determined from the resident's nutritional record, care plan, or kitchen spreadsheets that any further risk/benefit education was provided to the resident regarding a regular diet or incorporation of her preference of a limited sugar diet.</p> <p>The resident's October 2015 care plan documented her refusal to follow dietary recommendations and prescribed diet (initiated 12/24/14). An intervention was initiated on 12/24/14 to educate the resident on risks associated with non-compliance, for social services to assess reasons for non-compliance, and for social services to make routine visits to provide support. The resident's diabetes care plan documented on 3/4/15 that staff were to provide diabetes education and education related complications as appropriate. Resident #11's record did not include documentation that these education and social work interventions were completed.</p> <p>Physician's notes from 2/25/15, 4/15/15, 6/10/15, & 8/12/15 documented the resident's diabetes</p>	F 281			

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F 281	<p>Continued From page 19</p> <p>was "uncontrolled" and that the resident was "non-compliant" with glucose checks and diet. The 6/10/15 physician note documented the resident's most significant obstacle related to diabetic management was non-compliance, but that staff would continue to encourage adherence to a diabetic regimen. No further education of risks/benefits was documented and no further discussion of the resident's preferences, needs, or goals in relation to diabetic management was documented.</p> <p>On 10/7/15, LN #1 stated the facility's hyperglycemic protocol allowed physicians to determine at what point a hyperglycemic blood glucose assessment required physician notification. LN #1 also stated physician notification requirements were predetermined for those residents with sliding scale parameters (not all diabetic residents in the facility had a sliding scale for insulin administration). She stated she did not know when to notify the physician of a hyperglycemic blood level if a resident did not have a sliding scale. When asked, LN #2 stated she did not know when to notify the physician if a resident was assessed with a hyperglycemic blood glucose level.</p> <p>On 10/8/15 the Regional Nurse Consultant was asked to provide the facility's policy and protocol for hyperglycemia. She stated there was no such policy or protocol. The facility's hypoglycemia policy and protocol, dated (revised 1/2/14) was later provided, which included a hyperglycemia policy and protocol.</p> <p>On 10/8/15 at 3:45 p.m., the DON stated she was unsure of what to do if a resident had increased blood glucose readings that indicated</p>	F 281			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2015
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F 281	Continued From page 20 hyperglycemia; the Regional Nurse Consultant stated the nurses should follow facility protocol and notify the physician. She was unsure if the current Medical Director was aware of the facility's protocol for notification. Meals served to residents from 10/5/15 to 10/9/15 were observed to lack vegetables and there was a significant amount of carbohydrate food items. The facility failed to: *Assess residents who experienced repeated and frequent hyperglycemic episodes; *Develop and implement policies and procedures for hyperglycemic management that were consistent with professional standards; *Follow its own hyperglycemic policy and protocol by notifying the physician of blood glucose levels over 300 mg/dl or 400 mg/dl; *Staff were not aware of hyperglycemic protocol; *Staff failed to provide risk/benefit education for residents regarding non-compliance with diabetic restrictions; *Residents were not assessed and/or provided a carbohydrate-consistent diet that was compatible with policy-defined diet sample menus; *Resident goals for diabetic management and diet choice were not identified and incorporated into plans of care; *Residents were not educated about potential risks and consequences of their dietary choices;	F 281			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		12/16/15	

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F 314	<p>Continued From page 21</p> <p>individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure 1 of 15 sampled residents (Resident #7) did not develop pressure ulcers. The failure resulted in harm when the resident developed two stage II pressure ulcers after the facility did not address all identified risk factors for skin breakdown; initiate interventions for prevention; implement interventions when they were ordered; or initiate/revise skin breakdown care plans in a timely manner. Findings include:</p> <p>Resident #7 was admitted to the facility on 9/4/15 with multiple diagnoses including edema and abnormalities of gait and mobility.</p> <p>A 9/9/15 risk management form documented the resident developed two stage II pressure ulcers, one on each heel laterally. It documented the pressure sores were avoidable, and that it could not be verified that heels were floated upon admission. It documented pressure ulcers developed within 5 days of admit, the resident was compromised nutritionally, mobility was impaired, was unable to make even slight position changes without assistance to offload pressure, and had pitting edema to bilateral lower extremities.</p> <p>The 9/9/15 Skin Integrity Report for the left lateral</p>	F 314	<p>F314</p> <p>Affected Resident #7 was assessed by the Director of Nursing or designee on 10/24/15. Resident pressure ulcers were assessed and measured, and the skin integrity report was updated by the Director of Nursing or designee on 10/24/15. No new areas of concern were identified.</p> <p>Resident # 7's care plan will be reviewed and updated by the Director of Nursing or designee on or before 12/16/15 to reflect the resident's current wound care needs and prevention of further skin breakdown.</p> <p>The resident was discharged on 11/11/15</p> <p>Potential On or before 12/16/15 a skin assessment of current residents will be completed by the Director of Nursing or designee to identify residents with skin impairments. Residents identified with skin breakdown were reviewed by the Director of Nursing or designee on or before 12/16/15 for routine wound assessment, and</p>		

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F 314	<p>Continued From page 22</p> <p>heel documented the resident had a stage II pressure ulcer, with pain, and was a blister that measured 3.6cmx3cm and surrounding tissue was boggy, red, and non-blanchable. The 9/15/15 assessment of the wound documented the resident had pain, the wound measured 3.6cmx3cm with surrounding tissue unchanged. The 9/9/15 Skin Integrity Report for the right lateral heel documented the resident had a stage II pressure ulcer with pain, and was a blister, that measured 4cmx4.6cm and surrounding tissue was boggy, red, and non-blanchable. The 9/15/15 assessment of the wound documented the resident had pain, and that the wound was unchanged. An assessment of the wound was not documented for the week of September 21, 2015. No new interventions were ordered at this time.</p> <p>The resident's recapitulated physician's orders documented: *Monitor and apply skin prep to bilateral heels twice daily for heel blisters (ordered and started 9/12/15); *Pressure-redistribution cushion to chair (ordered 9/4/15); *Pressure-redistribution mattress to bed (ordered 9/4/15); and, *Skin check weekly on Wednesday (ordered 9/11/15 and started 9/16/15).</p> <p>The resident's ADL care plan, initiated 9/5/15, documented the resident required 2 person extensive assistance with bed mobility and transferred with a front wheel walker.</p> <p>The skin breakdown risk care plan documented the interventions (initiated 9/9/15): *Assist with repositioning approximately every 2 hours and prn;</p>	F 314	<p>preventative and actual wound plan of care. Follow-up will be completed as indicated.</p> <p>On 11/6/15 an audit was completed by the Director of Nursing or designee to identify residents at high risk for skin breakdown. Care plans for identified residents were reviewed and updated as needed to reflect resident's current wounds and preventative needs.</p> <p>On 11/6/15 a center round was completed to ensure that care planned interventions were implemented at the bedside. Follow-up was completed as indicated.</p> <p>A review of TAR's for the last 30 days was completed by the Director of Nursing on or before 12/16/15 regarding the completion of treatments as ordered. Residents identified to have missed treatments were assessed by the licensed nurse on or before 12/16/15 and the physician was notified. Follow-up was completed as needed.</p> <p>Systemic On or Before 12/16/15 the Nurse Practice Educator or designee will educate licensed nurses regarding pressure ulcer prevention, following physician orders for treatment, and the need for timely and regular skin assessments.</p> <p>Beginning 11/16/15 newly admitted residents and residents with newly identified wounds will be reviewed in morning clinical meeting to ensure that</p>		

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F 314	<p>Continued From page 23</p> <p>*Float heels while in bed; *If resident refuses care re-approach and use alternate staff prn; *Observe skin condition with ADL care daily and report abnormalities; *Pressure redistribution surfaces to chair as per protocol; and *Pressure reducing mattress to bed as per protocol.</p> <p>The resident's 9/11/15 admission MDS assessment documented the resident was severely impaired cognitively, had no refusals of care, required two person extensive assist to move in bed and to transfer, had 2 stage II pressure ulcers (not present on admission to the facility), had pressure reducing devices on the chair and bed, a turning/repositioning program, pressure ulcer care, and did not have a condition that would result life expectancy less than 6 months.</p> <p>The resident's skin breakdown care plan added the following interventions on 9/17/15: *Monitor skin for signs/symptoms of skin breakdown; *Norton/Braden assessment per policy; *Provide wound treatment as ordered; *Skin check per policy; and, *Weekly skin assessment by license nurse.</p> <p>The resident's non-compliance care plan, initiated 9/21/15, documented the resident refused cares including refusals of repositioning, heel offloading, bathing and cares. Interventions included checking during rounds to ensure heels were offloaded.</p> <p>The resident's skin breakdown risk care plan was</p>	F 314	<p>skin and risk is assessed, that skin integrity reports/ assessments are completed as indicated, that treatment orders are in place, and that potential and actual plans of care are implemented.</p> <p>A new center wound champion was identified on or before 12/16/15 that will monitor compliance with the skin integrity care process.</p> <p>A competency validation will be completed by the Nurse Practice Educator or designee for licensed nurses on or before 12/16/15 to validate nurses competency related to pressure ulcer risk assessment and developing plans for approaches and interventions to prevent skin breakdown.</p> <p>Beginning the week of 11/16/15 new admissions to the center will be reviewed by the IDT in clinical meeting for pressure ulcer risk assessment, care planned approaches/ interventions to prevent pressure ulcers, and completion of initial skin assessment. Follow-up will be assigned and completed as needed.</p> <p>Monitor Effective 12/16/15 an audit will be completed by the Director of Nursing or designee, of 3 residents, to ensure skin assessments are completed timely and appropriate pressure ulcer prevention interventions have been implemented as indicated. Audits will be completed weekly X 4 then Monthly X 2. These audits will be compiled by the Director of Nursing or designee and reported to the QAPI</p>		

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F 314	<p>Continued From page 24</p> <p>initiated 9/9/15, the day the pressure ulcers were identified, and the care plan for the pressure ulcers was initiated 9/17/15, 8 days after the breakdown was identified. Interventions and weekly skin assessments were not started until after pressure ulcers were identified.</p> <p>The September 2015 TAR documented the resident's heels were to be monitored and skin prep applied to bilateral heels two times a day starting on 9/12/15. It documented this was completed 15 of 38 opportunities.</p> <p>The resident's ADL record documented the resident transferred with extensive assistance of two people. The record documented the resident was not transferred out of bed during the night or evening shift for 12 days; evening shift transferred the resident 8 of the 12 days and the resident did not transfer for 4 consecutive days. "Not applicable" was documented for all locomotion opportunities in September 2015. The resident was not observed out of bed the week of the survey 10/5/15-10/9/15.</p> <p>On 10/8/15 at 6:00 p.m., the RCM and DNS were interviewed regarding the resident's pressure ulcers. The RCM was asked about skin assessments before 9/9/15, an interim care plan for the resident's skin upon admission, and alternative interventions offered to get the resident out of bed. She was also asked about attempts made to identify the resident's objectives to floating her heels or getting out of bed, and how these barriers were addressed.</p> <p>There was no documentation regarding skin assessments before 9/9/15, an interim skin care plan, alternative interventions offered to get the</p>	F 314	<p>committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and follow-up.</p>		

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F 314	Continued From page 25 resident off loaded and out of bed , or documentation of refusals and how this barrier was addressed. On 10/9/15 at 10:30 a.m., the resident's heels were observed. On both heels laterally, pressure ulcers were 2.5cmx2.5cm without depth. The skin was intact and continuous throughout, and the pressure ulcers were dark red/purple in color with no blanching. The resident was laying on an air mattress and heels were floated. The resident experienced harm when she developed 2 avoidable stage II pressure ulcers on her heels while residing in the facility. The facility did not recognize and assess factors that put the resident at risk of developing pressure ulcers upon admission. The resident did not have an interim care plan upon admission to protect her skin or skin assessment until the identification of the two pressure ulcers. Interventions to prevent pressure ulcers were not implemented as ordered. Mobility was identified as a risk factor for the resident's skin breakdown; the resident was transferred out of bed 9 of 38 opportunities. The skin breakdown risk care plan was created when skin had already broken down. The care plan was not revised to modify the prevention strategies and to address the presence and treatment of newly developed pressure ulcers for 8 days after their identification.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		12/16/15	

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F 323	<p>Continued From page 26 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: 4. Resident #13 was admitted to the facility with multiple diagnoses including heart failure, diabetes mellitus, and Congestive Obstructive Pulmonary Disease (COPD).</p> <p>The most recent quarterly MDS dated 10/6/15 coded the resident required two person extensive assist with bed mobility, transfers, and had impairment of bilateral lower extremities.</p> <p>The Safe Resident Handling/Transfer Equipment Policy, dated 12/08/14, documented, the sit to stand lift will be used fro those patients who meet the following criteria: Cannot be transferred from sitting to standing comfortably and safely by other transfer techniques and have some weight bearing ability and trunk control. Use of a transfer sling requires consultation with Risk Management and specialized training. Instructions for using the sit to stand lift included: Begin with the resident in a seated position; position the sling around the resident's lower back; place the belt toward the resident with the labels at the top and facing away from the resident; position the resident's arm outside of sling; ensure the back of the sling covers the resident from just below the shoulder blades to the lower back; fasten the safety belt around the waist and adjust to a snug but comfortable fit...</p> <p>On 10/7/15 at 6:45 PM, CNA #5 and CNA #9 were observed to transfer Resident #13 from his</p>	F 323	<p>F323</p> <p>Affected Resident #13 was assessed by the licensed nurse on 11/11/15 with no noted adverse effect related to standing lift use.</p> <p>Resident #13 was evaluated/ treated by Physical Therapist on 10/15/15 and resident transfer status was changed to a full mechanical lift.</p> <p>The beauty shop, nurse's bathroom, and medication room were checked for unsecured/ unlocked chemicals by the administrator on 10/23/15 and unsecured chemicals were removed and the door locks were changed to auto-lock style by the Director of maintenance on or before 10/23/15.</p> <p>Resident #1 was assessed for her ability to reach her personal items by the Director of Nursing or designee on or before 12/16/15 and environmental modifications were made to improve resident access to personal items by the Director of Nursing on or before 12/16/15.</p> <p>Resident #1 was evaluated for safe transfer status by the Physical Therapist on or before 12/16/15. The residents care</p>		

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F 323	<p>Continued From page 27</p> <p>bed to his wheelchair via the Sit-to-Stand mechanical lift. CNA #5 positioned the lift in front of the resident, directed him to place his feet on the foot plate and knees in the knee pads. CNA #5 positioned the sling, which included a "lower back strap," with a buckle around the resident's chest and under his arms. The sling was then attached to the lift and CNA #5 began to lift the resident without fastening the buckle. CNA #9 immediately stopped CNA #5 and stated we cannot transfer the resident without buckling the strap, because the resident could fall out the sling. The resident stated, "They have never used that strap on me before and your not going to start using it now." CNA #5 stated, "we have never used it on him before, he won't let us." CNA #9 explained to the resident they would not be able to use the lift if the "chest strap" was not securely fastened. The resident reluctantly agreed to use the strap and it was fastened loosely around his chest. As CNA #5 raised the lift, the resident was unable to straighten his knees and stand. CNA #5 continued to raise the lift to the highest position the lower back strap, which was placed around the resident's chest, slid upwards underneath the resident's arm pits which resulted in the resident's being suspended above his head. The improper placement and use of the sling resulted in excessive strain on the resident's upper arms and shoulders. The resident with his arms suspended over his head was transferred via lift, across the room, and lowered 2 inches into his wheelchair. The resident was observed to have facial grimacing during the transfer.</p> <p>On 10/7/15, When asked who determines which residents are appropriate to use of a mechanical lift on, and how the sling size is determined, CNA</p>	F 323	<p>plan was updated by the licensed nurse on or before 12/16/15 to reflect residents transfer status.</p> <p>Resident #1 was assessed by the licensed nurse on 11/11/15 for any adverse effects related to sit to stand transfer with no adverse effects noted.</p> <p>Potential Center residents will be observed /reviewed by the Director of Nursing or designee on or before 11/6/15 to ensure that transfer status is safe and the correct device/ support is being provided. Residents identified as requiring further evaluation will be referred to physical therapy for evaluation and treatment as indicated.</p> <p>An environmental round was completed by the Director of Nursing or designee for any unlocked chemicals or other hazardous materials on or before 11/5/15. Follow up was completed immediately for any identified issues.</p> <p>A round was completed for those residents identified to be at risk for falls by the Director of Nursing or designee on or before 12/16/15 to ensure that care plan interventions including keeping personal items within reach are implemented. Any identified issues were immediately corrected.</p> <p>Systemic Nurses and CNA's were educated on safe transfers and following</p>		

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F 323	<p>Continued From page 28</p> <p>#10 said the nurses and therapy department determine which residents need the lifts and the CNAs chose the sling size. When asked how she picks a sling for a resident, the CNA said the sit to stand slings come in different colors for different sizes and she usually picks the green sling unless the resident is "really big" and then she uses the orange sling which is extra large. When asked how the sling was applied the CNA stated, the sit to stand sling fits under the resident's arms and the waist strap and buckle wrap around the resident's torso and is fastened. When asked if the waist strap had to be fastened, she stated it must be securely "fastened to fit" and had to be worn at all times during the transfer. When asked what training she had received, she stated she was trained by the CNA who oriented her on the floor. She stated the sit to stand is used to help residents stand, it is not used to stand for them.</p> <p>On 10/7/15, CNA #11 was asked how she sizes a sling for the sit to stand. She stated, "It's common sense, I just eyeball the sling and the resident." She stated the color of the sling indicates the size, but she does not get too concerned about it because, "the slings are made sturdy." The CNA stated the top straps of the sling fit under and around the resident's armpits and the waist strap is placed around the resident's torso and the buckle is latched. She stated a proper fitting sling will have "slack" in the top strap and would not apply pressure to the resident's armpits. She stated the sit to stand is used for a resident who can stand on his/her own. She stated she did not receive formal training on the lifts, "I don't really need it I have been a CNA for a long time."</p> <p>On 10/8/15, the SDC was asked if the facility provided formal training and or yearly</p>	F 323	<p>manufacturers recommendations for mechanical lift use by the Nurse Practice Educator or designee on or before 12/16/15.</p> <p>CNA's will complete a transfer competency completed by the Nurse Practice Educator or designee for mechanical and non-mechanical transfers on or before 12/16/15.</p> <p>On or before 12/16/15 Mechanical lifts slings were assessed and inventoried by the Director of Nursing or designee to ensure that slings were available in all sizes to meet residents' needs.</p> <p>Center staff including housekeeping staff were educated by the Administrator on or before 12/16/15 regarding keeping chemicals and other hazardous materials locked.</p> <p>Beginning 12/16/15 nursing/CNA newly hired staff at the center will have education and competency completed by the Nurse Practice Educator or designee on safe resident handling/transfers to include following manufactures recommendations for lift use and sling selection.</p> <p>Monitor Effective 12/16/15 an audit of 3 residents transfers will be completed by the Director of Nursing or designee to ensure that transfers are safe and mechanical lifts are used per manufactures recommendation. An environmental audit will be completed</p>		

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F 323	<p>Continued From page 29</p> <p>competencies for the mechanical lifts. She stated she provides new employees information during orientation and CNAs receive training on the floor by the CNA training him/her. The SDC stated there is no formal education, the new CNAs do not have a check off form to be completed by the preceptor, and the facility does not perform yearly competencies. When asked how she knew the CNAs were sizing and using the slings appropriately, she stated she would be notified by the nurse if a CNA required additional training. She stated she does not spot check the CNAs to ensure slings and lifts are being used appropriately.</p> <p>On 10/8/15, the Administrator, DNS, and RNC were informed of the above concern.</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to store chemicals in a secure area. This practice had the potential to adversely affect any independently ambulating resident in the 100 hall. Additionally, the facility failed to implement fall interventions as care planned for Resident #1; and transfer two residents (#s 1 and 13) properly with the sit-to-stand mechanical lift. The failure created the potential for adverse health outcomes if residents ingested unlocked chemicals or sustained serious injury from improper mechanical transfers. Findings include:</p> <p>1. On 10/5/15 at 7:15 a.m., the beauty shop door was observed unlocked and open. Inside, there was an open cabinet in the room containing 16-oz container of neutralizer hair product. CNA #4 stated the door should be locked.</p>	F 323	<p>by the Administrator or designee to ensure that chemicals and other hazardous materials are properly stored. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the Director of Nursing or designee and reported to the performance improvement committee for review and remedial intervention. The Director of Nursing is responsible for monitoring and follow-up.</p>		

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F 323	<p>Continued From page 30</p> <p>On 10/5/15 at 7:20 a.m., the medication room and nurse's bathroom at the 100 hall nurse's station was observed unlocked. The nurse's bathroom contained an unsecured bottle of liquid deodorizer, and there was no call light in the bathroom. LN #3 stated the two doors were not for resident use and should be locked. The medication room contained hazards to residents including 28 IV needles, 8-oz of wound cleanser, five 8-oz bottles of peri-wash cleanser, and two 4-oz bottles of hydrogel. The 100 hall medication room door and nurse bathroom door were observed unlocked again at 11:30 a.m. and 2:30 p.m.</p> <p>On 10/7/15 at 12:05 p.m., the 100 hall medication room door and nurse bathroom door were unlocked.</p> <p>2. Resident #1 was admitted to the facility 12/31/14 with multiple diagnoses, including alcohol induced dementia.</p> <p>The resident's 8/12/15 MDS assessment documented the resident had moderately intact cognition, required extensive 2-person assistance for bed mobility and transfers, was totally dependent on one staff for locomotion in her wheelchair, had at least two non-injury falls, and experienced at least two falls with injury since admission.</p> <p>The resident's record documented she had 17 falls from 5/1/15 to 9/5/15 (4 months).</p> <p>Resident #1's fall risk care plan, revised on 9/11/15, documented the resident was to have a mechanical "reacher" to assist with out-of-reach items, all items were to be placed within the</p>	F 323		

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F 323	<p>Continued From page 31</p> <p>resident's reach when she was in bed, and the call light and water pitcher were to be within her reach at all times.</p> <p>On 10/5/15 at 11:00 a.m., the resident was observed sitting in a wheelchair in her room. The water pitcher was out of her reach on the bedside table behind her.</p> <p>On 10/6/15 at 9:30 a.m., the resident was observed laying in bed with the water mug on a side table approximately 3 feet away. At 2:00 p.m., the resident's reacher was observed out of her reach on the dresser at the end of the bed.</p> <p>On 10/7/15 at 8:00 a.m., the resident was observed laying in bed with the water pitcher at the end of the bed on the bedside table. At 12:40 p.m., the resident was observed sitting in a wheelchair in her room with the water pitcher behind her on the side table. The resident's call light was also not within her reach.</p> <p>On 10/8/15 at 10: 30 a.m., the resident was observed laying in bed with the water pitcher and her teeth approximately 3 feet away on the side table. The resident said she needed her teeth, then rolled over and threw her feet off the bed as a CNA intervened.</p> <p>On 10/8/15 at 6:00 p.m., the RCM stated the resident's glasses, water, and teeth should be at the bedside on her level and within reach. She stated if the bedside table was at the end of the bed or if the items were three-to-four feet away, the resident would not be able to reach them herself.</p> <p>3. Resident #1's fall risk care plan, revised on</p>	F 323			

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F 323	Continued From page 32 9/11/15, documented the sit-to-stand lift was to be used for all transfers. On 10/7/15 at 12:55 p.m., CNA #5 and CNA #7 were observed transferring the resident to the commode with the sit-to-stand lift. CNA #5 and #7 connected the safety strap below the resident's arm pits. The resident did not stand as fully erect as possible, her legs were bent, and the resident leaned back as she was transferred to the commode. The facility's Sit to Stand Lift Policy and Procedure documented the sling portion of the lift should be positioned around the resident's lower back, and the safety belt should be fastened around the waist.	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to recognize and assess sudden weight gain;	F 325	F325 Affected	12/16/15	

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F 325	<p>Continued From page 33</p> <p>provide a therapeutic diet for the resident's diagnosis of diabetes mellitus; and provide interventions or resources for the resident to be successful with weight loss goals for 1 of 15 residents (Resident #1). The failure resulted in a weight gain of 8.5% in one month for the resident. Findings include:</p> <p>Resident #1 was admitted to the facility 12/31/14 with multiple diagnoses including diabetes mellitus and hypertension.</p> <p>The resident's 8/12/15 quarterly MDS assessment documented the resident had moderately intact cognition.</p> <p>The resident's 9/11/15 care plan documented the resident exhibits or is at risk for fluid volume disorder as evidenced by edema and medications (diuretics and laxatives). It also documented the resident had a nutritional risk related to her desire to lose weight by 11/11/15, initiated 1/8/15. An intervention included encouraging low calorie snacks, also initiated 1/8/15.</p> <p>The resident's physician recapitulation orders documented the resident received Furosimide (Lasix) 20 mg by mouth one time a day for hypertension and edema, and the resident was on a regular/liberalized diet.</p> <p>The resident's 4/1/15 nutrition assessment note documented the resident was at 166.2 lbs on 3/2/15 and 180.4 lbs on 4/1/15 (an increase of 8.5 % in one month).</p> <p>The 4/1/15 nutrition assessment documented the weight from 2/4/15 which was 166.2 lbs. The 4/1/15 weight of 180.4 lbs was not identified on</p>	F 325	<p>On 10/12/15 the Registered Dietitian reassessed Resident #1 regarding current status, nutritional interventions, and adverse effects related to significant weight gain. The Director of Nursing or designee updated the resident's physician and responsible party about the resident's weight gain on 11/02/15 with no new orders received. The Registered Dietitian reviewed Resident #1's diet on 10/19/15 and found it to be appropriate. The Registered Dietitian reviewed and updated the resident's nutritional care plan on or before 12/16/15.</p> <p>Potential</p> <p>On 11/10/15 an audit was conducted by the Director of Nursing or designee, of resident's weights & re-weights completed within the last 30 days for any significant weight gain or loss. Residents with identified concerns will have physician and family notification completed by the licensed nurse, and referral to the Registered Dietitian for assessment, medication review, and nutritional intervention.</p> <p>On 11/2/15 an audit was conducted to identify diabetic residents. Identified residents will be reviewed by Nursing & Registered Dietitian to determine appropriateness of the resident's current diet. Risks vs Benefits will be discussed with residents and POA.</p> <p>Systemic</p> <p>On or before 12/16/15 the Nurse Practice Educator or designee will educate</p>		

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F 325	<p>Continued From page 34</p> <p>the assessment. The assessment documented the resident was on a regular diet, and consistent carbohydrate was checked as a therapeutic diet. It did not document a percentage of weight gain, that there was not a gain of 5% or more in the last month, and that there was no weight loss/gain trend. Under the education section, it was documented that no education should be provided, and that evaluation for the need of education would happen closer to discharge. It documented the resident had a BMI over 25, was on a CCHO (consistent carbohydrate) diet, and had a diagnosis of diabetes. The resident's blood glucose was 287 and had glucose in her urine of 1000. The conclusion of the nutrition assessment documented the resident was having extra CHO-containing foods and inconsistent carbohydrate intake. It documented the resident had previously expressed a desire to lose weight but weight had stayed stable despite discussing possible strategies. It documented the etiology of this related to the diagnosis of diabetes, with a "nutrition prescription" of a CCHO diet. No further interventions or changes to the plan of care were documented. A review of medications was not documented and notification of the physician was not documented.</p> <p>A 4/22/15 weight change note documented the resident's weight on 3/2/15 was 166.2, similar to previous weights, and on 4/22/15 it was 182.4 lbs, It documented the etiology of sudden weight gain was unclear. There was no assessment addressing this weight on 4/22/15 or the weight of 180.4 on 4/1/15 to investigate the sudden weight gain.</p> <p>On 10/5/15 at 12:15 p.m., the resident was observed at the lunch meal service in the dining</p>	F 325	<p>licensed nurses, regarding the weight process, including MD/POA, and Registered Dietitian notification and the need to identify and follow up on resident weight changes.</p> <p>The Registered Dietitian was re-educated by the Regional Dietitian Consultant on or before 12/16/15 regarding resident nutritional assessment including review of resident conditions including diabetes, as well as medications and conditions that may contribute to weight fluctuations.</p> <p>The Registered Dietitian was re-educated on or before 12/16/15 by the Regional Dietitian Consultant on discussing dietary options and the risk associated with not electing the recommended diet with the resident / responsible party.</p> <p>Monitor Effective 12/16/15 the Director of Nursing or designee will conduct an audit of 3 residents with weight change for review by nursing and RD and implementation of appropriate interventions. Weekly X 4 them monthly X 2. The results of these audits will be compiled by the Director of Nursing and reported to the QAPI committee for review and remedial intervention monthly X3 months or until resolved. The Director of Nursing is responsible for monitoring and follow-up.</p>		

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F 325	<p>Continued From page 35</p> <p>room. The resident had breaded chicken filet sandwich with lettuce, tomato, and mayonnaise and French fries with ketchup. She also had vegetable soup with crackers. The resident was observed to eat 100% of her meal and 50% of her soup. The resident reached for her neighbor's plate of food, then CNA stopped her and offered her more French fries; at 1:00 p.m. the French fries arrived (one plate full) and resident fed herself.</p> <p>On 10/8/15 at 12:55 p.m., the resident was observed at the lunch meal service. The resident's tray came to her with dessert (marble cake with mocha frosting), grilled ham and swiss on rye bread (full portion), and French fries. The resident ate 100% of her meal, and was observed giving the ham out of her sandwich to another resident. The resident filled out her meal order form for the next day, 10/9/15, and ordered wheat toast with scrambled eggs for breakfast; cheese and vegetable pizza for lunch; and shepherd's pie with salad and gelatin with whipped topping for dinner. The meal order form was for regular diet choices.</p> <p>On 10/8/15 the resident's meal tray card documented the resident was to receive a regular/liberalized diet and disliked spinach.</p> <p>On 10/9/15 at 12:50 p.m., the Registered Dietician was asked about the resident's sudden weight gain. She stated the resident had some edema in December 2014, and that if edema wasn't documented on the nurse's quarterly assessment she did not consider edema as a risk factor of weight gain. At the time of the assessment on 4/1/15, she stated she did not consider edema but thought it was related to</p>	F 325			

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F 325	Continued From page 36 snacking. She stated there was no documentation on discussion of healthy snack preferences or education for staff regarding snack choices. She also stated there is no monitoring for the resident's snacking or carbohydrate intake. She stated she defers notification of weight gain to nursing, and for diabetic residents assessments are done quarterly with the HgA1c and as needed if there is a problem. She stated diabetic education is not intensive, and might include snacks that are better or healthy choices the resident could make. New interventions for carbohydrate control were not initiated after weight gain. On 10/9/15 at 1:40 p.m. the CDM stated the resident's meal tray card should say "CCHO" and that the resident should be receiving a carbohydrate consistent diet. The resident experienced an 8.5% weight gain in one month; the reasons for the sudden weight gain were not assessed and the physician was not notified. Possible underlying medical or medication causes of the weight gain were not assessed. The resident had a diagnosis of diabetes mellitus and received a regular diet instead of a consistent carbohydrate diet. The resident had a goal to lose 12 lbs (to 166 lbs) by 4/8/15, and interventions to reach this goal were not monitored, evaluated, or revised to help the resident be successful.	F 325			
F 329 SS=D	483.25(I) 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	F 329		12/16/15	

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F 329	<p>Continued From page 37</p> <p>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 observation, staff interview, and record review, it was determined the facility failed to ensure a resident did not receive an antidepressant medication to control or suppress the resident's sexual feelings. This was true for 1 of 4 (#4) residents sampled for use of psychotropic medications. This practice placed the resident at risk for feelings of shame, embarrassment, and/or a diminished sense of self worth.</p> <p>Resident #4 was admitted to the facility on 4/13/12 with multiple diagnoses, including Major depressive disorder and history of CVA.</p>	F 329	<p>F329</p> <p>Affected Resident #4 was assessed/ interviewed by the Licensed Social Worker on 10/20/15 related to psycho social well being, current medication regimen (including risk vs benefits of current treatment plan), sexual well being, and privacy needs. The Licensed Social Worker updated the residents <input type="checkbox"/> guardian, primary physician, and the Geropsychiatrist of assessment results. Physician <input type="checkbox"/>s orders were implemented,</p>		

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F 329	<p>Continued From page 38</p> <p>Review of MDS assessments dated 2/9/15, 5/12/15, 7/15/15, and 9/29/15 documented the resident did not display behavioral symptoms that were distressing or potentially harmful to the resident, other facility residents, and/or staff members. Additionally, the 2/9/15, 5/12/15, and 9/29/15 MDS assessments documented the resident was cognitively intact.</p> <p>Current Physician Orders documented the resident was to receive Sertraline (Zoloft) 75 mg by mouth one time daily for increased libido.</p> <p>The current care plan identified the resident enjoyed private time and had a history of increased libido. She displayed inappropriate sexual behavior by making sexual comments to staff and displayed sexual expression in public places. Interventions directed staff to avoid conversations which might encourage or initiate inappropriate sexual behaviors; display an accepting non-judgmental manner to encourage discussion related to the "resident's" concerns about sexuality; and provide a sign to place on the door to allow for increased privacy. The resident was to request assistance from staff for personal hygiene after private time; counseling services were to be provided; puzzles, newspapers, and magazines were to be provided "as a means of distraction; and staff were directed to encourage the resident to return to her room during periods or sexual expression.</p> <p>Psychiatric progress notes and Psychotropic Medication Evaluations documented: * 7/7/15 - "Staff reports that the patient has been using her vibrator excessively ... Patient at one time was being considered for hospitalization to</p>	F 329	<p>and the resident's plan of care was reviewed and updated by the Licensed Social Worker and the Director of Nursing.</p> <p>Resident #4 was assessed by the Geropsychiatrist on 11/2/15 and resident's treatment plan was reviewed with the resident, including a review of resident's current psychotropic medications and the risk vs benefits of their use. Follow-up was completed by the Licensed Social Worker on or before 12/16/15.</p> <p>Potential On or before 12/16/15 a review of residents on psychotropic medications was completed by the Licensed Social Worker to ensure that residents and or residents responsible parties were involved and aware of current treatment plan, and risk vs benefit of psychotropic medications Follow-up care conferences were completed and the residents' treatment plans, and plan of care were updated to meet residents' emotional needs, resident centered treatment goals, and resident choice on or before 12/16/15.</p> <p>Systemic On or before 12/16/15 the Nurse Practice Educator or designee will provide education to nursing staff and the IDT regarding the need to provide services that meet resident's emotional needs, identify resident centered treatment goals, and maintain or enhance resident choices</p>		

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F 329	<p>Continued From page 39</p> <p>inpatient psychiatric unit, but the patient did not meet the criteria for severity. Patient herself does not recognize anything wrong with her behavior of excessive use of the vibrator. Patient reports, "I have got to relieve that tension some way when I get horny. I do not have a man around." She was receiving Sertraline for mood disorder and anxiety symptoms ... Additionally, it was documented the Sertraline may reduce her need to use vibrator to such an excessive extent ..."</p> <p>The psychiatrist documented he/she discussed the resident's care plan with staff, including pros and cons of other psychiatric medicines and psychosocial interventions to use for distraction, however the care plan did not identify those psychosocial interventions. The progress note did not document the resident was consulted about care and treatment options related to her libido, vibrator use, and/or sexual tension.</p> <p>* 7/22/15 - The resident exhibited no change in her behavioral symptoms and continued to receive Zolof for increased libido as evidenced by sexually inappropriate behavior. The facility offered puzzles, newspapers, and magazines as an alternative to the resident's sexual expressions.</p> <p>* 9/14/15 - Staff reported the resident inappropriately touched one staff on one occasion sometime between 7/22/14 and 9/14/15, and made inappropriate sexual comments about female staff's breast size. The progress note did not document whether a dialogue had occurred between the psychiatrist and the resident regarding the inappropriate comment and/or touching incident. Interventions implement at this time directed staff to set firm limits; explain to the resident that what she was saying and doing was</p>	F 329	<p>in full recognition of their individuality.</p> <p>Residents with newly ordered psychotropic medication will be reviewed in morning clinical meeting by the Licensed Social Worker beginning 11/16/15 to ensure that residents are consulted related to their treatment plan, medication regimen, and goals. Follow-up will be completed as needed.</p> <p>Monitor Effective 12/16/15 a review of 3 residents with psychotropic medication will be completed by the Director of Nursing or designee to ensure that ordered medications have an indication for use and that residents/responsible party's choice related to treatment have been addressed. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the Director of Nursing and reported to the QAPI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and follow up.</p>		

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(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 329	<p>Continued From page 40</p> <p>disrespectful; and not to say anything that might inadvertently reinforce behaviors.</p> <p>On 10/7/15 at 8:15 PM, CNA #1 and CNA #2 were observed preparing the resident for bed and initiating a conversation with the resident related to the size and position of womens' breasts. When CNA #2 removed the resident's shirt, the resident remarked about the size and position of her own breasts. CNA #2 lifted her own breasts and stated to the resident, "That's what happens when we get old." CNA #1 and CNA #2 continued to discuss breast size and position of womens' breasts with the resident. CNA #1 stated in a joking manner that she would give the resident some of her breasts because she had more than enough to share. No additional comments in this vein were made by the resident during or after this conversation.</p> <p>The resident was observed interacting multiple times with staff on various shifts from 10/5/15 to 10/9/15 without making inappropriate statements or gestures towards staff or other residents .</p> <p>On 10/9/15, the resident's physician stated Resident #4 had a "kind of odd, alternative lifestyle" and he had "never" had a conversation with her in which she did not bring up sexual topics. The physician stated he "allowed" the facility to provide the resident with a vibrator, which "quieted her down" for awhile until the batteries ran out. He stated the Zolofit "controlled" the resident's libido and she was now "less inclined" to use the vibrator. The physician stated when the resident brings up sexual topics he "ignores" or redirected the resident and instructed staff to do the same.</p>	F 329			

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

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F 329	Continued From page 41 On 10/9/15, the MSW stated it was not the resident who felt she used a vibrator excessively, but rather staff who felt it was excessive. She said staff was concerned the resident's use of a vibrator was increasing incidents of incontinence and damaging the resident's bladder. Although the resident's ADL flow sheets for May, June, and July 2015 documented the resident was incontinent of bladder most days across all shifts, the MSW stated the resident's urologist stated there was no damage associated with the use of the vibrator and that it was safe for continued use by the resident. The MSW stated she requested a psychiatric consult for the resident related to increased use of the vibrator, depression, anxiety, and to assess the resident for activities other than "masturbation" in which she could participate. When asked if the resident had requested her libido to be suppressed, the MSW stated the resident had not requested medication to suppress her sexual urges. Additionally, the MSW stated she could not recall if the risk and benefits of the medication had been discussed with the resident.	F 329			
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on Resident Group interview, test tray	F 364		12/16/15	
			F 364		

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F 364	<p>Continued From page 42</p> <p>evaluation, and staff interview, it was determined the facility failed to prepare palatable food. This affected 9 of 10 residents who attended the Group interview and had the potential to affect all residents who dined in the facility. This practice created the potential to negatively affect residents' nutritional status and psychosocial well-being related to unpalatable food.</p> <p>On 10/6/15, during the Group interview, 9 of 10 residents stated food was cold for all meals, specifically eggs, chicken, pork, and meatloaf were tough and dry, food was bland and had no flavor, vegetables were always undercooked and hard, and the ice cream was "like eating soup."</p> <p>On 10/6/15, at 5:52 PM, a dinner meal test tray was evaluated by the survey team and the Dietary Manager in Training. The test tray included parsley potatoes with a temperature of 135-degrees (F), which the DMT said could be warmer and more flavorful. A green bean casserole had a temperature of 115- degrees (F), which the DMT said could be warmer and more flavorful. The breaded fish had a temperature of 140-degrees (F), which the DMT said could be warmer and more flavorful with tarter sauce. The potatoes, green bean casserole, and breaded fish were determined not be hot and/or flavorful, and were unpalatable.</p>	F 364	<p>Affected On or before 12/16/15 center residents will be re-interviewed by Administrator or designee regarding food temperatures and palatability of food.</p> <p>Potential On 11/5/15 a group interview was held by Administrator or designee to discuss food temperatures and palatability of food.</p> <p>Systemic On or before 12/16/15 staff, Administrator, Dietary Manager, Food and Nutrition Staff will be educated by the Nurse Practice Educator or designee regarding food temperatures and tray assessment for palatability. On or before 12/16/15 Food and Nutrition Staff will be educated by the Regional Manager of Food and Nutrition on food temperatures and palatability of food.</p> <p>Monitor Effective 12/16/15 Food Temperatures will be documented at each meal. A test tray will be prepared 3 X weekly and tested by the Administrator or designee, to determine appropriate food temperatures and palatability of food.</p> <p>Test tray Audits will be completed weekly X 4 then monthly X2 months. The results of these audits will be compiled by the Administrator and reported to the QAPI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved.</p>		

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F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</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>	F 441		12/16/15	

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F 441	<p>Continued From page 44</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure infection control procedures were followed for 3 of 15 residents sampled residents (#6, #13, and #14) when CNAs performing perineal care did not change gloves or perform hand hygiene consistent with professional standards. This failure resulted in the potential for cross-contamination of bacteria, viruses and other microorganisms. Findings include:</p> <p>1. On 10/6/15 at 9:45 a.m., CNA #6 was observed providing perineal care for Resident #6. The CNA, who emptied the resident's catheter bag, applied a stat lock to the his/her thigh, cleaned the catheter tubing from insertion site distally, cleaned the perineal area, applied lotion to the resident's buttocks, applied a new adult brief and pulled up the residents pants, did not change gloves at any time during the process.</p> <p>2. On 10/7/15 at 6:45 a.m., CNA #5 was observed as she applied gloves and cleaned Resident #13 of bowel movement (BM). With visibly soiled gloves, she then reached into a fecal-soiled packet of clean wipes, and without first changing gloves, applied a new adult brief. CNA #5 then removed the gloves, wiped her hands on her pants, and applied new gloves. No handwashing was performed at this time. The CNA then helped the resident apply tubi-grips, pants, slippers; touched the resident's salt and pepper shakers; and then grabbed the resident's hands to help him into a sitting position. CNA #5 then transferred the resident with the sit-to-stand lift, finished dressing the resident, and removed gloves. Without first washing her hands, the CNA</p>	F 441	<p>F441</p> <p>Affected On or before 12/16/15 the Director of Nursing or designee will assess Resident #6, 13, and 14 for signs and symptoms of infection / negative outcome. Negative findings will be addressed as indicated. Identified staff were re-educated on or before 12/16/15 regarding proper hand washing procedures by the Nurse Practice Educator.</p> <p>Potential On 11/3/15 the Director of Nursing or designee conducted a review of residents for signs and symptoms of infection. Identified residents will be reported to the MD and positive findings will be addressed as indicated.</p> <p>Systemic On or before 12/16/15 the Nurse Practice Educator or designee will provide education to staff regarding proper hand hygiene and proper peri-care.</p> <p>On or before 12/16/15, the Nurse Practice Educator or designee will complete a hand-washing competency for staff that provides cares.</p> <p>On or before 12/16/15 the Nurse Practice Educator or designee will complete a peri-care competency for staff that provides peri-care.</p>		

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F 441	Continued From page 45 then entered room 216 to turn off that resident's alarm, then returned to Resident #13's room to make the bed. CNA #5 then donned clean gloves, removed a trash bag from its bin, removed her gloves, and applied hand sanitizer. 3. On 10/7/15 at 7:45 a.m. CNA #6 and #7 were observed providing perineal care for Resident #14. Without changing gloves or performing hand hygiene after providing the perineal care, CNA #7 was observed touching the resident's dresser drawers, transferring the resident with a hoier lift, dressing the resident, touching the resident's oxygen canister, chair, and pillows, and then brushing the resident's hair. CNA #7 stated gloves should have been changed after perineal care.	F 441	Monitor Effective 12/16/15 the Unit Manager or designee will conduct a weekly audit of 3 staff members for proper hand hygiene. Effective 12/16/15 the Unit Manager or designee will conduct an audit of 3 residents, for proper peri-care. These audits will be completed weekly X 4 then Monthly X 2. Results will be compiled by the Director of Nursing or designee and reported to the QAPI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and follow-up.		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and a review of the facility's compliance history, it was determined the facility's administration failed to take actions that identified and resolved systematic problems for 4 of 15 sampled residents (#1, #4, #7 and #13) with the potential to affect all residents in the facility. This failure resulted in the management team providing insufficient direction and control	F 490	F 490 Affected Resident #1, #4, #7, and #13 Please refer to F314 and F323 for actions taken for identified residents. Potential Residents residing in the facility had the	12/16/15	

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F 490	Continued From page 46 necessary to ensure residents' Quality of Life and Quality of Care needs were met. Findings included: The facility failed to provide sufficient implementation, monitoring, evaluation and continued oversight to maintain regulatory compliance in the following areas: a. Refer to F314-The facility failed to ensure residents did not develop pressure ulcers while residing in the facility. b. Refer to F323-The facility failed to ensure residents were free from accident hazards, transferred safely to prevent falls or injury, and provided with fall interventions as ordered.	F 490	potential to be affected under this citation. Please see F314, and F323 Systemic On or before 11/20/15 the Regional Vice President will educate the centers QAPI committee on running a comprehensive Performance Improvement program including the reports, tools, location of policy and procedures and how to reference them, root cause analysis, and metrics that are available to the committee in real time. The training will also include conducting productive monthly QAPI meetings. The center Performance Improvement committee which includes Administrator, Director of Nursing and other management team members will bring key clinical process metrics, audits results, resident council reports, and other information warranting the Committee's discussion/actions to the monthly Performance Improvement meeting. The Pharmacy Consultant and Medical Director will also be in attendance at least quarterly. Monitor During the week of 11/16/15 the Administrator will chair the Performance Improvement Committee meeting and review the resources brought to meeting by Committee members along with the compliance audits from this survey and resident council meeting minutes to ensure recommendations, audit results, and metric trends are acted upon.		

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F 490	Continued From page 47	F 490			
F 520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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.</p> <p>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.</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</p>	F 520	<p>Results of recommendations and audits will be discussed by team members to include but not limited to cause identification with systematic reviews for necessary changes. The QAPI meeting will occur monthly with regional support available as needed.</p>	11/27/15	

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F 520	<p>Continued From page 48</p> <p>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 15 sampled residents (#s 1-9) and 5 random residents (#s 11-15). 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 practices as determined by the recertification survey of 10/5/15 through 10/14/15.</p> <p>a. Refer to F281 as related to the facility's failure to provide services consistent with professional standards of care related to diabetic management.</p> <p>b. Refer to F314 as related to the facility's failure to ensure residents did not develop pressure ulcers while residing in the facility.</p> <p>c. Refer to F323 as related to the facility's failure to ensure residents were free from accident hazards, transferred safely to prevent falls or injury, and provided with fall interventions as ordered.</p>	F 520	<p>F 520</p> <p>Actual Residents #1, 2,3,4,5,6,7,8,9,10,11,12,13,14,and 15. Please refer t to F 281, F314, and F323 for actions taken for identified residents.</p> <p>Potential Residents residing in the facility had the potential to be affected under this citation. Please also see F 281, F314, and F323.</p> <p>Systemic On or before 12/10/15 the Regional Vice President will educate the centers QAPI committee on running a comprehensive Performance Improvement program including the reports, tools, location of policy and procedures and how to reference them, root cause analysis, and metrics that are available to the committee in real time. The training will also include conducting productive monthly QAPI meetings.</p> <p>The center Performance Improvement committee which includes Administrator, Director of Nursing and other management team members will bring key clinical process metrics, audits results, resident council reports, and other information warranting the Committee's discussion/actions to the monthly Performance Improvement meeting. The Pharmacy Consultant and Medical Director will also be in attendance at least quarterly.</p>		

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F 520	Continued From page 49	F 520	<p>Monitor</p> <p>During the week of 12/16/15 the Administrator will chair the Performance Improvement Committee meeting and review the resources brought to meeting by committee members along with the compliance audits from this survey and resident council meeting minutes to ensure recommendations, audit results, and metric trends are acted upon.</p> <p>Results of recommendations and audits will be discussed by team members to include but not limited to cause identification with systematic reviews for necessary changes. The QAPI meeting will occur monthly with regional support available as needed.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001120	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2015
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility October 5-9, 2015. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Kendra Deines, RN, BSN Abbreviations included:	C 000		
C 409	02.120,05,i Required Room Closet Space i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room. This Rule is not met as evidenced by: Based on staff interview, it was determined the facility did not provide the required closet space of 20 inches x 22 inches, for 1 of 3 halls (the 100 hall) - all closets in rooms 101-120, 201 and 203. During survey, the Maintenance Supervisor indicated a waiver would again be requested for the closets. All closets in the 100 hall measured 36 inches wide and 24 inches deep. The closets had dividers separating them, which created individual closet space of 18 inches wide by 24 inches deep. The same was true of rooms 201 and 203.	C 409	C 409 Waiver requested.	12/16/15

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/10/15
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Bureau of Facility Standards

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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E-mail: fsb@dhw.idaho.gov

November 24, 2015

Shelly Henderson, Administrator
Payette Center
1019 Third Avenue South
Payette, Idaho 83661-2832

Provider #: 135015

Dear Ms. Henderson:

On **October 9, 2015**, an unannounced on-site complaint survey was conducted at Payette Center. The complaint was investigated in conjunction with the facility's recertification survey from October 5 to October 9, 2015.

The following observations were completed:

- Staff were observed throughout the survey to use mechanical lifts when transferring residents;
- Four of five sampled residents were observed to be transferred via mechanical lift; and,
- Staff were observed to use two people with mechanical lift transfers.

The following documents were reviewed:

- The facility's grievance file from May 2015 to October 2015;
- Resident Council minutes from May 2015 to October 2015;
- Incident and Accident reports from May 2015 to October 2015;
- The medical records of five residents who required mechanical lift transfers; and,
- The facility's policy and procedure for mechanical lift transfers.

The following interviews were conducted:

- Two residents and two resident advocates were interviewed for quality of care concerns;
- Several staff members on all shifts were interviewed related to the use of mechanical lift transfers;

- The Staff Development Coordinator; and,
- The Director of Nursing Services.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006803

Allegation #1:

The complainant "believed" an identified resident was transferred without the use of a mechanical lift.

Findings #1:

During the survey, mechanical lift observations and resident and staff interviews were conducted. Resident records, incident and accident reports, grievances, and policies and procedures were reviewed with the following results:

The facility's Fall Incident and Accident reports and grievances for May of 2015 to October 2015 did not include concerns regarding the lack of mechanical lifts used during transfers.

The records of five sampled residents who required mechanical lifts for transfers did not document concerns regarding transfers. Activities of Daily Living care plans were consistent with the facility's policy and procedures regarding mechanical lift transfers.

Two residents, one resident advocate, certified nursing assistants, licensed nurses, the Staff Development Coordinator, and the Director of Nursing Services were interviewed and did not verbalize concerns related to the appropriate use of mechanical lifts.

It could not be determined mechanical lifts were not used by staff for resident transfers; the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

The complainant reported an identified resident who required two people for transfers via mechanical lift was transferred by one person and without the use of the lift.

Findings #2:

During the survey, mechanical lift observations and resident and staff interviews were conducted. Resident records, incident and accident reports, grievances, and policies and procedures were reviewed with the following results:

The facility's Fall Incident and Accident reports and grievances for May of 2015 to October 2015 and did not include concerns regarding the lack of mechanical lifts used during transfers.

The records of five sampled residents who required mechanical lifts for transfers were reviewed and did not document concerns regarding transfers. Activities of Daily Living care plans were consistent with the facility's policy and procedures regarding mechanical lift transfers.

Two residents, one resident advocate, certified nursing assistants, licensed nurses, the Staff Development Coordinator, and the Director of Nursing Services did not verbalize concerns related to the appropriate use of mechanical lifts.

It could not be determined mechanical lifts were not used by staff for resident transfers; the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

The complainant stated the identified concerns were reported "many times" to management and each time management initiated a read and sign inservice related to facility's policy for the use of mechanical lifts. The complainant stated improper transfers continue "because people don't take a 'read and sign' inservice seriously."

Findings #3:

Based on observations, staff interviews, and review of the facility's Safe Resident Handling/Transfer Equipment Policy, it was determined the facility failed to ensure formal and continuing education were provided and certified nursing assistants were competent to operate mechanical lifts and to size lift slings. This failure had the potential to adversely impact the quality of life and quality of care for residents in the facility dependent on mechanical lifts for transfers.

It was determined certified nursing assistants were not adequately trained to appropriately size and/or use the mechanical lift; the allegation was substantiated and cited at F323.

Shelly Henderson, Administrator
November 24, 2015
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CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a smaller "Scott" following it.

David Scott, RN, Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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November 24, 2015

Shelly Henderson, Administrator
Payette Center
1019 Third Avenue South
Payette, ID 83661-2832

Provider #: 135015

Dear Ms. Henderson:

On **October 9, 2015**, an unannounced on-site complaint survey was conducted at Payette Center. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from October 5, 2015 to October 14, 2015.

The following observations were completed:

- Residents' cares;
- Three residents with foley catheters;
- The accessibility of fluids for all residents;
- Signs and symptoms of dehydration among all residents;
- Urine odor in the skilled hall;
- Residents taken to the dining room for meals;
- Residents served meals in their room;
- Staffing each shift;
- Staff laying down residents after meals;
- Call lights were observed throughout the survey;
- Activities available for residents;
- Residents attending activities;
- Medication administration;

- Residents' appearance and hygiene;
- Residents being provided a bath or shower;
- Breakfast, lunch, and dinner meals;
- Therapy provided for residents with swallowing difficulty.

The following documents were reviewed:

- The medical record of 15 sampled residents for quality of life and quality of care concerns;
- The facility's Incident and Accident reports from May to October 2015;
- Actual hours worked for licensed nurses and CNAs for September 14, 2015 through October 2, 2015;
- Activities calendar for October 2015;
- October 2015 physician recapitulation orders for all residents observed during medication passes;
- The care plans of 15 sampled residents for October 2015;
- Grievances from May-October 2015;
- Resident Council minutes from May to October 2015;
- Social work assessments and notes for nine sampled residents from August to October 2015;
- Speech therapy notes and assessments for two residents;
- Documentation regarding weight loss for three residents (including weights, nutritional assessments, notes, and speech therapy interventions).

The following interviews were completed:

- Three individual resident interviews regarding quality of life and quality of care concerns;
- One RN interviewed regarding urine odor;
- Three CNAs on varying shifts regarding staffing and showers;
- A group interview with 10 residents including discussion about activities available in the facility and showers;
- Interview with the Recreation Director;
- The DON regarding various quality of life and quality of care concerns;
- The social worker regarding quality of life concerns

The complaint allegations, findings and conclusions are as follows:

Complaint or Entity-Report Incident #ID00007040

Allegation #1:

The complainant reports catheter bags had dark urine in them.

Findings #1:

Residents in the facility were observed to have access to fluids as permitted and residents did not show signs and symptoms of dehydration; documented fluid intakes were adequate.

Based on record review and observations, it was determined the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

The complainant reported the "skilled hall" had a very strong urine odor.

Findings #2:

Upon observation, a strong urine smell was present around the 300 hall utility closet, nurse's station, Room 303, and shower room; interview with an RN confirmed this.

Based on observations and staff interview, the allegation was substantiated at F-252.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3:

The complainant reported there were not enough CNAs to take care of residents, and as a result residents were not getting up for meals, were served meals in their room, and that CNAs would not have enough time to lay residents back down once they were out of bed.

Findings #3:

There were observations of adequate staffing to care for residents each shift. Residents' call lights were answered in a timely manner and all residents who wanted to go to the dining room for meals were accommodated. Review of nurse's and CNA's actual hours worked documented adequate staffing ratios. A group interview with 10 residents, review of grievances, and review of Resident Council minutes did not reveal any concerns regarding meal services or enough staffing to get residents out of bed. Interviews with CNAs revealed no concerns with time to care for residents.

Shelly Henderson, Administrator
November 24, 2015
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Based on observations, review of records, and staff interviews, the allegation was unsubstantiated based on lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #4:

The complainant reported there was a lack of activities for the residents.

Findings #4:

Review of the activity calendar for October 2015 did not document any evening activities, "outing" type activities, and a lack of activities on Sundays. Residents in the group interview stated there were no chances to travel outside the facility through activities, a lack of activities in the evening after 6:00 p.m., and a lack of activities on the weekends. Interview with the Recreation Director confirmed these findings.

Based on review of records, group interview, and staff interview, the allegation was substantiated at F-248.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #5:

The complainant reported medications were not given as ordered by the physician; a resident received medications by mouth instead of by PEG tube and medications were not given to residents at the ordered time.

Findings #5:

During the survey, no resident had a PEG tube that could be observed. Observation of medication passes revealed no concerns with timing and medications were given per physician order and on time.

Based on observation and record review, the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #6:

The complainant reported a resident was having trouble eating and did not receive a speech therapy evaluation.

Findings #6:

Speech therapy notes and assessments were documented for two residents with swallowing difficulties; interventions and timing of assessments were appropriate. Residents were observed in the dining room for ability to eat and speech therapy was observed working with residents in the dining room. Three residents were reviewed for weight loss concerns; their medical records indicated appropriate and timely interventions for weight loss, including speech therapy assessment and intervention.

Based on observation and record review, the allegation was unsubstantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #7:

The complainant reported a resident appeared disheveled, had refused all showers, and had not been contacted by the Licensed Social Worker.

Findings #7:

Residents were clean and neatly kept during the survey; residents were observed being showered and bathed. Social work assessments and notes documented contact with residents and resulting interventions in the care plans. Review of grievances and resident council minutes did not document concerns regarding showers or social work. Interviews with 10 residents during the group interview and two CNAs regarding showers revealed no concerns.

Based on observation, record review, and interview, the allegation was unsubstantiated due to lack of evidence.

Shelly Henderson, Administrator
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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

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

David Scott, R.N., Supervisor
Long Term Care

DS/lj