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

November 6, 2015

Tom De Oro, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue,
Coeur D'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. De Oro:

On **October 23, 2015**, a survey was conducted at Lacrosse Health & Rehabilitation 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 to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 23, 2015.** Failure to submit an acceptable PoC by **November 23, 2015**, may result in the imposition of civil monetary penalties by **November 23, 2015**.

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 27, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 27, 2015**. A change in the seriousness of the deficiencies on **November 27, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 27, 2015** includes the following:

Denial of payment for new admissions effective **January 23, 2016**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 23, 2016**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 23, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

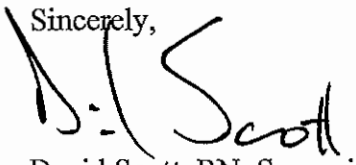
- BFS Letters (06/30/11)

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

This request must be received by **November 23, 2015**. If your request for informal dispute resolution is received after **November 23, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



David Scott, RN, Supervisor
Long Term Care

DJS/pmt
Enclosures

12/31/2015

RECEIVED
JAN - 5 2016
FACILITY STANDARDS

David Scott
3233 Elder St.
PO BOX 83720
Boise ID, 83720

Greetings David,

Enclosed please find our federal and state plan of correction to satisfy violations observed during our annual survey dated 10/23/15 with the updated 2567 dated 12/30/15. Please note our stated date for substantial compliance is 1/4/16 for the revised POCs. Thank you for your assistance through the process. Please let me know if any questions arise from the attached plan of correction.

Sincerely,

Thomas de Oro

Tom de Oro, NHA
Administrator
Lacrosse Health and Rehab
210 W. Lacrosse Ave
Coeur d'Alene ID, 83814

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

PRINTED: 12/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135042		10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHABILITATION CENTER	210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814

(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 and complaint survey conducted at the facility from October 19, 2015 to October 23, 2015. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Becky Thomas, RN Linda Hukill-Neil, RN Angela Morgan, RN Presie Billington, RN Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BP = Blood Pressure CAA = Care Area Assessment cm = Centimeters CNA = Certified Nurse Aide CP = Care Plan DON = Director of Nursing HOB = Head of Bed LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = Milligram MSDS = Materail Safety Data Sheet PRN = As Needed ROM = Range of Motion TAR = Treatment Administration Record TF = Tube Feeding UM = Unit Manager VS = Vital Sign WC = Wheelchair	F 000	RECEIVED JAN - 5 2016 FACILITY STANDARDS	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas de Ero
TITLE: Administrator
(X6) DATE: 12-31-15

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

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F 241	Continued From page 1 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain residents' dignity when arm protectors were dingy and dirty, non-skid socks were torn and loose, and a urinary catheter collection bag was exposed. This was true for 2 of 15 sampled residents (#4 and #6) and created the created the potential for a negative effect on their self esteem. Findings included: 1. Resident #6 was admitted to the facility on 12/29/14 with multiple diagnoses, including dementia and depressive disorder. The quarterly MDS assessment, dated 10/18/15, documented the resident had short- and long-term memory impairment, was severely cognitively impaired, and required extensive assistance with dressing, personal hygiene and bathing. The resident's skin integrity Care Plan, dated "10/15," identified dermal fragility and dry skin as problems. Interventions included arm protectors to the bilateral upper extremities while out of bed. The intervention was added to the resident's Care Plan on 1/13/15. The resident's bilateral arm protectors were observed to be dingy and dirty on 10/20/15 at 12:05 p.m. during the lunch meal, and on 10/22/15 at 9:35 a.m. and 2:00 p.m. while the resident ambulated in the hallway near the nurse station. Both light-colored arm protectors were	F 241	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F241** will be corrected as follows: **1) Correction/s as it relates to the resident/s:** Resident #6 received new arm protectors. Resident #4 had his catheter bag placed in his privacy bag. Resident #4 is covered and free from exposure. **2) Action/s taken to protect residents in similar situations:** Resident's with arm protectors have received clean replacements. All residents with catheters have been provided privacy bags. All residents have been covered to ensure they are free of exposure. Privacy curtains are in every room. **3) Measures taken or systems altered to ensure that solutions are sustained:** All staff has been educated on changing arm protectors daily, catheter bags placed in privacy bags, covering residents from exposure during care. Additional arm protectors have been purchased to meet this need. Dignity and respect has been trained to all staff.	

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F 241	Continued From page 2 blackened around the thumb hole. On 10/22/15 at 3:30 pm, the DON said the resident's arm protectors looked dirty. When asked how often the arm protectors were changed, the DON said they were changed on shower days, or at least twice a week, or whenever they were dirty. The DON removed the arm protectors and looked for another pair in the resident's drawer, but did not find any. He then instructed the CNA to locate clean arm protectors for the resident. On 10/22/15 at 3:30 p.m., during a skin check by the DON with two surveyors present, Resident #6's right foot sock was observed to be loose and torn at the ankle. The DON was asked about the condition of the resident's sock. The DON said "Yes, it looks worn out." 2. Resident #4 was admitted to the facility 2/13/13, and readmitted on 5/22/15, with multiple diagnoses, including quadriparesis. Resident #4's most recent quarterly MDS assessment, dated 8/15/15, documented the resident was cognitively intact and required extensive of at least two staff for bed mobility, hygiene, and bathing. a. Resident #4's urinary collection bag was observed outside of a privacy bag during on 10/20/15 at 7:45 AM and 12:16 PM, and on 10/22 at 6:55 PM. On 10/20/15 at 8:25 AM, CNA #10 stated the resident's urinary collection bag should have been inside a privacy bag.	F 241	**4) Plans to monitor performance to ensure solutions are sustained and person responsible:** Weekly audits will be done on arm protectors, privacy bags and privacy during care. Results will be monitored monthly for three months and presented at QAPI. **5) Date of Compliance:** 11/27/15 **6) Person's Responsible** DON and ICN	

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F 241	Continued From page 3 On 10/20/15 at 8:28 AM, LN #3, also stated the resident's urinary collection bag should have been be in a privacy bag. On 10/20/15 at 7:45 AM, Resident #4 was observed lying in bed with his buttocks partially uncovered by his sheet. At 7:55 AM, RT #9 entered the resident's room and provided trach cares while the door was ajar. At 8:27 AM, the RT stated she did not realize the resident's buttocks were exposed.	F 241	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F246** will be corrected as follows:	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a call light was accessible for 1 of 15 sampled residents (#9). This failure created the potentional for harm if the residents' needs were unmet, a negative effect on the resident's psychological well-being when assistance could not be summoned, and increased the resident's fall risk should he/she attempt to transfer without assistance. Findings included: 1. Resident #9 was admitted to the facility on	F 246	**1) Correction/s as it relates to the resident/s:** Resident #9 was provided their call light to be within reach. **2) Action/s taken to protect residents in similar situations:** All residents have their call lights unless care planned otherwise. **3) Measures taken or systems altered to ensure that solutions are sustained:** All staff in serviced on providing call lights to be within reach. **4) Plans to monitor performance to ensure solutions are sustained and person responsible:** Weekly call light audits will be performed to ensure they are within reach. Audits will be done daily, Monday throngh Friday, for four weeks and weekly thereafter for eight weeks. Audit results will be monitored monthly for three months and presented at QAPI.	

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F 246	Continued From page 4 8/13/12 with multiple diagnoses, including Parkinson's Disease and physical deconditioning. The most recent Annual MDS Assessment, dated 8/7/15, documented the resident had disturbances of balance, gait, and positioning ability. The CAA identified the resident as functionally incontinent requiring two-person extensive assistance for toileting. The resident's Fall Care Plan, dated 8/24/15, documented: * Assessment: Shuffled and unsteady gait * Intervention: Encourage resident to use call light. On 10/20/15 at 7:30 AM and 10:20 AM, Resident #9's call light was observed lying on the floor under her bed. The resident, when asked where her call light was located, said, "I don't know." On 10/23/15 at 8:25 AM, RCM #1 was informed of the above observations and said the call light should be within the resident's reach.	F 246	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F253** will be corrected as follows:	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to perform maintenance services necessary to maintain in good condition resident room doors and the	F 253	**1) Correction/s as it relates to the resident/s:** There were no residents affected by this deficiency. **2) Action/s taken to protect residents in similar situations:** All marred and chipped doors will be repaired of such damage. The wheelchair scale will have the black tape replaced with new material.	

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F 253	Continued From page 5 weighing scale in the Oxygen Room in 200 Hall. This failure had the potential to affect any resident at the facility, including those using the scale. Findings include: On 10/22/15 at 10:20 a.m., during an environmental tour of the facility with Maintenance Supervisor (MS), the following was observed: 1. The door to the Main Dining room and several doors in the 200, 500 and 600 halls were marred and chipped on the lower third of the hinge side of the door. 2. The veneer covering on the door of Room 507 was peeling away at the bottom. 3. Black tape covering the ramp of the weighing scale in the Oxygen Room in 200 Hall was observed with several tears. When asked about the appearance of the of the doors and the weighing scale, the MS said the doors had been in their observed condition for years and the covering of the scale needed to be replaced.	F 253	3) **Measures taken or systems altered to ensure that solutions are sustained:** Staff was educated on reporting identified maintenance findings and communicate using the "building service work order request". These request forms will be reviewed in morning stand-up meeting to ensure follow up. Maintenance Director will bring any uncompleted work orders for follow up each day to the morning meeting. Audits will be completed weekly for 12 weeks by Maintenance Director and Administrator to ensure timeliness for identified repairs needed in the facility. 4) **Plans to monitor performance to ensure solutions are sustained and person responsible:** Monthly audit results will be monitored monthly for three months and presented at QAPI. 5) **Date of Compliance:** 1/4/16 6) **Person's Responsible** Maintenance Supervisor	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280		

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F 280	Continued From page 6 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to revise care plans for 5 of 15 (#s 1, 4, 5, 8, & 11) sampled residents. The care plans for: *Resident #1 did not document daily weights were to be taken; *Resident #4 did not document the resident received a nutritional supplement; *Resident #5 did not document PEG tube hydration interventions and the type of assistance needed with meals; *Resident #8 did not document a nutrition intervention for all liquids to be in spouted cups and that straws were not to used; and, *Resident #11 documented fluid restrictions which had been discontinued. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in their respective care plans. Findings included: 1. Resident #1 was readmitted to the facility on 4/24/15 with multiple diagnoses, including congestive heart failure (CHF).	F 280	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F280** will be corrected as follows: **1) Correction/s as it relates to the resident/s:** Resident #1 has had his care plan reviewed and updated to reflect weight monitoring as per MD order. Resident #4 has had the nutritional care plan reviewed and it has been updated to reflect nutritional supplements. Resident #5 has had his care plan updated to reflect both hydration plan and type of assistance needed for meals. Resident #8 has had his care plan updated to include all liquids to be in spouted cups and that straws are not to be used. Resident #11 has had his care plan updated and the fluid restriction discontinued. **2) Action/s taken to protect residents in similar situations:** Residents with daily weights have the potential to be effected by the deficient practice.	

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F 280	Continued From page 7 The resident's 9/8/15 Physician's Telephone Orders and September and October 2015 TARs, documented the resident's weights were to be taken daily related to CHF. (See F309). The resident's CHF care plan, dated 8/29/15, contained a section regarding weights. The section was left blank. On 10/19/15, Resident #1 said staff had not weighed him, even though his doctor had ordered it. On 10/21/15 the DON reviewed the care plan, said the weight section was blank, and stated the care plan should have been updated. 2. Resident #8 was admitted to the facility on 8/28/09 with multiple diagnoses, including gastroesophageal reflux disease (GERD) and dysphagia (difficulty in swallowing). The resident's orders, progress notes, nutrition notes, and Speech Therapy (ST) notes documented the resident received a liquid diet due to swallowing issues, experienced frequent vomiting and had an appointment scheduled for a gastrointestinal consultation. (See F309). The resident's 10/15/15 ST note documented the therapist had given the resident, "...verbal reminders to avoid straws to decrease chance of vomiting." The resident's 10/19/15 ST order documented all liquids were to be served in spouted cups with "mo straws."	F 280	Residents with daily weights have been reviewed and their care plans accurately reflect MD orders for weight monitoring. Resident's nutritional care plans have been reviewed and accurately reflect nutritional supplements, fluid management, needed assistance for meals and special precautions related to Speech Therapy recommendations. **3) Measures taken or systems altered to ensure that solutions are sustained:** Members of the IDT have been in serviced on effective care planning for weight monitoring and nutritional needs Resident's nutritional/fluid needs and ordered daily weights will be communicated using the 24 hour report. This information from the 24 hour report pertaining to ordered daily weights and nutritional/fluid needs will be care planned accurately and in a timely manner to reflect revisions to the care plan. . **4) Plans to monitor performance to ensure solutions are snstained and person responsible:** Facility will perform weekly audits of care plans related to daily weights, supplements, assistance with meals, assistive devices and fluid restrictions. Additional weekly audits will include review of 24 hour report ensuring any Speech recommendations have appropriate follow through.. These audits will be conducted weekly times four weeks and then monthly times eight weeks. All audits will be reviewed at month QA meeting for efficacy of	

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F 280	Continued From page 8 From 10/19/15 to 10/21/15, the resident's water mug was observed five times in his room on the counter with a plastic straw sticking out of it. On 10/20/15, the resident was asked about his water mug with the straw in it. He said he drank water out of the mug. On 10/21/15, the Speech Therapist said she evaluated the resident and he would drink too fast when he had a straw which caused him to vomit. She said the spouted cups were also provided to slow the rate of liquid the resident drank. When asked if she saw those two interventions on the care plan, she said they were not there but they should have been. 3. Resident #5 was admitted to the facility on 11/18/13, and readmitted on 9/30/14, with diagnoses of pressure ulcer to the buttock, complicated open wound to the buttock, dysphagia, and protein calorie malnutrition. The most recent annual MDS assessment, dated 9/12/15, documented the resident was severely cognitively impaired and required extensive assistance of one staff for eating, toilet use and personal hygiene. The resident required total assistance of at least two staff for transfers and bathing, and required extensive assistance of at least two staff for bed mobility and dressing. The resident had bilateral lower extremity limitation in range of motion. The resident's recapitulated October 2015 Physician's Orders documented the following 8/20/15 orders:	F 280	systems with interventions for correction should a need arise. 5) **Date of Compliance:** 11/27/15 6) **Person's Responsible** Director of Nursing, Facility Educator, Medical Records	

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F 280	Continued From page 9 *Water Flushes 240 ml 3 times daily; *Bolus Feeding 2 Cal HN (calorie and protein rich nutrition supplement) - 1 can 3 times daily via peg tube (240 ml each time); and, *Flush with 50 ml water after each bolus. The resident's care plan did not include interventions to monitor for signs of dehydration, provide TF (Tube Feeding) and flush per order, monitor tolerance of tube feeding, required extensive assistance with meals, or to keep HOB (Head of Bed) elevated for meals, and monitor for signs and symptoms of aspiration. On 10/21/15, LN #4 stated the care plan should have been updated to include these considerations. 4. Resident #11 was admitted to the facility on 10/25/13 with multiple diagnoses including edema and bipolar. The resident's Nursing Notes documented: 7/20/15 - Continues to have 3+ edema. Is not compliant with fluid restriction and not compliant with elevating legs. 7/22/15 - Continues with edema. Continues to be noncompliant with fluid restriction. Resident accused this LN of being mean to him. 7/23/15 - Continues with firm edema to bilateral lower extremities. Non compliant with elevating legs and fluid restriction. Resident #11's 7/23/15 Physician's Orders documented: Fluid Restriction discontinued due to the resident's non-compliance.	F 280		

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F 280	Continued From page 10 The resident's October 2015 recapitulation Physician's Orders documented: Regular diet with a limit of 2 grams of sodium; Fluids: Thin; and, Torsemide 20 mg (milligrams): Give 2 tablets orally once a day for edema. Resident #11's October 2015 Care Plan documented: Assessment/Problem: Weight gain and edema/diuretic Interventions: Monitor for signs of dehydration; encourage fluids unless contraindicated; monitor for signs and symptoms of fluid overload, edema, jugular neck vein distension, and shortness of breath; and fluid restriction 1200 cc (cubic centimeters) daily. On 10/22/15 at 11:40 AM, the DON stated Resident #11 did not have a fluid restriction, the restriction was discontinued in July, and the Care Plan should be updated to reflect this. 5. Resident #4 was admitted to the facility on 2/13/13, and readmitted on 5/22/15, with multiple diagnoses, including quadriparesis with chronic recurrent wounds. The most recent annual MDS assessment, dated 2/25/15, documented the resident was cognitively intact, totally dependent on staff for bed mobility, and required extensive assistance for eating. Recapitulated October 2015 Physician's Orders documented the resident was to receive one ounce of Prostat orally daily with juice for wound healing. Start date 7/21/15. The resident's care plan did not include the	F 280		

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F 280	Continued From page 11 intervention to provide the Prostat. On 10/22/15 at 10:15 AM, the RDM stated the Prostat should have been on the resident's care plan.	F 280	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."*	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure professional standards of quality of care were maintained when a CNA restarted a paused tube feeding pump without delegation and training by an LN. This was true for one of one resident (#3) sampled for enteral nutrition. Failure to adhere to professional standards created the potential for harm should the resident not receive nutrition as ordered, develop gastric distress and/or aspiration pneumonia. Findings include: Resident #3 was admitted to the facility on 7/8/14, and readmitted on 10/16/15, with multiple diagnoses, including medullary injury related to a craniotomy with hydrocephalus. On 10/19/15 at 1:53 PM, CNA #10 was observed restarting a tube feeding that was paused while performing cares for Resident #3. The resident was in a flat position in bed while the pump was paused; CNA #10 elevated the resident's head-of-bed to approximately 30-degrees whn the pump was restarted. When asked if restarting	F 281	Deficiencies related to **F281** will be corrected as follows: **1) Correction/s as it relates to the resident/s:** Resident #3's tube feeding is managed by a licensed nurse. **2) Action/s taken to protect residents in similar situations:** Residents with tube feeding have all had their tube feeding managed by a licensed nurse. **3) Measures taken or systems altered to ensure that solutions are sustained:** In service provided to CNA and licensed nurses regarding tube feeding management. Specifically CNA's cannot turn on or off a resident's tube feeding. **4) Plans to monitor performance to ensure solutions are sustained and person responsible:** Facility will perform weekly audits of residents receiving tube feeding to ensure care is provided by licensed nurses. These audits will be conducted weekly times four weeks and then monthly times eight	

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F 281	Continued From page 12 a tube feeding was within her scope of practice, CNA #10 stated, "For cares we can put them on hold and restart tube feeding." On 10/23/15 at 8:25 AM, RCM #1 was informed of the above concern and said CNA's are not delegated to stop or restart a tube feeding.	F 281	weeks. All audits will be reviewed at month QA meeting for efficacy of systems with interventions for correction should a need arise. 5) **Date of Compliance:** 11/27/15	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure: *Resident #1 was weighed and received medications as ordered; *Resident #4's splint was used as ordered; *Resident #5 received appropriate ostomy care and medications as ordered; *Resident #8 was not provided with a straw for liquids as ordered; *Resident #9's orders for physical and occupational therapy were clarified and did not experience a delay in treatment for physical therapy; *Resident #11's blood pressure and heart rate were monitored as ordered; and, *Resident #15 received appropriate dialysis care.	F 309	6) **Person's Responsible** Director of Nursing *"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F309** will be corrected as follows: 1) **Correction/s as it relates to the resident/s:** Resident #1 is being weighed as per MD order and his weights are reflected appropriately in the MAR. Resident #1 is receiving his insulin as per MD order. Resident #8 has been re-evaluated by Speech Therapy and the recommendations are care planned and being followed.	

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F 309	Continued From page 13 This affected 7 of 15 (#s 1, 4, 5, 8, 9, 11, & 15) sampled residents. These failures created the potential for harm if residents experienced complications and/or compromised medical status. Findings included: 1. Resident #1 was readmitted to the facility on 4/24/15 with multiple diagnoses, including congestive heart failure (CHF) and Type II diabetes. a. The resident's September 2015 MAR documented an order, dated 7/1/15, for 100 units of Lantus via injection daily at bedtime for diabetes. The MAR documented the resident received the injection in the morning on 9/26/15. The resident's 9/26/15 Progress Notes documented, "Resident inadvertently given Lantus this AM instead of PM. MD called...Will continue to monitor." A facility Incident & Accident (I&A) report documented an investigation summary on 10/2/15: "Nurse didn't follow the 6 rights of medication administration...Staff disciplinary action was taken. Resident's blood glucose was monitored through the day [of the incident]. Resident had no adverse outcomes from Lantus being given in the morning." On 10/19/15, Resident #1 was interviewed and said he had been given the wrong medications by nursing staff. He said he now questioned nurses when receiving medications to ensure he was given the correct medication at the correct dosage and correct time.	F 309	Resident #5 is receiving ostomy care as per MD order and is reflected correctly on the TAR Resident #5 has had his skin impairment evaluated by the physician and has treatment orders reflected correctly in the TAR. Resident #11 has blood pressure monitoring and apical pulse and the parameters are being followed as per MD order related to metoprolol use. Resident #4 has had the use of the splint for his right hand evaluated and is wearing his right hand evaluated and is wearing the splint as indicated in his care plan. Resident #9 has heen screened for physical therapy needs and is receiving physical therapy as per MD order. Resident #15 has had his dialysis care plan reviewed and corrected. The DCCR's including monitoring and dressing changes are being completed as required. Pre and post dialysis check list is completed in accordance with dialysis schedule. 2) **Action/s taken to protect residents in similar situations:** Residents residing at the facility requiring routine weights for medical management have the potential to be affected by this deficient practice. Residents with individual weight orders have been reviewed and are being weighed as per order. There is documentation present in the MAR to reflect accurate weights.	

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F 309	Continued From page 14 On 10/21/15, the DON reviewed the medication I&A and said the Lantus was given at the wrong time and physician orders were not followed. b. Resident #1's 9/8/15 Physician's Telephone Orders and September and October 2015 TARs documented the resident's weights were to be taken daily, related to CHF. The physician was to be notified when there was a two-to-three pound weight gain over a one-to-two day period or a five pound weight gain in a week. The resident's September 2015 TAR documented weights were not taken 7 of 22 days and the October 2015 TAR and Weight Detail Report documented weights were not taken 17 of 19 days. On 10/19/15, Resident #1 said staff had not weighed him, although his doctor had ordered it. On 10/21/15, the DON reviewed the order and the TARs and said the weights had not been taken as ordered. 2. Resident #8 was admitted to the facility on 8/28/09 with multiple diagnoses, including gastroesophageal reflux disease (GERD) and dysphagia (difficulty in swallowing). The resident's 8/10/15 quarterly MDS assessment documented the resident was severely cognitively impaired. The resident's orders, progress notes, nutrition notes, and Speech Therapy (ST) notes documented the resident was on a liquid diet due to swallowing issues, experienced frequent	F 309	Residents residing at the facility requiring scheduled insulin are at risk for deficient practice. Residents requiring scheduled insulin have been reviewed and are receiving insulin as ordered. Residents with speech therapy recommendations have been reviewed and theses recommendations are implemented as per ST. Resident with colostomies have been evaluated and are receiving colostomy care as per MD order. This care is reflected accurately on the TAR. Residents identified with scratches have been evaluated and have current orders in place. Documentation related to treatments are accurately reflected in the TAR. Residents receiving metoprolol have been evaluated for necessary monitoring and parameters to hold metoprolol. This is accurately reflected in the MAR. Residents utilizing splints have been evaluated. Residents residing at the facility with the use of splints are wearing the splints as per care plan and use is documented accurately in TAR. Residents with ordered physical therapy have discipline in place as per order. Residents undergoing dialysis have the DCCR completed for pre and post dialysis.	

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F 309	Continued From page 15 vomiting and had an appointment scheduled for a gastrointestinal consultation. The resident's 10/15/15 ST note documented the therapist gave the resident "...verbal reminders to avoid straws to decrease [the] chance of vomiting." The resident's 10/19/15 ST order documented all liquids were to be served in spouted cups with "no straws." From 10/19/15 to 10/21/15, the resident's water mug was observed five times in his room on the counter with a plastic straw sticking out of it. On 10/20/15 the resident said he drank water out of the mug. On 10/21/15 at 3:55 PM, the Speech Therapist said she evaluated the resident, who would drink too fast when he had a straw which caused him to vomit. She was then asked to observe the resident's room. On the way to the room, the resident was observed in the hallway outside his room and next to a nurse passing medications. The resident had a nearly empty spouted cup with a plastic straw sticking out. The therapist acknowledged the resident had a straw both in the cup he was holding as well as in the water mug inside his room. The Speech Therapist said the resident should not have had the straws in the mug or cup. 3. Resident #5 was admitted to the facility on 11/18/13, and readmitted on 9/30/14, with diagnoses of pressure ulcer to the buttock,	F 309	3) **Measures taken or systems altered to ensure that solutions are sustained:** Licensed nurses have been educated on weight monitoring as per MD order, scheduled insulin, colostomy care, skin impairment with treatment orders (scratches), prescribed metoprolol with parameters and completion of DCCR for residents undergoing dialysis therapy. Therapy has been educated on communicating recommendations with nursing via the 24 hour report. Physical therapy has developed a tracking system for request made to initiate physical therapy with MD signature within 72 hours. Restorative nurse and aides have been educated on the splint schedules to ensure the splints are in use per MD order. Daily observations rounds will be performed by Administrator/DON/nurse manager to ensure compliance for insulin administration, colostomy care, skin impairments and treatment orders, parameter followed for use of Metoprolol. Any identified non-compliance will be corrected upon identification.	

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F 309	Continued From page 16 complicated open wound to the buttock, paraplegia and chronic kidney disease. The resident's most recent annual MDS assessment, dated 9/12/15, documented the resident was severely cognitively impaired and required extensive assistance of one staff for eating, toilet use and personal hygiene; total assistance of at least two staff for transfers and bathing; and extensive assistance of at least two staff for bed mobility and dressing. The resident had functional limitation in range of motion with impairment on both sides for his lower extremity. The resident's recapitulated October 2015 Physician's Orders documented: *10/7/14 - Monitor stoma for rose bud like appearance every shift +/-, If (-) notify MD; change every 7 days and as needed for leakage or soiling (Ostomy). The MARs for September and October of 2015 documented the resident's ostomy was changed on 9/28/15 and 10/11/15. The ostomy was not changed for 12 days. A 10/9/15 Physician's Telephone Order documented, Triple the resident was to receive antibiotic ointment to his/her arms BID [twice daily] until resolved for the diagnosis of chronic renal failure. The October 2015 MAR documented the Triple Antibiotic Ointment was administered for two days, on 10/19 and 10/20, but not administered from 10/9 until 10/19. On 10/20/15 at 10:15 AM, Resident #5 was observed scratching his arms, causing them to	F 309	**4) Plans to monitor performance to ensure solutions are sustained and person responsible:** Facility will perform weekly audits for weight monitoring, scheduled insulin, ostomy care, metoprolol use, splint management, skin impairment (scratches), and the DCCR form is complete. These audits will be performed weekly for 12 weeks. Monthly audits will be performed for speech recommendations and therapy order tracking for 12 weeks. Results will be monitored monthly for three months and presented at Quality Assurance to ensure compliance. Any identified deficiencies in this action plan will be corrected at the time of identification. **5) Date of Compliance:** 11/27/15 **6) Person's Responsible** Director of Nursing, Director of Rehab, Restorative Nurse	

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F 309	Continued From page 17 bleed. The resident's family member stated he had cleaned the resident's arms, would apply the ointment, and replace the arm protectors. On 10/21/15, LN #4 was shown Resident #5's MARs and nodded her head up and down. She stated she would educate the nurses, but did not have documentation the ostomy was changed for 12 days or the Triple Antibiotic Ointment had been applied as ordered. She stated, "It's not being documented so it's not being done." 4. Resident #11 was readmitted to the facility on 8/11/14 with multiple diagnoses, including atrial fibrillation and hypertension. The resident's recapitulated October 2015 Physician's Orders and MAR documented: 4/23/15 - Metoprolol Tartrate 25 mg tablet: Give 1/2 tablet = 12.5 mg orally 2 times a day (Heart Rate Control) *Hold for HR (heart rate) less than 60 or BP (blood pressure) 100/60 or less. Resident #11's October 2015 MAR documented: *The resident received the morning dose of Metoprolol Tartrate 10 times and the medication was held 10 times from 10/1/15 through 10/20/15 because of a HR less than 60 bpm [beats per minute]. The resident's HR and systolic BP was recorded 19 times, except on 10/4/15, when the Metoprolol was administered. Resident #11's morning diastolic BP was not recorded from 10/1/15 through 10/20/15, thus it was unknown if the resident's diastolic BP was under 60 on 10 mornings the Metoprolol was administered. *The resident received the evening dose of Metoprolol Tartrate 5 times and the medication	F 309		

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F 309	Continued From page 18 was held 12 times from 10/1/15 through 10/18/15 due to of a HR of less than 60. The resident's diastolic BP was not recorded on 4 nights the Metoprolol was administered. The resident's BP and HR were not documented as being taken on the evening shifts of 10/10, 10/11, and 10/19/15 when the Metoprolol was not administered. On 10/21/15 at 9:15 AM, the DON said the resident's BP and the HR were not taken consistently. The DON stated there were parameters for the BP and HR on the Physician's Orders, but the MAR did not contain a space to document the diastolic BP. 5. Resident #4 was admitted to the facility 2/13/13, and readmitted on 5/22/15, with multiple diagnoses, including quadriparesis. Resident #4's most recent quarterly MDS assessment, dated 8/15/15, documented intact cognition and functional limitation in range of motion in both lower and upper extremities. Resident#4's Physician's Orders, initiated on 2/17/15, documented a right hand splint with finger separators was to be worn twice daily for 4 hours. Resident #4's Skin Integrity Care Plan, dated 2/17/15, documented: *Assessment/Problem: Right hand splint with finger separators *Interventions: Apply a right hand splint twice daily for four hours, notify LN if refused. The resident's Restorative Resident Summary	F 309		

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	135042		10/23/2015

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F 309	Continued From page 19 Report from 8/21/15 through 10/20/15 documented the hand splint was applied 12 of the 121 opportunities and 18 areas were documented as refusals. On 10/21/15 at 9:05 AM, Resident #4 said he did not wear hand splints. The resident was observed not wearing hand splints on: *10/19/15 at 12:50 PM *10/20/15 at 7:45 AM, 12:16 PM, 2:25 PM and 5:05 PM *10/21/15 at 9:05 AM On 10/23/15 at 8:25 AM, RCM #1 stated Resident #4 had hand splints, but did not wear them for four hour increments. When asked if he should be wearing hand splints, RCM #1 stated, "Yes." 6. Resident #9 was admitted to the facility on 8/13/12 with multiple diagnoses, including Parkinson's Disease and physical deconditioning. A physician's progress note, dated 7/10/15, documented, "Maintain physical and occupational therapy." Resident #9's Pain Management Care Plan, dated 8/24/15, documented PT/OT was to evaluate and treat the resident as ordered to improve functional status. Resident #9's recapitulated August, September and October 2015 Physician's Order documented the resident was to receive Skilled PT 5 days a week for 6 weeks for wheelchair management. A physician order, dated 9/14/15, documented Resident #9 was to receive Physical Therapy (PT) evaluation and treatment.	F 309		

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F 309	Continued From page 20 The resident's medical record documented Resident #9 received Occupational Therapy (OT) 5 days per week beginning on 6/30/15, rather than PT. On 10/22/15 at 9:45 AM, RCM #1 stated Resident #9 did not receive the PT evaluation that was ordered by the physician in September 2015 and received OT services, rather than the physician-ordered PT services. On 10/22/15 at 4:25 PM, PT #15 stated Resident #9 was not receiving PT services. 7. Resident #15 was admitted to the facility on 8/28/13 with diagnosis of End Stage Renal Disease. Resident #15's recapitulated Physician's Orders for October 2015 and the TARs for August through October 22, 2015 included: * Hemodialysis 3 times a week on Monday, Wednesday, and Friday; * Monitor the dialysis site; * Check for bruit/thrill; * Check for signs and symptoms (s/s) of infection daily; * Remove dialysis bandage four hours after dialysis on treatment days; and * Complete the pre-dialysis and post-dialysis check list. Resident #15's Hemodialysis Care Plan, dated 7/30/15, identified three access sites and no blood pressure (BP) on the right arm. The access sites were "old left arm," right arm AV (arteriovenous) fistula, and a central venous catheter. Interventions included, completion of	F 309		

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F 309	Continued From page 21 Dialysis Center Communication Record (DCCR) before and after dialysis, and staff were to measure blood pressure only on the resident's right arm, which contradicted the earlier direction for staff not to use the right arm to measure the resident's blood pressure. The resident's TARs for August 2015 through October 22, 2015, contained numerous blanks in documentation regarding monitoring of the bruit/thrill, s/s infection, and removal of the bandage four hours after dialysis. On 10/22/15, the facility was asked to provide all documentation regarding the resident's dialysis for August 2015 through October 22, 2015. The resident's DCCR contained three sections which included a section for the "Center [facility] Nurse" to complete prior to dialysis, a section for a dialysis nurse to complete after dialysis and prior to return to the facility and a section for the "Center Nurse" to complete upon return to the facility after dialysis. The DCCRs, dated 8/5/15 through 10/21/15, were completely blank in the section for the post-dialysis assessment by the facility nurse in 11 of 27 (41%) of the records; the pre-dialysis sections were incomplete for 25 of 27 (93%) records; and Progress Notes, dated 7/28/15 through 10/22/15, did not contain explanations for the missing information. Extended Care Facility Notifications from the dialysis provider included a 10/20/15 fax which documented problems with the access site. The Notifications documented, "Pt [patient] arrived with pressure gauze dressing from the 16th and	F 309		

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F 309	Continued From page 22 no dressing on his catheter site." On 10/23/15 at 9:55 a.m., UM #11 was shown the DCCRs and asked about the missing documentation. The UM did not respond.	F 309	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."*	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview, it was determined the facility failed to ensure bathing and/or nail care were consistently provided for 4 of 15 residents (#s 2, 4, 5, & 11) reviewed for ADL assistance. This deficient practice had the potential for more than minimal harm if residents experienced rashes, skin issues and/or unpleasant odors due to not being bathed regularly and/or feet problems due to not having regular nail care. Findings included: 1. Resident #11 was admitted to the facility on 10/25/13 with multiple diagnoses, including diabetes, cerebrovascular accident with hemiplegia, and bipolar disorder. The ADL Care Plan documented one staff member was to assist, encourage, and provide the resident with showers on a regular, routine basis, and that diabetic nailcare was to be	F 312	Deficiencies related to **F312** will be corrected as follows: **1) Correction/s as it relates to the resident/s:** Resident #11, #5, #2 and #4 have received nail care as per care plan. Resident's #2 and #11 are receiving bathing per resident's choice. Resident #5 has clean arm protector in place with a cleaning/changing schedule 2x a week and PRN to ensure the cleanliness with the use of arm protectors. **2) Action/s taken to protect residents in similar situations:** Resident residing at the facility has the potential to be affected by the deficient practice related to bathing and nail care. Facility wide audit for bathing preference has been performed. Bathing schedule and care plans have been updated to reflect resident preference. All bathing and nail care is current as per care plan. Residents identified at the facility needing arm protectors for dermal fragility have the potential to be affected by the	

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F 312	Continued From page 23 provided by a licensed professional. Resident #11's 4/14/15 Physician's Orders documented a licensed nurse was to provide weekly diabetic nail care. The resident's TAR documented: *August 2015 - Refused nail care on 8/4, 8/11, and 8/25. The record did not document staff reapproached the resident later that day or at any other time. *September 2015 - The space on 9/29/15 was blank and did not reflect whether the resident refused or was offered nail care. *October 2015 - Refused on 10/6 and 10/20. The space for documentation was left blank on 10/13 and it could not be determined if nail care was offered.The record did not document staff reapoproached the resident following the refusal. Resident #11's bathing/shower schedule documented the resident was not bathed for 7 days from 9/6/15 until 9/13/15; 7 days from 9/16/15 until 9/23/15; and 8 days from 9/30/15 until 10/8/15. There was no documentation to show if the resident had refused, whether he had been reapproached at a later time, or if he was offered to bathe another day. On 10/21/15 at 9:15 AM, the DON said the facility offered bathing at least twice a week and accommodated residents who wanted to bath/shower more often. The DON stated the facility did not have set times residents were scheduled with a podiatrist, but the visits were scheduled on an individualized basis. The DON said LNs should alert the RCMs or the DON when a resident refused bathing or nail care so the issues/concerns could be addressed with the	F 312	deficient practice. Residents utilizing arm protectors have a changing schedule in place per care plan. 3) **Measures taken or systems altered to ensure that solutions are sustained:** Education will be provided to nurses and aides on the new bathing schedules that includes resident preferences and nail care. Licensed nurses have been educated on diabetic nail care and frequency. Any refusal of bathing or nail care will be documented on the 24hr report and reviewed by IDT for the purpose of reproaching. Licensed nurses and aides will be educated on changing schedule for arm protectors. This will be reflected on resident's care plan. 4) **Plans to monitor performance to ensure solutions are sustained and person responsible:** Facility will perform weekly audits of bathing, nail care, and changing of arm protectors for 4 weeks and then monthly for 8 weeks. Results will be monitored monthly for three months. Any identified deficiencies in this action plan will be corrected at the time of identification. The audits will be presented at Quality Assurance to review for further educational opportunities 5) **Date of Compliance:** 11/27/15 6) **Person's Responsible**	

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F 312	Continued From page 24 resident. 2. Resident #2 was admitted to the facility on 1/13/04, and readmitted on 11/1/14, with multiple diagnoses, including diabetes with neuromanifestations, obesity, and chronic airway obstruction. The resident's ADL Care Plan documented one staff member was to assist, encourage, and provide per resident preference bathing 2 to 3 times a week on Monday, Wednesday, and Friday, and that diabetic nailcare was to be provided as needed by licensed professional. Resident #2's 4/22/15 Physician's Orders documented an LN to perform diabetic nail care each week and that the resident could receive care from a podiatrist as needed. The resident's TAR documented: *August 2015 - The spaces for the LN to document the resident received diabetic nail care on 8/1/15, 8/8/15, 8/15/15, and 8/29/15 were blank with no documentation that the resident was offered, refused or reapproached for nail care. The resident's diabetic nail care documention was requested, but not provided by the facility, for October 2014 through March 31, 2015. The resident's 3/24/15 Social Service Progress Note documented: "3/2-3/8 no bath ... attended dermatologist appt [appointment] on 3/2 with facility CNA...(Family member stated) "looked clean"...saw next time on 3/8 and noticed "hair looks greasy." Res [Resident] told her (family member) hasn't had	F 312	Director of Nursing, Facility Educator	

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F 312	Continued From page 25 bath since Monday b/c [because] "They had to pull the bath aides." On 10/21/15 at 10:08 AM, the DON stated Resident #2 missed 1 shower out of her 3 for the week of 3/2 through 3/8/15 and she had not been to a podiatrist, but the resident's nail care was performed by the LNs. The DON said the resident had severely misshappened toenails and had injured her right great toe in March, when a CNA propelled the resident through a doorway in a wheelchair and the resident's foot struck the door jam. The DON stated the family trimmed the resident's toenails and clipped her skin, which had caused some bleeding issues. 3. Resident #5 was admitted to the facility on 11/18/13, and readmitted on 9/30/14, with diagnoses of pressure ulcer to the buttock, complicated open wound to the buttock, paraplegia, and chronic kidney disease. The resident's most recent annual MDS assessment, dated 9/12/15, documented the resident was severely cognitively impaired and required extensive assistance of one staff for eating, toilet use, and personal hygiene. The resident required total assistance of at least two staff for transfers and bathing, and extensive assistance of at least two staff for bed mobility and dressing. The resident's recapitulated October 2015 Physician's Orders documented an 8/25/15 order for nursing to trim and clean fingernails. Resident #5's Mood and Behavior Symptom	F 312		

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F 312	Continued From page 26 Assessment Care Plan/Dementia Care Plan, initiated 9/2015, documented staff were to provide weekly nail care. On 10/20/15 at 9:20 AM, Resident #5 was observed with arm protectors with dried blood stains on both arms and dried blood under the resident's nails. At 10:15 AM, the arm protectors had been removed and the resident was observed scratching both arms, which caused scabbed areas to bleed. The resident's family member stated he had removed the soiled arm protectors and would clean and lotion the resident's arms. The resident's September 2015 TAR did not include the 8/25/15 order for nursing to trim and clean fingernails. The October 2015 TAR included the 8/25/15 order, but did not contain documentation that this care was provided. On 10/21/15, LN #4 stated nail care should be performed by bath aides, floor aides and nursing staff. When shown the 8/25/15 order, LN #4 stated there was no documentation about nail care and, if the resident refused, there should be documentation for refusals. 4. Resident #4 was admitted to the facility 2/13/13, and readmitted on 5/22/15, with multiple diagnoses, including quadriparesis. Resident #4's most recent Resident Bathing Type documented the resident received 22 bed baths from 8/1/15 through 10/20/15.	F 312		

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F 312	Continued From page 27 Resident #4's Comprehensive Care Plan Review, dated 6/12/15, documented the resident could make all needs and preferences known. The resident's ADL Care Plan, dated 9/9/15, documented staff were to provide nail care as needed. Resident #4's 6/11/15 Physician's Orders documented the resident could receive care from a podiatrist as needed. On 10/20/15 at 7:45 AM, Resident #4 stated he did not get his nails trimmed during bed baths. During the interview, the resident's nails were observed to be thick and long. On 10/23/15 at 8:25 AM, when informed of the above concerns, RCM #1 stated the nail care should have been performed by the CNAs when bed baths were given.	F 312	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F314** will be corrected as follows:	
F 314 SS=D	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 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to	F 314	**1) Correction/s as it relates to the resident/s:** Resident #6 has no pressure areas. **2) Action/s taken to protect residents in similar situations:** Resident with heel pressure ulcers have been reviewed and have appropriate interventions care planned. Weekly assessments are being conducted for such residents. **3) Measures taken or systems altered to ensure that solutions are sustained:** IDT training conducted on care planning for skin issues. Resident care managers have been in serviced on conducting weekly skin assessments. Weekly the facility educator will observe and round with staff nurses as well as resident care managers to ensure proper skin assessment procedures and treatment interventions are followed.	

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F 314	Continued From page 28 ensure residents who entered the facility without pressure ulcers (PUs) did not develop PUs, skin integrity care plans were revised and updated to reflect the resident's current status and weekly assessments were consistently completed. This was true for 1 of 8 residents (#6) reviewed for PUs. The resident was at risk for more than minimal harm when a stage II heel PU developed three days after admission. Findings included: Resident #6 was admitted to the facility on 12/29/14 with multiple diagnoses including dementia and aftercare following surgical repair of a left hip fracture. An Occurrence Report (OR) for the resident, dated 1/1/15 at 11:00 p.m., documented, "LN removed left sage [sic] boot...Left lateral heel...intact blister. Resident had gotten the right boot off, most likely caused by rubbing foot against nylon material of boot." The OR documented the blister was "House acquired" and "N/A [not applicable]" regarding current treatments such as pressure relieving device for bed/chair, preventive/protective skin care, special shoes and turning or repositioning program. The resident's 1/5/15 admission MDS coded severe cognitive impairment, fluctuating inattention, wandering 1-3 days out of 7 days, extensive assistance with bed mobility, transfers and locomotion on the unit, wheelchair (w/c) use and unhealed stage II PUs. PU risk assessments documented the resident was at high risk on 12/29/14 and 1/5/15. The resident's 1/5/15 PU CAA documented an "actual" problem. Care plan considerations	F 314	4) **Plans to monitor performance to ensure solutions are sustained and person responsible:** Facility will perform weekly audits on Skiu Grid-Pressure/Venous Insufficiency Ulcer/Other. Weekly audits for pressure ulcer care plans will be conducted. These audits will be conducted weekly times four weeks and then monthly times eight weeks. All audits will be reviewed at month QA meeting for efficacy of systems with interventions for correction should a need arise. Any identified deficiencies in this actiou plan will be corrected at the time of identification. 5) **Date of Compliance:** 1/4/16 6) **Person's Responsible** Director of Nursing	

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F 314	Continued From page 29 included weekly and prn (as needed) skin checks. The resident's skin integrity care plan, dated 1/1/15 then 1/6/15, documented a stage II left heel PU as a problem. The problem was not dated. Undated interventions included protect the heels if exposed to friction, inspect skin for signs or symptoms of breakdown, individualized turning schedule and increased turning if an area of redness was non-blanchable. Other interventions included a white off loading boot to the left foot when in the w/c with a shoe on the right foot to help propel the w/c on 1/26/15. Additionally, the interventions "Sage boots on in bed" and "heel pro" both had a single line drawn through them on 12/29/14. The Conclusion in the Follow up Report for the 1/1/15 OR, dated 1/8/15, documented the resident was at high risk for skin breakdown on admit and an alternating air mattress and heel pro was initiated. This contradicted the OR regarding current treatments/interventions in place on 1/1/15. The Conclusion further documented the left Sage boot was "out of place" and "...resident in bed...moving...BLE [bilateral lower extremities] back and forth. Blister reasonably related to resident movement in bed causing friction on sage [sic] boots..." The resident's 12/29/15 Nursing Comprehensive Admission Data Collection and Assessment Skin section referred to a separate Skin Assessment. The 12/29/15 Skin Assessment contained front and back body diagrams and right and left foot diagrams. There were no markings or notations on or near the foot diagrams nor any comments about the resident's heels.	F 314		

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F 314	Continued From page 30 Progress Notes (PNs) documentation, dated 12/29/14 to 10/3/15, included "blue Sage boots" in place on 12/30/14. The resident's heels were not mentioned until 1/2/15 at 6:00 a.m., when a 4 centimeter (cm) by 2.5 cm "intact fluid filled blister" to the left lateral heel was noted. The entry also noted the resident "slides" foot in boot "causing friction from nylon material." Skin prep and a sock were applied before the Sage boot was reapplied. Beginning 1/5/15, the resident was frequently noted as "busy" self-propelling the w/c in the halls and about the facility. The left lateral heel blister (a stage II PU by definition) was documented as "intact" until 2/4/15 "hard covering of discolored skin is off" and "skin pink [not] open" was noted. The resident's Skin Grid-Pressure/Venous Insufficiency Ulcer/Other (SG for short) records also contained front and back body diagrams and right bottom and left bottom foot diagrams. A SG documented the left lateral heel stage II PU was initially identified 1/1/15 and it was reassessed 1/7/15, 1/19/15 (12 days later), 1/27/15 (8 days later) and 2/4/15 (8 days later) when it was noted as "resolved." The resident was observed numerous times each day from 10/19/15 through 10/23/15 self-propelling a w/c without foot rests throughout the facility, in the dining room and hallways. The resident always wore black tennis shoes with Velcro straps. On 10/21/15 at 9:35 a.m., Unit Manager (UM) #11 was asked about the resident's left heel PU. UM #11 referred the surveyor to UM #4 whom she said was knowledgeable and involved in the	F 314		

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F 314	Continued From page 31 resident's care regarding the PU. About that time, UM #4 arrived and joined the interview. UM #4 reviewed the SG then said the left lateral heel PU developed a "few" days after the resident's admission. On 10/22/15 at 3:30 p.m., the DON removed the resident's shoes and socks per the surveyor's request. The resident's heels were both intact without any s/s of PUs. Resident #6, who was identified at high risk for skin impairment on admission, developed a left heel stage II PU three days after admission. The resident's care plan did not include interventions for friction caused by rubbing off the Sage boots or kicking the heel pro off the bed and there was no documented evidence that any such interventions were implemented. In addition, the care plan was not revised and updated when interventions changed. Lastly, weekly PU assessments were not consistently done.	F 314	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F318** will be corrected as follows: 1) **Correction/s as it relates to the resident/s:** Resident #10 is provided with a clarification to resident's restorative program to read "For up to 6 days a week therapy". 2) **Action/s taken to protect residents in similar situations:** All restorative programs have been reviewed to ensure accuracy according to their assessment.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure a	F 318	3) **Measnres taken or systems altered to ensnre that solutions are sustained:** Restorative nurse has been provided further education on proper development of restorative programs. Monthly audits will be performed by Director of Nursing. 4) **Plans to monitor performance to ensure solutions are sustained and person responsible:** Weekly checks will be completed to ensure frequency of the restorative nursing is delivered according to care	

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F 318	Continued From page 32 resident received interventions to prevent a decrease in range of motion (ROM). This was true for 1 of 11 (#10) sampled resident who did not receive services to prevent the deterioration of existing ROM limitations. Findings included: Resident #10 was admitted to the facility on 8/31/10, and readmitted on 4/15/11, with diagnoses of coronary atherosclerosis, systemic lupus erythematosus, and osteoporosis. The Annual MDS, dated 7/16/15, documented the resident was cognitively intact, did not reject cares, and participated in an Active ROM program 5-days per week. The resident's recapitulated October 2015 Physician's Orders documented an 7/17/12 order for Physical Therapy to assess and plan a program to increase mobility and strength, and reduce back pain. The resident's ADL/Mobility Plan of Care, revised 10/7/15, documented problems of arthritis and history of cervical fracture. Interventions included therapy per physician order. The goal documented the resident would ambulate independently with a FWW (front wheeled walker) by January 2016. Resident #10's Restorative CNA Program, initiated 7/9/15, documented an Active ROM Program for a minimum of 15 minutes/day, 6 days/week and to notify the LN of pain, intolerance or refusals. The Plan documented 2 to 3 pound dumbbell exercises; leg kicks in all directions while standing in parallel bars; and, attend exercise groups three times weekly. The "Goal" documented the resident would maintain	F 318	action plan will be corrected at the time of identification. Audits will be reviewed for three months and presented at Quality Assurance to ensure compliance and to identify additional education opportunities. 5) **Date of Compliance:** 1/4/16 6) **Person's Responsible** Director of Nursing	

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F 318	Continued From page 33 the ability to ambulate independently with a walker. The Restorative Program Summary Report for 9/1/15 through 10/16/15, documented the resident did not receive the minimum of 15 minutes per day 6 days per week. On 10/22/15, LN #11 was shown the resident's Restorative Program Summary Report, which documented the resident met the Active ROM goal twice in a six week period. LN #11 stated the week of 9/1 the resident should have been offered restorative therapy 1 more time; the week of 9/13 the resident should have been offered restorative therapy 1 more time; the week of 9/20 the resident should have been offered restorative therapy 2 more times; and the week of 9/27 the resident should have been offered restorative therapy 2 more times.	F 318	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F322** will be corrected as follows: 1) **Correction/s as it relates to the resident/s:** Resident #20 G-tube placement has been verified prior to each use. Resident #3's tube feeding will be placed on hold during cares that require them to lay flat.	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating	F 322	2) **Action/s taken to protect residents in similar situations:** Residents with tube feeding have their PEG tube placement verified before each use. Residents with tube feeding are placed on hold during cares requiring them to lay in a flat position. 3) **Measures taken or systems altered to ensure that solutions are sustained:** Licensed nurses have been in serviced on G-tube placement prior to each use. In service provided to CNA and licensed nurses regarding placing tube feeding on hold during cares requiring residents to	

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F 322	Continued From page 34 skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to ensure there was correct placement of a PEG (percutaneous endoscopic gastrostomy) tube prior to the administration of medications. This was true for one random resident (#20) and one sample resident (Resident #3), and created the potential for residents to experience gastrointestinal distress, aspiration pneumonia, and/or to receive less than optimal benefit of medications administered. Findings included: 1. On 10/19/15 at 8:10 AM, LN #3 was observed administering medication into Resident #20's gastrostomy tube. When asked, the LN stated she did not check for placement before administering the medication. Clinical Nursing Skills & Techniques, 8th edition, 2014, by Perry, Potter, and Ostendorf, pages 784, stated, "For intermittently tube-fed patients, test placement immediately before each feeding and before medications," and "Draw up 30 mL of air ... flush tube with 30 ml of air before attempting to aspirate fluid." LN #3, when asked if she should check placement before administering a medication, stated, "I checked earlier this morning." When asked if the tube could migrate between the time	F 322	lay in a flat position. 4) **Plans to monitor performance to ensure solutions are sustained and person responsible:** Facility will perform weekly audits of G-tube placement prior to each use. Additional audits will be conducted to ensure tube feeding is placed on hold during cares requiring residents to lay in a flat position. These audits will be conducted weekly times four weeks and then monthly times eight weeks. All audits will be reviewed at month QA meeting for efficacy of systems with interventions for correction should a need arise. 5) **Date of Compliance:** 11/27/15 6) **Person's Responsible** Director of Nursing	

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F 322	Continued From page 35 she checked its placement and the time she administered the medication, LN #3 stated, "I suppose it could if he was moving." 2. Resident #3 was admitted to the facility on 7/8/14, and readmitted on 10/16/15, with diagnoses including medullary injury related to craniotomy with hydrocephalus and intracranial bleeding. On 10/20/15 at 9:55 AM, Resident #3 was observed lying in a flat position with his tube feeding infusing at 70 ml per hour while LN #3 performed the resident's dressing change. Immediately after the dressing change, the LN was asked if the resident's tube feeding should have been infusing while he is in a flat position. The LN stated the tube feeding was on hold. The LN was informed the tube feeding was continuously infusing and was asked to look at the tube feeding pump to verify the observation. The LN verified the tube feeding was infusing and had not been paused during the dressing change. The LN then stated, "I wasn't paying attention." On 10/21/15 at 08:30 AM, LN #2 and CNA #12 were observed performing peri-care and repositioning Resident #3 while the resident was in a flat position with the resident's tube feeding infusing at 70 ml per hour. Immediately after cares were performed, LN #2 was asked if the resident's tube feeding should have been paused during cares. The LN stated, "I did not realize it was still running."	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 36 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure that adequate supervision was provided to one sampled resident (#6) observed wandering throughout the facility, residents were protected from accessing hazardous chemicals in the Housekeeping Room, and bed side rails were assessed for safety for 1 of 7 (#5) sampled residents. These deficient practices created the potential for injury when Resident #6 bumped into things or people while wandering; cognitively impaired and mobile resident were exposed to the potential for skin/eye/respiratory/gastrointestinal damage from contact with unsecured chemicals; and siderails were not assessed to be safe for individual resident safety. Findings included: 1. Resident #6 was admitted to the facility on 12/29/14 with multiple diagnoses, including dementia and depressive disorder. The resident's Behavioral Symptoms CAA's dated 7/29/15 documented Resident #6 "wanders throughout facility without exit seeking" and "self-propels in wheelchair and will bump self into walls, LN cart, [and] linen bins ... [she is] unable to state where she is going or what she would like to do." The quarterly MDS assessment, dated 10/18/15,	F 323	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F323** will be corrected as follows: **1) Correction/s as it relates to the resident/s:** Resident #6 receiving 15 minute supervision checks as care planned. Biohazard door is now closed and locked. Resident #5 has a side rail safety assessment in place. **2) Action/s taken to protect residents in similar situations:** Residents that require increased supervision are at risk due to this deficiency. Residents that are care planned for increased supervision are receiving the 15 minute checks accordingly. Biohazard door is locked and closed preventing any resident's access to this area. All residents with side rails have a safety assessment in place. . **3) Measures taken or systems altered to**	

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F 323	Continued From page 37 documented the resident experienced short- and long-term memory deficits and had severe cognitive impairment. Resident #6's ADL/Mobility Care Plan, dated 9/8/15, documented, "Redirect resident away from [other] resident ... when passing by. 15 min[ute] checks for [increased] supervision." Resident #6's Mood and Behavior Care Plan, dated 10/15/15, documented the resident "bumps into walls, LN carts, and other residents." Intervention included, "Prefers high traffic areas; likes audio and visual stimulation. Don't leave alone in room but rather [at] nurse station, [Activity room], etc." The resident's 24-Hour Resident Flow Sheet Record, dated 9/8/15 to 10/18/15, documented the resident was to be checked every 15 minutes and contained spaces to document those 15-minute checks over a 24 hour period. The records documented that Resident #6 was not monitored every 15 minutes: Thirty-seven of 43 records were blank in multiple spaces, particularly during between 6:00 a.m. to 9:00 p.m. All 24-hour flow sheets were requested, but none were provided by the facility for 9/19/15 and 9/20/15. The resident's Progress Notes (PN), dated 12/29/14 to 10/3/15, documented the resident repeatedly ran into other residents and objects with her wheelchair [w/c]. The resident was observed self-propelling in her w/c in different hallways throughout the facility multiple times between 10/20/15 and 10/22/15. On 10/21/15 at 4:09 p.m., a visitor wheeled the resident past the main nursing station and into the 200 hallway. The visitor, who identified her/him self as another resident's visitor, said Resident #6 asked to be taken to her room. The visitor said she/he took the resident to the 200	F 323	**ensure that solutions are sustained:** All staff has been educated on 15 minute check program and proper follow through documentation. In service to housekeeping department to ensure biohazard door is locked and remains closed at all times. Licensed nurses in serviced on proper side rail safety assessments and documentation. Edncator/Nurse manager will perform observation of safety assessments and documentations and any non-compliance will be addressed immediately. Nurse will receive a skills test to ensure proper compliance is followed. 4) **Plans to monitor performance to ensure solutions are sustained and person responsible:** Audits of 15 minute check program and documentation will be conducted weekly times four weeks and monthly for eight weeks thereafter. Audit of the biohazard door will be done weekly times four weeks and monthly for eight weeks thereafter. Audit of side rail safety assessment will be done weekly time four weeks and monthly for eight weeks thereafter All audits will be reviewed at month QA meeting for efficacy of systems with interventions for correction should a need arise. 5) **Date of Compliance:**	

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F 323	Continued From page 38 hall because the nurses did not want the resident to stay in her room. On 10/22/15 at 3:20 p.m., Resident #6 was observed near the exit door at the end of 600 Hall. On 10/22/15 at 9:00 am, CNA #14 was asked about the 15-minutes checks. The CNA displayed the 24-Hour Resident Flow Record for 10/22/15, which did not have any documentation after 5:45 am and said she made a "mental note" of where the resident was that morning and could not stop what she was doing to document on the form every 15-20 minutes. On 10/22/15 at 9:10 a.m., UM #11 was asked about the incomplete 24-Hour Resident Flow Record for Resident #6. The UM said the record was not complete and should have been completed by the CNA assigned to the resident. When asked how staff would know where the resident was, the UM said if the resident was not in 200 Hall, "somebody" from another hall would bring her back to 200 Hall. She said the CNA assigned to the resident was sometimes busy with other residents. On 10/22/15 at 9:20 a.m., UM #4 said Resident #6 "wanders freely" in the hallways, but had an "altercation" with another resident with dementia and sho also "wanders." The UM said staff ensured Resident #6 was not affected and kept her away from the other resident. 2. On 10/20/15 at 7:30 a.m, the "Biohazard" room on the 400 hall was observed slightly opened. However when the surveyor pulled the door knob, the door locked. On 10/20/15 at 12:05 pm, the "Biohazard" room on the 400 hall was observed with the door appearing closed, but when pushed the door	F 323	1/4/16 6) **Person's Responsible** Director of Nursing	

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F 323	Continued From page 39 opened to large containers of Quat Disinfectant Cleaner and Odor Elimination Liquid that were not secured. Each container had a spout with a turn knob. On 10/20/15 at 12:10 p.m., CNA #5, who was at the nurse's station near the housekeeping room, said that the door should "always" be closed. On 10/22/15 at 11:00 a.m., the Maintenance Supervisor (MS) said he was aware the biohazrd room was not secured on 10/20/15, and stated, "Yes, and they reported to me that this room was opened and I checked it." Material Safety Data Sheets documented that contact with either of the unsecured chemicals could cause eye, skin, respiratory and/or gastrointestinal irritation. 3. Resident #5 was admitted to the facility on 11/18/13, and readmitted on 9/30/14, with diagnoses of pressure ulcer to the buttock, complicated open wound to the buttock, protein calorie malnutrition, dementia, and paraplegia. The resident's most recent annual MDS assessment, dated 9/12/15, documented the resident was severely cognitively impaired, required total assistance of at least two staff for transfers and bathing, and required extensive assistance of at least two staff for bed mobility and dressing. Resident #5's ADL/Mobility Care Plan, initiated 9/5/15, documented problems due to paraplegia, generalized weakness, easily fatigued, decreased ability to understand others and antidepressant therapy. The interventions documented the resident required a mechanical lift, needed bed rest, and should not be in a wheelchair for more	F 323		

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F 323	Continued From page 40 than one hour per day. Resident #5's Safety Device Care Plan, initiated 9/5/15, documented the following Problem/Devices: *Hi-Low bed for decreased safety awareness, applied 10/2/14; *Bed against wall to maximize room space, applied 2/5/15; and, *Dolphin bed with bolster sheet for dermal fragility. On 10/19/15 at 12:20 PM and throughout the survey week, Resident #5 was observed in a Hi-Low bed with a specialty mattress which had bilateral 1/2 side rails. On 10/21/15, LN #4, when asked if a Side Rail Safety Assessment had been completed for Resident #5, stated, "We don't have one."	F 323	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F329** will be corrected as follows: 1) **Correction/s as it relates to the resident/s:** Resident #10 Metoprolol has been given according to MD order. Resident #4 has received a Gradual Dose Reduction for Valium. 2) **Action/s taken to protect residents in similar situations:**	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	Residents on Metoprolol have been reviewed and are receiving the medication according to MD orders. Residents on Valium have been reviewed for GDR and intervened accordingly. 3) **Measures taken or systems altered to ensure that solutions are sustained:** Licensed nurses have been in serviced on proper administration of Metoprolol per MD parameters. IDT has been in serviced on Valium GDR. 4) **Plans to monitor performance to ensure**	

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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	Continued From page 41 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure resident #10's blood pressure was monitored as ordered before administration of blood pressure medication. This was true for 1 of 11 sampled residents (#10). This created the potential for harm when medications are given when the blood pressure is too low. Findings included: 1. Resident #10 was admitted to the facility on 8/31/10, and readmitted on 4/15/11, with diagnoses of coronary atherosclerosis with graft, lupus, and osteoporosis. The resident's recapitulated October 2015 Physician's Orders documented the following: *4/15/11 - Metoprolol Succinate ER (Extended Release), 50 mg tablet orally, daily at bedtime for hypertension; and, *9/1/11 - Hold medication if BP (blood pressure) systolic less than 100 or diastolic less than 50. Notify MD if two consecutive doses held, several doses held over short period of time or BP greater than 160 systolic or greater than 100 diastolic over 24 hours (Metoprolol).	F 329	**solutions are sustained and person responsible:** Weekly audits of MAR's for residents on Metoprolol to ensure MD ordered parameters are followed. Audit will be performed weekly times four weeks and monthly for eights thereafter. Monthly audit of residents on Valium will be conducted to verify GDR's have been reviewed. Audits will be performed monthly for 12 weeks. All audits will be reviewed at month QA meeting for efficacy of systems with interventions for correction should a need arise. 5) **Date of Compliance:** 11/27/15 6) **Person's Responsible** Director of Nursing	

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F 329	Continued From page 42 Wolters Kluwer/Lippincott Williams & Wilkins Nursing 2016 Drug Handbook, 36th Edition, page 941, under Nursing Considerations for Metoprolol, documented, "Always check patient's apical pulse rate before giving drug. If it's slower than 60 beats/minute, withhold drug and call prescriber immediately." The July 2015 MAR , documented Metoprolol was given without staff first checking the resident's blood pressure or pulse on 7/1/15, 7/2/15, and 7/13/15. The MAR was blank for 7/3/15 without an explanation. There was documentation the medication was given on 7/14/15 when the resident's blood pressure (BP) was 205/84 and on 7/16/15 when the resident's BP was 162/82. The September 2015 MAR documented Metoprolol was given without a BP or pulse on 9/1/15, 9/3/15, 9/22/15, and 9/30/15. The October 2015 MAR documented Metoprolol was given without consistent assessment of the resident's systolic and diastolic BP or apical pulse. On 10/21/15, LN #11 was shown the nursing consideration to check the apical pulse for Metoprolol. She stated the facility had documentation of systolic BP, but had not consistently assessed the diastolic BP or the apical pulse. LN #11 provided the resident's vital sign flowsheet which documented vital signs only for 7/14/15; no other vital signs documentation was found for the month of July, August or September 2015. For the month of October 2015, the flowsheet documented vital signs only for 10/10 and 10/11.	F 329		

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure food was prepared in a sanitary environment. This had the potential to affect 15 of 15 sampled residents (#s 1-15) and any resident who ate their meals in the facility. An unsanitory food preparation environment created the potential for cross contamination of food and exposed residents to potential sources of pathogens. Findings included: The 2009 FDA Food Code chapter 4 Equipment, Utensils, and Linens, Subpart 4-202 Cleanability documented, "4-202.11 Food-Contact Surfaces. (A) Multiuse food-contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections..." The 2009 FDA Food Code, Chapter 6 Physical Facilities, part 6-5 Maintenance and Operation Subpart 6-501 Premises, Structures, Attachments, and Fixtures - Methods, 6-501.11 Repairing, indicated, Physical facilities shall be	F 371	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to F371 will be corrected as follows: 1) **Correction/s as it relates to the resident/s:** There were no residents affected by this deficiency. 2) **Action/s taken to protect residents in similar situations:** All cracked or pitted bowls have been replaced. Missing drawer cover was replaced and covered. 3) **Measures taken or systems altered to ensure that solutions are sustained:** Daily audits will be performed by the Dietary Manager to ensure all soup bowls are free of cracks or pits. Audits will also be performed monthly to ensure all drawers are in working order. Any equipment issues will be provided to the Maintenance Supervisor. 4) **Plans to monitor performance to ensure solutions are sustained and person responsible:** Daily audit inspections of bowls will be performed by the Dietary Manager. Any	

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F 371	Continued From page 44 maintained in good repair. On 10/19/15 at 10:20 AM, during the initial tour of the kitchen with the Dietary Manager in attendance, the following observations were made: *8 of 16 plastic soup bowls were pitted and cracked around the interior sides. The Dietary Manager stated he had a case of plastic bowls in storage and would replace them. *The Dry Storage area was observed to have a row of cabinets with a missing drawer. The missing drawer allowed uncovered, upright stacks of glass and plastic bowls to be exposed to possible contaminates located in the cabinet directly underneath the drawer. The Dietary Manager stated the drawer had been missing since he started two years prior.	F 371	identified deficiencies in this action plan will be corrected at the time of identification. Audit results will be evaluated monthly for three months and presented at QAPI. **5) Date of Compliance:** 1/4/16 **6) Person's Responsible** Dietary Manager and Maintenance Supervisor *"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."*	
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the outside trash containers were in good condition and unused beds were disposed of properly. This created the potential for harm should rodents and bugs become attracted and enter the trash containers. Findings included: On 10/22/15 at 10:20 a.m., during the environmental tour of the facility with the Maintenance Supervisor (MS) and the	F 372	Deficiencies related to **F372** will be corrected as follows: **1) Correction/s as it relates to the resident/s:** There were no residents affected by this deficiency. **2) Action/s taken to protect residents in similar situations:** Trash can lid fixed of all damages and ensured it closes properly. Beds have been removed and disposed off properly. Fly traps were removed.	

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F 372	Continued From page 45 Administrator, three trash containers located behind the facility were observed: The lid of one of the three trash containers had a split, 12 inches by 1 inch and bowed creating a gap between the lid and the rim of the trash containers. To the right of the trash container were 5 unused beds stacked together against the wall. Two fly trap bags, one-third full of dead flies, were noted hanging on one of the beds. The MS said the fly traps were hung on the beds about one month prior to the observation. When asked about the beds, the Administrator said they would be taken to the dump.	F 372	3) **Measures taken or systems altered to ensure that solutions are sustained:** Weekly audits will be done by Maintenance supervisor to ensure trash cans are in good order and fly traps are empty. Administrator will do weekly rounds of facility to ensure no beds are stored outside. . 4) **Plans to monitor performance to ensure solutions are sustained and person responsible:** Weekly audits results will be monitored monthly for three months and presented at	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	QAPI. 5) **Date of Compliance:** 11/27/15 6) **Person's Responsible** Administrator and Maintenance Director	

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F 431	Continued From page 46 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure expired medications were not available for administration to residents; expired biological supplies were not available for laboratory testing; and, ensure prescription medications were properly stored. This created the potential for sub-optimal efficacy for any resident who could have received the expired medications; any resident who had blood drawn who could have altered laboratory results with the use of expired test tubes; and, the improper storage of Resident #21's prescribed Nystatin Cream in an unlabeled medication cup in his/her room. Findings included: 1. On 10/22/15 at 10:03 AM, during an observation of the 600 Hall Medication Room with LN #6 in attendance, eight Vacutainer 25 gauge needles with an expiration date of 12/2014, five drug level test tubes with an expiration date of 8/2015, and six PT/INR (protime/international ratio) laboratory test tubes with an expiration date of 7/2015, were found. LN #6 said the laboratory testing supplies were expired and should not be	F 431	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F431** will be corrected as follows: **1) Correction/s as it relates to the resident/s:** Resident #21 has his Nystatian cream stored properly No residents were affected by the expired aspirin, skin prep and lab equipment. **2) Action/s taken to protect residents in similar situations:** All residents with Nystatian cream have their creams stored properly. All expired aspirin, skin prep and lab equipment has been disposed. **3) Measures taken or systems altered to ensure that solutions are sustained:** Licensed nurses education provided for proper storage of Nystatian cream. Licensed nurses have been educated on proper rotating stock. **4) Plans to monitor performance to ensure solutions are sustained and person responsible:**	

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F 431	Continued From page 47 available for use. LN #6 said she/he would properly dispose of the expired tubes. 2. On 10/22/15 at 10:35 AM, during an observation of the 100 Hall Medication Cart with LN #7 in attendance, a 100-tablet bottle of 325 mg aspirin with an expiration date of 7/2015 and a bottle of Skin Prep Protective Spray with an expiration date of 9/2015 were found. LN #7 said each nurse on the 100 Hall Cart was responsible for checking for expired medications, but had missed the expired medications. LN #6 stated she had one resident currently that received the 325 mg aspirin. LN #6 said the medications were expired, should not be available for use, and that he/she would dispose of them immediately. 3. On 10/22/15 at 10:45 AM, during an observation of the 100/500 Hall Medication Room with LN #6 in attendance, one blood culture vial with an expiration date of 6/2015, 23 PT/INR laboratory test tubes with an expiration date of 6/2015, 13 PT/INR laboratory test tubes with an expiration date of 12/2014, three drug level test tubes with an expiration date of 8/2015, and 45 blood serum laboratory test tubes with an expiration date of 2/2015, were found. The LN #6 stated the expired laboratory supplies would be disposed of properly. 4. On 10/19/15 at 9:35 AM, during the initial tour of the facility, a 30 ml clear measuring cup was observed on the bedside table of Resident #21. The measuring cup contained a white cream and was identified by the handwritten words "neck cream" written on the cup. LN #8 said the cream	F 431	Facility will perform weekly audits of proper storage of Nystatin cream and rotating stock of aspirin, skin prep and lab equipment. These audits will be conducted weekly times four weeks and then monthly times eight weeks. All audits will be reviewed at month QA meeting for efficacy of systems with interventions for correction should a need arise. 5) **Date of Compliance:** 11/27/15 6) **Person's Responsible** Director of Nursing	

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F 431	Continued From page 48 inside the cup was Nystatin. When asked if the medication should be on Resident #21's bedside table, LN #8 stated, "No." On 10/23/15 at 8:25 AM, RCM #1 was informed about the above concern. The RCM said the resident was not safe to administer her own medications and the Nystatin medication should not have been at the bedside. The RCM also said Resident #21 was not assessed to self-administer medications safety.	F 431	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F441** will be corrected as follows:	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	**1) Correction/s as it relates to the resident/s:** Resident #13 has the required infection control standards in place and is receiving treatment as per MD order for C-Diff. Resident #4 continues to utilize a foley privacy bag. The privacy bag is placed to avoid contact with the floor during cares. **2) Action/s taken to protect residents in similar situations:** Residents residing at the facility have been reviewed. Residents requiring standard precaution/isolation to prevent the spread of infection have appropriate isolation measures in place. Residents residing at the facility have the potential to be affected by the deficient practice of improper handwashing by staff. All staff have received education and completed return demonstration for effective handwashing. Residents residing at the facility have the potential to be affected by the improper handling of linens. There were no	

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F 441	Continued From page 49 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and review of the facility's Infection Control Policies and Procedures, it was determined the facility failed to ensure standard precautions were used and infection control measures were consistently implemented by staff when: *Effective hand washing practices were not followed; *Dirty laundry was found on the floor; *A urinary privacy bag was in contact with the floor; *The facility had no policies and procedures for infection control related to the Dietary Department; *The facility had no policies and procedures for infection control related to scissors and podiatry equipment shared between residents; and, *Resident #13 developed Clostridium-Difficile (C-Difficile) after admission to the facility. This was true for 13 of 13 (#s 1-13) sampled residents and all residents who resided in the facility. These deficient practices created the potential for harm and placed residents at risk for	F 441	residents identified that were affected by this deficient practice. Residents using privacy bags for foley catheters have their privacy bags placed as to not let the bag touch the floor. ICN has in serviced all nursing on how to clean scissors and podiatry equipment shared between residents. Dietary department has policy and procedure for infection control in place. **3) Measures taken or systems altered to ensure that solutions are sustained:** LN's have been in serviced on standard precautions/isolation requirements to prevent the spread of infection. Infection Control policy and procedure for handwashing, use of privacy bags for foley catheters, handling of linens, cleaning scissors and podiatry equipment shared by residents have been in serviced to staff. Infection control policy and procedures for the dietary department has been in serviced and is available to dietary staff. Return demonstrations for handwashing, the use of privacy bags for foleys and cleaning scissors and podiatry eqnipment shared by residents has been completed with staff as appropriate to job duties. Infection control policies and procedure for handwashing, standard precaution/isolation requirements, the handling of linen and cleaning equipment have been added to general orientation for	

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F 441	Continued From page 50 infections due to cross-contamination of bacteria, viruses and other microorganisms. Findings included: 1. The Centers for Disease Control (CDC) and Prevention in the Clostridium difficile Infection Information for Patients, documented: "Clostridium difficile (C. difficile) is a bacterium that causes inflammation of the colon, known as colitis. People who have other illnesses or conditions requiring prolonged use of antibiotics, and the elderly, are at greater risk of acquiring this disease. The bacteria are found in the feces. People can become infected if they touch items or surfaces that are contaminated with feces and then touch their mouth or mucous membranes. Healthcare workers can spread the bacteria to patients or contaminate surfaces through hand contact." The facility's Policy and Procedure for Clostridium Difficile Infection, effective July 2015, documented criteria for identification of signs and symptoms of infection but did not provide staff with direction on how to prevent transmission. Resident #13 was readmitted to the facility on 8/7/15 with diagnoses of acute osteomyelitis, acute respiratory failure, and urinary tract infection. An 8/7/15 Physician Progress Note from a local hospital documented the resident was anxious to go to the facility, had a previous hip infection, status post left hip arthroplasty, history of endocarditis, and would be followed by a physician for continued lifelong antibiotic coverage.	F 441	new hires as appropriate to job duties. **4) Plans to monitor performance to ensure solutions are sustained and person responsible:** Facility will perform weekly audits of privacy bags, cleaning of equipment, handling linen. Audits will also include that dietary infection control policy/procedure is in place. These audits will be conducted weekly times four weeks and then monthly times eight weeks. Observations of handwashing will be performed daily by facility educator/nurse manager and any identified deficiencies in this action plan will he corrected at the time of identification. All audits will be reviewed at month QA meeting for efficacy of systems with interventions for correction should a need arise. **5) Date of Compliance:** 1/4/16 **6) Person's Responsible** Director of Nursing, Facility Educator, ICN	

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F 441	Continued From page 51 The resident's 8/14/15 Admission MDS assessment documented the resident was cognitively intact, required total assistance of at least two staff for transfers, extensive assistance of two staff for bed mobility and dressing, and required extensive assistance of one staff for toilet use and personal hygiene. Nurses Notes documented: *8/18/15 - The resident had an abnormal temperature of 102-degrees Fahrenheit. The physician was notified and ordered BC (Blood Cultures) x 2; *8/20/15 - The resident was positive for C-Difficile, MD was notified and gave order to continue with Vancomycin (Vanco) regimen; *8/21/15 - The resident had two positive blood cultures and IV Vanco orders given; and, *8/23/15 - Vital Signs - Blood Pressure (BP) 86/42, Pulse 110, Respirations/labored 16, 02 at 83%, physician notified and resident sent to the hospital. Physician orders documented: *8/18/15 BC x 2, CBC (complete blood count), UA (urine analysis), CNS (culture and sensitivity) if indicated; *8/19/15 Send stool sample out to check for C-Difficile; *8/20/15 Vanco 125 mg one tab orally QID (4 times daily) x 10 days for diagnosis of C-Difficile; *8/21/15 Vanco IV 1 gm Q (every) day x 8 weeks; and, *8/23/15 Send to (local hospital) for evaluation and treatment. On 10/22/15, the Infection Control Nurse (ICN) stated the facility used a map to identify rooms of	F 441		

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F 441	Continued From page 52 residents who had infections. She provided the August 2015 color coded map which documented two other residents on the same hall as Resident #13 who had C-Difficile. The ICN stated the resident was admitted to their facility with a chronically infected left total hip arthroplasty and provided the History and Physical (H&P) from a local hospital. The H&P, dated 7/19/15, documented the resident would be admitted to the ICU for sepsis with her chronic left hip infection as a possible source. She had recently received IV antibiotic therapy for a chronically infected left total hip arthroplasty, which was felt to be polymicrobial that included MRSA (methicillin/oxacillin-resistant Staphylococcus aureus), Enterococcus faecalis, Staphylococcus epidermidis, Corynebacterium striatum and Bacteroides nonfragilis. The ICN stated she was unable to say where the C-Difficile for Resident #13 was acquired since she had longterm antibiotic use prior to admission to the facility. 2. The facility's Policy and Procedures for Hand Hygiene - Plain Soap and Water Handwash, effective July 2015, documented ..."6. Rub hands together vigorously for 15-20 seconds generating friction on all surfaces of the hands and fingers." The CDC documented, "Place your hands together under water (warm if possible);" and, "It is best to wash your hands with soap and warm water for 20 seconds." On 10/20/15, Staff were observed performing improper handwashing technique on the 100 Hall as follows: *9:05 & 10:50 AM, LN #7 washed her hands 5 seconds; and, *10:30 & 10:42 AM, CNA #5 washed her hands	F 441		

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	135042		10/23/2015

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F 441	Continued From page 53 for 5 seconds. On 10/20/15 at 1:55 PM, LN #7 and CNA #5 were observed washing their hands during a wound vacutainer dressing change for Resident #5 as follows: *LN #7 washed her hands 5 times during the procedure for 10 seconds, 5 seconds, 5 seconds, 7 seconds and 4 seconds; and, *CNA #5 washed her hands at the end of the procedure for 4 seconds. *On 10/22/15, CNA #5 stated she had been educated to wash her hands for at least 25 seconds and would "definitely start counting" when she washed her hands. On 10/20/15, LN #7 stated hands should be washed for 20 seconds and that she did not do it long enough. On 10/21/15 at 11:35 AM, the Dietary Manager was observed washing his hands for 10 seconds and stated he knew handwashing should be for 20 seconds. 3. Review of the facility's Policy and Procedures for Handling Linen, effective July 2015, documented all soiled linen would be bagged and/or placed in containers at the location where it was used. On 10/19/15 at 10:25 AM, during the initial tour of the facility with the Dietary Manager present, a resident blanket and washcloth were found wadded up on the floor of the Utility Room in the hall across from the Kitchen. The Dietary Manager stated the blanket and washcloth should not have been on the floor, picked up the dirty linen and took it to the Laundry.	F 441		

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F 441	Continued From page 54 On 10/23/15, the ICN was informed of the handwashing and dirty linen observations. She stated the staff were not washing their hands long enough and the blanket and washcloth should not have been on the floor. When asked if the facility had in-serviced staff on handwashing, she stated handwashing in-services were done when employees were hired, a skills validation was placed in their personnel file, and the facility had a computer course addressing handwashing. She stated the facility did not have actual handwashing in-services. 4. On 10/23/15, the ICN was asked if the facility had infection control policies and procedures specific to the Dietary Department. She stated their policy referred them to the Infection Prevention Section and to the Nutrition Services Practice Manual, which did not have an Infection Control Section. The ICN was asked about the facility's policies and procedures for the cleaning of scissors and podiatry equipment shared among residents. She stated the facility did not have a policy and procedure which addressed the cleaning of scissors or podiatry equipment. 5. On 10/20/15 at 5:05 p.m., the bottom of Resident #4's indwelling urinary drainage bag in a cloth privacy bag was observed in contact with the floor by the resident's bed when LNs #1 and #2 and 2 surveyors entered the resident's room. As the LNs prepared to provide wound care and dressing change, LN #2 raised the resident's bed which raised the urinary bag privacy bag off the floor. By 6:00 p.m., the wound care and dressing change was completed and LN #2 lowered the	F 441		

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F 441	Continued From page 55 resident's bed. The bottom of the urinary bag privacy bag was again in contact with the floor while the LNs repositioned the resident in bed. On 10/20/15 at 6:05 p.m:, LN #1 was asked about the urinary bag privacy bag in contact with the floor. LN #1 said the urinary bag privacy bag should not touch the floor. The LN said the privacy bag had only 1 strap. The LN adjusted the privacy bag strap which raised the urinary bag privacy bag off the floor.	F 441	*"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."* Deficiencies related to **F514** will be corrected as follows:	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain clinical records for each resident that were complete and accurate. This was true for 2 of 18 sampled residents (#s 3 & 7) and 2 random residents (#s 20 & 22) and created the potential for medical decisions to be based on incomplete	F 514	**1) Correction/s as it relates to the resident/s:** Resident's #3, #7, #20 and #22 have had their medical records reviewed, accurate and complete. **2) Action/s taken to protect residents in similar situations:** Residents with orders for NPO residing at the facility have been reviewed and the NPO status is accurately reflected in the care plan and on the MAR. Residents receiving ferrous sulfate have had their medical record reviewed and are receiving ferrous sulfate per the correct route order for administration. Residents with order for fluticasone nasal spray have been reviewed and residents are receiving the correct dosage and route for fluticasone as per MD orders Residents residing at the facility have had their therapy medical records reviewed and have accurate diet orders.	

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F 514	Continued From page 56 or inaccurate information, which increased the risk for complications due to inappropriate care or interventions. Findings included: 1. Resident #20 was readmitted to the facility on 9/24/15 with multiple diagnoses, including respiratory failure. The resident's handwritten 9/24/15 Admission Physician's Orders documented: * Diet: NPO (nothing by mouth); * Fluids: No; * Ferrous Sulfate 325 mg (milligrams) to be administered via peg tube twice a day; and, * Fluticasone 1 spray each nostril twice a day. Resident #20's October 2015 recapitulated Physician's Orders documented: * No documentation to reflect the resident was NPO; * Ferrous Sulfate 325 mg tablet: Give 1 tablet orally 2 times; and, * Fluticasone Nasal Spray 50 mcg (micrograms): Give 1 spray nasally twice daily. On 10/20/15 at 9:00 AM during the medication pass observation, LN #3 administered Resident #20's Ferrous Sulfate tablet crushed via the peg tube and stated the resident was NPO. The LN administered one spray in each nostril of the Fluticasone Nasal Spray and stated the resident's October Physician Orders would be corrected to reflect the correct dosages and routes of administration. 2. Resident #3 was admitted to the facility on 7/8/14, and readmitted on 10/16/15, with multiple	F 514	**3) Measures taken or systems altered to ensure that solutions are sustained:** LN's have been in serviced on documentation requirements to reflect NPO status as per order. LN's have been in serviced using Omniview pharmacy handouts on medications that can be crushed and medications that cannot be crushed. LN's have been in serviced on the use of fluticasone. Medications records for the residents with orders for fluticasone are accurate and reflect correct dosage. LN's have been in serviced on available diets and how to incorporate Speech Therapy dietary recommendations/orders into the dietary orders. This will be reflected in the medical record and through the dietary communication tool. Medical records have been in serviced on proper filing of therapy records into resident's chart. **4) Plans to monitor performance to ensure solutions are sustained and person responsible:** Facility will perform weekly audits of dietary orders, fluticasone orders, ferrous sulfate and therapy records filing times four weeks and monthly times eight weeks. Audit results will be brought to QA meeting for review. **5) Date of Compliance:** 11/27/15 **6) Person's Responsible**	

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F 514	Continued From page 57 diagnoses, including medullary injury related to craniotomy with hydrocephalus, and intracranial hemhorrage. During a review of Resident #3's medical record on 10/20/15 and 10/21/15, it was discovered that Resident #22's records pertaining physical, therapy, occupational therapy, and speech therapy, including Speech Evaluation/Notes, were located in Resident #3's medical record. On 10/22/15 at 5:35 PM, the DON and Administrator were made aware of the above issue. 3. Resident #7 was admitted to the facility on 12/17/13 with multiple diagnoses, including dementia. The resident's recapitulated Physician's Orders and MAR for October 2015 included a "Dysphagia #3," nectar thick diet order. Resident #7's Nutrition Care Plan, dated 2/2/15, documented, "Dysphagia 2, NTL [nectar thick liquids]." A Speech Language Pathologist (SLP) Order, dated 6/2/15, documented a diet clarification "NDD2 [National Dysphagia Diet] with nectar thick liquids." On 10/21/15 at 8:25 a.m., when asked to describe Resident #7's diet order, the Dietary Manager (DM) reviewed the resident's meal card and compared it to food served to the resident. The DM then stated the resident was on a	F 514	Director of Nursing, Facility Educator, HIM	

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F 514	Continued From page 58 "Dysphagia 2" diet. On 10/21/15 at 9:10 am, UM #11 was shown the physician's diet order and SLP's clarification order for Dysphagia 2 diet. The UM said she would update the physician's order and the MAR regarding the Dysphagia 2 diet.	F 514		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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December 8, 2015

Tom De Oro, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue,
Coeur D'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. De Oro:

On **October 23, 2015**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006946

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from October 19 to October 23, 2015.

The following observations were completed:
Call light response was observed throughout the survey;
Residents' cares were observed;
Interactions between residents, staff, and the Management Team were observed;
Medication pass was observed;
Breakfast and lunch service was observed; and,
Residents' adaptive equipment was observed.

The following documents were reviewed:
The medical record of the identified resident;
Fourteen other residents' records were reviewed for Quality of Care and Quality of Life concerns;

The facility's Licensed Nurses and Certified Nurse Aides (CNA) staffing hours were reviewed from September 27 to October 17, 2015;
The facility's Grievance file from March to October 2015;
Resident Council minutes from August to October 2015;
The facility's Incident and Accident reports from May to October 2015; and,
The facility's Allegation of Abuse reports.
The following interviews were completed:
The identified resident was interviewed;
Three other residents were interviewed regarding Quality of Care and Quality of Life concerns;
Family members of two residents were interviewed regarding Quality of Care concerns;
Eleven residents in the Resident Group were interviewed;
The Director of Nursing (DON) and the Administrator were interviewed regarding various Quality of Care concerns;
Seven CNAs, four Licensed Nurses, one housekeeper, the DON, and the Administrator were interviewed about the Abuse and Neglect reporting and investigation process;
Six Licensed Nurses and seven CNAs were interviewed regarding call light responses, bed linen changes, mechanical lift transfers, and Quality of Care concerns; and,
The Social Worker was interviewed regarding missing belongings procedures.

Allegation #1: The complainant reported a resident was found laying in urine from the resident's shoulders to his/her knees.

Findings #1: Call lights were observed throughout the survey and staff response times were appropriate. Residents were toileted appropriately. Residents' beds and wheelchairs were observed throughout the survey and were noted to be clean and dry. The facility's Grievance file from March to October 2015 did not document an issue with soaked beds or wheelchairs or residents sleeping in their urine or/and stool. Resident Council minutes from August to October 2015 did not document an issue regarding residents being toileted or bedding changed when soiled. Three residents and two family members did not express a concern with soiled bedding or toileting practices. Seven CNAs, six nurses, and housekeeping staff were interviewed regarding these issues and they said residents are changed when needed, do not sit or stay in their urine or stool and bed linens are changed as needed.

Based on observation, record review, resident, family, and staff interviews, it was determined the allegation was unsubstantiated due to insufficient evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The complainant reported a resident developed skin breakdown on their coccyx while at the facility.

Findings #2: There were 14 residents' records reviewed for Quality of Care concerns, including the identified resident. The identified resident's hospital admission and discharge records were reviewed. Residents were observed while receiving personal care and received appropriate care throughout the survey. Four residents at risk for skin impairment concerns were reviewed. Two residents' wound care was observed during the survey. Two licensed nurses were interviewed regarding wound care. Three residents and two residents' family members were interviewed regarding Quality of Care concerns.

Based on observation, record review, resident and staff interview, it was determined the allegation for the identified resident was unsubstantiated due to the lack of sufficient evidence. There were concerns identified for other residents regarding pressure ulcers and the facility was cited at F314. Please refer to the survey report for the detailed findings.

Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: The complainant reported a resident's dental treatment was delayed for three months.

Findings #3: There were eight residents, including the identified resident's medical records reviewed regarding Quality of Care concerns and dental/oral health treatment. Breakfast and lunch were observed during the survey process and residents were served meals with textures appropriate for their needs. Residents' cares were observed to be appropriate throughout the survey. Speech Therapy was interviewed regarding eating concerns with residents who have dental/oral issues and there were no problems identified. Three residents were interviewed regarding Quality of Care concerns and there were no oral health concerns. The DON was interviewed regarding residents' oral health needs and the facility's responsibility in providing dental appointment scheduling, transportation, and adaptive equipment needs. The facility had accommodated the identified resident's oral health needs with unpreventable and unforeseeable delays and within the scope of regulatory requirements.

Based on observation, record review, resident and staff interviews, it was determined the allegation was unsubstantiated due to insufficient evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The complainant stated a portable oxygen tank was found empty on a resident's recliner.

Findings #4: Medical records of the identified resident were reviewed for oxygen delivery and no issues were identified. Medical records of three residents who received oxygen were reviewed without any issues.

Residents' cares were observed without any failed practice regarding oxygen delivery. The identified resident's oxygen delivery was observed throughout the survey without any issues. Five other residents' oxygen delivery was observed, including portable oxygen buddies throughout the survey process and there were no identified concerns.

Four residents were interviewed regarding Quality of Care concerns and oxygen delivery was not a concern. There were 11 residents in the Resident Group interview and there were no oxygen concerns.

Based on observations, record review, and resident interviews, it was determined the allegation was unsubstantiated due to insufficient evidence.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The complainant reported the facility failed to notify the Power of Attorney(s) when the resident had changes in his/her condition.

Findings #5: Eleven residents' medical records were reviewed for notification of significant changes in a resident's condition to the MD, resident, resident's legal representatives or interested family members and there were no concerns identified. The facility's Grievance file from March to October 2015 did not document any further grievances regarding notification for a resident's change in condition. The identified resident's medical record was reviewed for notification of interested parties and/or Power of Attorney when changes in his/her condition had taken place. The facility had complied with regulatory requirements. Three licensed nurses and three CNAs were interviewed about residents having significant changes in their condition and/or accidents and the process of notification. There were no identified concerns in their procedure. Eleven residents in the Resident Group were interviewed and there were no identified concerns with notification of appropriate parties, when residents had a significant change in their condition.

Based on observations, record review, and resident, family, and staff interview, it was determined this allegation could not be substantiated based on the lack of evidence.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The complainant stated the facility was not able to provide updates on residents' conditions.

Findings #6: The identified resident's medical record was reviewed without any concerns in regards to staff awareness on the resident's condition. There were 14 residents' records, including the identified resident reviewed for Quality of Care and Quality of Life concerns without issues. Residents' cares were observed throughout the survey without any concerns.

Residents, families, and staff interactions were observed throughout the survey without any identified issues. The identified resident was interviewed about his/her care and did not voice any concerns with Quality of Care and the nurses who provided his/her care. Three other residents were interviewed about their Quality of Care and Quality of Life concerns and the nurses who provided their care and they had no issues.
Six Licensed Nurses and seven CNAs were interviewed regarding the report process on residents' conditions and there were no issues identified.

Based on observations, record review, and interviews, it was determined this allegation was unsubstantiated based on lack of sufficient evidence.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The complainant reported the facility was not providing incontinent care to the resident when requested.

Findings #7: Call lights were observed throughout the survey and staff response times and attitudes were appropriate. The facility's Licensed Nurses and CNAs staffing hours were reviewed from September 27 to October 17, 2015 and the hours were appropriate and within regulatory requirements. Residents' appearances and body odor were observed/noticed in their rooms, the dining room, hallways, and other common areas and there were no identified areas of concern. Residents' cares were observed and residents were toileted, cleaned, and changed appropriately throughout the survey week. Residents' beds and wheelchairs were observed throughout the survey and they were clean and dry. Three residents and two family members did not express any Quality of Care concerns. Seven CNAs, six nurses, and housekeeping staff were interviewed regarding this issue and they said residents are changed when needed, do not sit or stay in their urine or stool and bed linens are changed as needed. The facility's Allegation of Abuse reports and the investigations were reviewed with no identified areas of concern.

Based on observations, record review, and interviews this allegation can not be substantiated due to insufficient evidence.

Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: The facility asked the resident to sign documents which should be signed by the resident's Power of Attorney.

Findings #8: The identified resident was interviewed with no concerns identified in Resident Rights. There were 14 residents' records reviewed for Residents Rights and Quality of Life concerns and there were no issues identified. The identified resident's medical record was reviewed and there were no documents signed by the resident.

The facility had determined the resident was cognitively intact and moderately independent in his/her ability to make his/her own daily decisions. The identified resident had a Durable Power of Attorney for Health Care and a General Power of Attorney in place. The Administrator and DON were interviewed regarding the facility's policy for residents' financial and medical paperwork, when the resident had a Power of Attorney in place.

There were no problems identified in which the facility had acted inappropriately and had not followed the regulatory requirements.

Based on record review and staff interview, this allegation could not be substantiated due to the lack of sufficient evidence.

Conclusion #8: Unsubstantiated. Lack of sufficient evidence.

Allegation #9: The resident was not provided a proper wheelchair with a headrest.

Findings #9: The medical record of the identified resident was reviewed for assistive devices and there were no concerns identified. The identified resident was observed throughout the survey process and was positioned in a wheelchair and bed that accommodated his/her needs. There were 10 other residents' medical records reviewed for assistive devices and there were no concerns identified. Residents with assistive devices, that included specialized wheelchairs, mechanical lifts, front wheel seated walkers, adaptive eating devices, etc. were observed in use for residents during the survey process. The assistive devices were functional and in good repair. There were 11 residents in the group interview and they had no concerns regarding adaptive equipment. Four residents were interviewed regarding Quality of Care and Quality of Life concerns and there were no adaptive equipment issues. The Administrator and the DON were interviewed regarding specialized adaptive equipment being provided for residents. The facility demonstrated they provided adaptive equipment as quickly and efficiently as possible. There was no proven action to show the facility was not in regulatory compliance.

Based on observations, record review, and interviews, it was determined this allegation could not be substantiated based on insufficient evidence.

Conclusion #9: Unsubstantiated. Lack of sufficient evidence.

Allegation #10: The complainant stated the resident had concerns related to the thoroughness of cares provided by an identified CNA.

Findings #10: Call lights were observed throughout the survey and were answered in a timely manner. Residents' cares were observed throughout the survey and there were no identified issues.

Residents and staff interactions were observed throughout the survey and determined to be appropriate. The identified resident was interviewed and there was no mention of issues with any staff member in Quality of Care areas. Four other residents and family members of two residents were interviewed and had no concerns with any staff member and the Quality of Care. There were 11 residents in the group interview that expressed they were happy with the staff and felt they received good care.

The DON, Administrator, seven CNAs, four Charge Licensed Nurses and one Housekeeper were interviewed about the Abuse and Neglect reporting and investigation process and there were no issues. The facility's Abuse and Neglect reports, along with the investigations were reviewed and there were no reports that thorough and appropriate action had not taken place.

Based on observation, record review, and interviews, it was determined this allegation could not be substantiated due to the lack of sufficient evidence.

Conclusion #10: Unsubstantiated. Lack of sufficient evidence.

Allegation #11: The complainant stated staff responses to requests for help led to reluctance for the resident to ask for help.

Findings #11: Residents' cares and interactions with staff, including the identified resident were observed throughout the survey and there was no inappropriate body language or communication techniques. The identified resident was interviewed and there was no mention of issues with any staff member or Management Team member in Quality of Care areas. The identified resident considered the facility as home and enjoyed living there. Four other residents and family members of two residents were interviewed and had no concerns with any staff member and the Quality of Care. The 11 residents in Resident Group had not expressed concerns about any issues with staff. The DON, Administrator, seven CNAs, four Charge Licensed Nurses and one Housekeeper were interviewed about the Abuse and Neglect reporting and investigation process and there were no issues. The facility's Abuse and Neglect reports, along with the investigations were reviewed and there were no reports in which thorough and appropriate action had not taken place, including one report for the identified resident.

Based on observation, record review, and interviews, it was determined this allegation could not be substantiated due to the lack of sufficient evidence.

Conclusion #11: Unsubstantiated. Lack of sufficient evidence.

Allegation #12: The complainant reported on two occasions a resident went for six days without bathing.

Findings #12: The identified resident's Care Plan was reviewed for the resident's preference on bathing and the documentation supported the resident wanted a shower two to three times a week on Mondays, Wednesdays, and Fridays. Shower documentation was reviewed for the identified resident and documented the resident received a bed bath on January 28 and January 30, 2015. The shower record also documented the resident received a bed bath on March 2, a shower on March 4, and a bed bath on March 6, 2015. The DON said the identified resident had missed one bathing day for a one week period in March.
The DON said residents should be offered a shower at least twice a week and the facility tried to accommodate residents' requests for more often and/or as needed. The Administrator and DON were interviewed regarding the facility's shower aides. The Administrator said the shower team had been pulled to work the floor as needed, poor follow-up on refusals, and future reschedules had not occurred if bathing was missed.

Based on record review, resident and staff interview, this allegation was substantiated and the facility was cited at F312. Please refer to the survey report for further details.

Conclusion #12: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #13: The complainant reported the resident's toenails had not been cut.

Findings #13: The identified resident's medical record was reviewed for nail care and there were concerns identified. Two licensed nurses were interviewed regarding the residents' nail care and there were concerns identified. Two residents were interviewed about their nail care and concerns were identified. Two residents' nails were observed and there were concerns identified. The DON was interviewed regarding residents' nail care and there were concerns identified.

Based on observations, record review, and resident and staff interview, this allegation was substantiated. The facility was cited at F312 and further details can be reviewed in the survey report.

Conclusion #13: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #14: The complainant stated a mechanical lift was used improperly to transfer a resident.

Findings #14: Six residents' medical records were reviewed for mechanical lift transfers and there were no issues. Six residents were observed who required a mechanical lift transfer without any concerns. Three CNAs were interviewed regarding mechanical lift transfers and there were no concerns identified. The facility's Incident and Accident Reports were reviewed and there were no incidents, accidents, and/or investigations that took place because of a mechanical lift transfer event.

The DON was interviewed regarding residents having control of the mechanical lift remote for repositioning and residents being found in the air unsupervised. The DON stated this never happened. This practice currently would not be allowed for a resident to have unsupervised control of a remote for the mechanical lift.

Based on observation, record review, and staff interview, this allegation was substantiated based on findings related to the lack of supervision of residents. Refer to F323 in the survey report for further details.

Conclusion #14: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #15: The complainant stated an identified resident has personal items in his/her room that the facility staff have broken.

Findings #15: The identified resident's personal belongings were observed. The facility's Grievance file from March to October 2015 was reviewed and missing items and some broken items, along with the identified resident, were replaced with facility funds. The identified resident during an interview, stated personal items were broken, stolen and he/she was not pleased with the facility's resolution.

There were 10 residents in the Group Interview said when items were missing and could not be found the facility did their best to replace most of these items. The Social Worker was interviewed and she said the facility replaced items for residents and/or tried to work towards an agreeable resolution. The facility's Grievance file from March to October 2015 documented resolutions within acceptable regulatory requirements.

Based on observations, record review, resident and staff interview, the allegation could not be substantiated.

Conclusion #15: Unsubstantiated. Lack of sufficient evidence.

Allegation #16: The complainant reported the facility was not answering call lights in a timely manner.

Findings #16: Call lights were observed throughout the survey and there were no identified delayed response times. The facility's Licensed nurses and CNA staffing information from September 27 to October 17, 2015 was reviewed and the staffing hours were appropriate and met the regulatory requirements. The facility's Grievance file from March to October 2015 was reviewed and resolutions were being addressed. Resident Council minutes from August to October 2015 were reviewed and Management Staff were aware of residents' concerns and had worked on satisfactory resolutions.

The DON and Administrator were interviewed about Quality of Care concerns and had identified areas of concern and Management Staff were working on ways to improve any issues. The identified resident was interviewed and he/she said the facility was home and they were okay with the staffs' care and response time. Seven Licensed Nurses and six CNAs were interviewed regarding call lights and staffing and they said there were enough staff to meet the residents' needs.

Based on observation, record review, resident and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #16: Unsubstantiated. Lack of sufficient evidence.

Allegation #17: The complainant said the facility left a resident in bed for meals, when the resident asked to get up.

Findings #17: The identified resident's medical record was reviewed for dining preferences and there no concerns. Breakfast and lunch dining were observed during the survey process without concerns. Staff were observed providing assistance to the residents taking them to the dining room, activity room, and other common areas throughout the survey without concerns. The identified resident was observed in the dining room during the survey. The identified resident was observed in his/her room for meals per his/her request.

Appropriate and professional interactions between residents, staff, and the Management team were observed. Four other residents were interviewed for Quality of Care and Quality of Life concerns and there were no issues. The identified resident was interviewed regarding Quality of Care and Quality of Life concerns and there were no issues.

Based on observation, record review, and staff and resident interview, the allegation could not be substantiated based on lack of sufficient evidence.

Conclusion #17: Unsubstantiated. Lack of sufficient evidence.

Allegation #18: The complainant reported a resident's feet were not being positioned correctly on the wheelchair foot pedals.

Findings #18: Residents' positionings were observed throughout the survey process, in their wheelchairs while they were in their rooms and being propelled by staff and independently down the halls without any concerns. The identified resident's positioning was observed in his/her wheelchair in his/her room and while propelled by staff throughout the survey without any concerns.

The facility's Incident and Accident reports were reviewed, along with the identified resident's accident in his/her wheelchair, and the facility's investigations were thorough, complete, and within regulartory guidelines.

Based on observations and record review, it was determined this allegation could not be substantiated based on the lack of sufficient evidence.

Conclusion #18: 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,

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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December 8, 2015

Tom De Oro, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue,
Coeur D'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. De Oro:

On **October 23, 2015**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007171

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from October 19 to October 23, 2015.

The following observations were completed:
Call light response was observed throughout the survey;
Bathrooms and shower rooms were observed;
Residents' garbage cans and urinals were observed;
Medication pass was observed;
Breakfast and lunch service was observed; and,
Residents' beds and wheel chairs were observed.

The following documents were reviewed:
The medical record of the identified resident;
Fourteen other residents' records were reviewed for Quality of Care concerns;
Three other residents' Insurance non-coverage documentation;
The facility's nurse staffing information from 9/27/15 to 10/17/15;
The facility's Grievance file from March to October 2015;

Resident Council minutes from August to October 2015;
The facility's Incident and Accident reports from May to October 2015; and,
The facility's Allegation of Abuse reports.

The following interviews were completed:
The identified resident was interviewed;
Three other residents were interviewed regarding Quality of Care concerns;
Family members of two residents were interviewed regarding Quality of Care concerns;
Eleven residents in the Resident Group were interviewed;
The Director of Nursing (DON) and the Administrator were interviewed regarding various Quality of Care concerns;
The Certified Dietary Manager (CDM) and Registered Dietician (RD) were interviewed regarding nutrition and food concerns;
Seven CNAs and six nurses were interviewed regarding call lights, bed linen changes and Quality of Care concerns;
A Social Worker and the Assistant Business Office Manager were interviewed regarding insurance appeals and missing belongings procedures.

ALLEGATION #1: The complainant stated the facility would not transport an identified resident to offsite physical therapy appointments.

FINDINGS #1: The identified resident was interviewed and he/she said transportation to appointments was no longer an issue.

CONCLUSION #1: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2: The facility falsified information given to the identified resident's insurance company which caused the resident to loose insurance coverage.

FINDINGS #2: The identified resident's insurance coverage and appeals were reviewed and no issues were identified;
Three other residents' insurance coverage and appeals documentation was reviewed and no issues were identified;
The identified resident was interviewed and he/she said the insurance company has now paid their portion of the resident's claim;
The Assistant Business Office Manager was interviewed and she said the facility filed the resident's appeal correctly; and,
The Administrator was interviewed and he said the facility filed the resident's appeal correctly.
Based on record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION #2: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3: Personal belongings of the identified resident were lost by the facility and the facility required the resident replace them with his/her own money.

FINDINGS #3: The facility's Grievance file from March to October 2015 was reviewed and missing items for the identified resident and other residents had been replaced with facility funds;
The identified resident was interviewed and he/she said the facility replaced most of the items, except for a medical device, but staff told him/her they would replace that too;
Ten residents in the Group interview said when items were missing and could not be found, they were replaced by the facility;
The Social Worker said the identified resident requested a specific type of medical device to replace his/her missing one and the medical supply store did not have that specific one in yet and she would pick it up and pay for it with facility funds once it was available; and,
The Administrator was observed replacing the missing medical device to the identified resident.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION #3: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4: The identified resident did not receive the appropriate medications and physician orders were not followed.

FINDINGS #4: The identified resident's medical record was reviewed;
A medication error report was reviewed:
The identified resident said nurses dave him/her incorrect medications and had not followed physician orders; and,
The DON said the resident received a medication incorrectly and certain physician orders had not been followed.

Based on record review and resident and staff interview, the allegation was substantiated and the facility was cited at F309.

CONCLUSION #4: Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5: Call lights take 45 to 90 minutes to be answered and the facility does not have enough staff.
FINDINGS #5: Call lights were observed throughout the survey and were answered in a timely manner;
The facility's nurse staffing information from 9/27/15 to 10/17/15 was reviewed and the staffing numbers met the regulatory requirements;
The facility's Grievance file from March to October 2015 was reviewed;
Resident Council minutes from August to October 2015 were reviewed;

The identified resident was interviewed and he/she said call lights and staffing were no longer an issue; and,
Nine nursing staff were interviewed regarding call lights and staffing and they said call lights were answered in a timely manner and there was enough staff to meet the residents' needs.

Based on observation, record review, resident and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSION #5: Unsubstantiated. Lack of sufficient evidence.

ALLEGATIONS #6: The identified resident's garbage can and urinal were not emptied frequently enough.

FINDINGS #6: The identified resident was interviewed and he/she said the trash and urinal were being emptied and it was no longer an issue.

CONCLUSION #6: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7: Bathrooms were too small to accommodate wheelchairs.

FINDINGS #7: The identified resident's bathroom was observed and it met the regulatory requirement;
The shower room on the resident's unit was observed to have a large door and a toilet to accommodate the resident's wheelchair;
The identified resident was interviewed and he/she said he/she did not really use the bathroom in their room, except to pour his/her urinal into the toilet, but staff were now doing that; and,
The Director of Nursing was interviewed and he said the shower room toilets can be used for residents with larger wheelchairs.

Based on observation, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION #7: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8: Residents are left in bed or in wheelchairs soaked in urine and were left sleeping in their own stool.

FINDINGS #8: Residents' beds and wheel chairs were observed throughout the survey without any issues;
The facility's Grievance file from March to October 2015 did not document an issue with soaked beds or wheelchairs or residents sleeping in their stool;
Resident Council minutes from August to October 2015 did not document an issue;
Three residents and two family members did not express a concern;

Four nursing staff and one housekeeper were interviewed regarding these issues and said residents are changed when needed, do not sit or stay in their urine or stool, and bed linens are changed as needed.

Based on observation, record review, and resident, family, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION #8: Unsubstantiated. Lack of sufficient evidence.

ALLEGATIONS #9: The identified resident was only provided one shower a week.

FINDINGS #9: Shower documentation was reviewed for the identified resident and five other residents;
The identified resident was interviewed and he/she said it was no longer an issue;
Four residents in the Group Interview said they were not receiving showers consistently; and,
The Director of Nursing said residents should be offered a shower twice a week.

Based on record review, resident and staff interview, the allegation was substantiated and the facility was cited at F312.

CONCLUSION #9: Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #10: The facility does not follow the dietician's nutritional orders for the identified resident.

FINDINGS 10: Breakfast and lunch were observed for the identified resident and 10 other residents and menus and tray cards matched the observed food items;
The identified resident's meal preferences, nutritional orders and tray card was reviewed;
The identified resident was interviewed and he/she said he/she was not receiving the correct diet;
The Certified Dietary Manager said he has worked almost daily with the identified resident because the resident changes his/her meal choices quite often and he has always tried to accommodate the resident's preferences; and,
The Registered Dietitian was interviewed and she said the resident received the correct nutritional diet based on her recommendations and the resident also has the ability to alert the kitchen staff when he/she wanted something different based on preference.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION #10: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #11: The identified resident was dropped by staff getting him/her out of bed and he/she hit his/her head on metal. The identified resident was not sent to the hospital for a check for a possible concussion.

FINDINGS #11: An Incident and Accident report for the identified resident was reviewed;
Three other residents were reviewed for falls and no concerns were identified;
The identified resident said he/she lost balance and hit his/her head on the metal walker. The resident said he/she was not sent to the hospital and felt nursing staff did not evaluate him/her appropriately. The resident said during a recent neurologist appointment, the physician said the resident had not received a concussion; and,
The Director of Nursing said the appropriate care was provided.

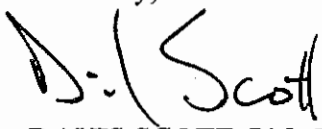
Based on record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION #11: 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,



DAVIS SCOTT, RN, Supervisor
Long Term Care

DS/pmt