



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

December 21, 2015

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On **December 4, 2015**, a survey was conducted at Bridgeview Estates by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) 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 **January 3, 2016**. Failure to submit an acceptable PoC by **January 3, 2016**, may result in the imposition of civil monetary penalties by **January 3, 2016**.

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 **January 11, 2016 (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 **January 11, 2016**. A change in the seriousness of the deficiencies on **January 11, 2016**, may result in a

Jeffrey Corriher, Administrator
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change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 11, 2016** includes the following:

Denial of payment for new admissions effective **March 4, 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 **June 4, 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 **December 4, 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:

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Page 4

<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:

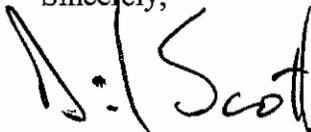
- BFS Letters (06/30/11)

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

This request must be received by **January 3, 2016**. If your request for informal dispute resolution is received after **January 3, 2016**, 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, Co-Supervisor
Long Term Care

DJS/pt
Enclosures

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

PRINTED: 12/21/2015
FORM APPROVED
OMB NO. 0938-0391

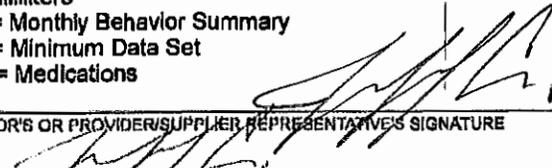
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135113	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2015
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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1929 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301
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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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from November 30, 2015 to December 4, 2015.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Kendra Delnes, RN, BSN Brad Perry, LSW Linda Hukill-Neil, RN Linda Kelly, RN Angela Morgan, RN, BSN Presie Billington, RN</p> <p>Definitions included: ABX = Antibiotic ADL = Activities of Daily Living BID = Twice daily BMFS = Behavior Monitor Flow Sheets CAA = Care Area Assessment CDM = Certified Dietary Manager CHF = Congestive Heart Failure CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease COTA = Certified Occupational Therapy Assistant c/o = Complained Of CVA = Cerebrovascular Accident DNS = Director of Nursing Services F = Fahrenheit G-Tube = Gastrostomy Tube ICN = Infection Control Nurse IV= Intravenous LN = Licensed Nurse ml = Milliliters MBS = Monthly Behavior Summary MDS = Minimum Data Set Meds = Medications</p>	F 000	<p><i>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</i></p>	
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RECEIVED
JAN 22 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Executive Director</i>	(X6) DATE <i>1-20-16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1829 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301	
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F 000	Continued From page 1 NN = Nursing Progress Notes NS = Normal Saline OT = Occupational Therapist OTA = Open to Air PEG = Percutaneous Endoscopic Gastrostomy PN = Progress Notes POA = Power of Attorney PRN = As Needed PT = Physical Therapist PTA = Physical Therapy Assistant PUSR = Pressure Ulcer Status Record QAA = Quality Assessment & Assurance RNA = Restorative Nursing Assistant RNC = Regional Nurse Consultant RNP = Restorative Nursing Program ROM = Range of Motion RSD = Resident Service Designee SDTI = Suspected Deep Tissue Injury SVN = Small Volume Nebulizer UM = Unit Manager	F 000		
F 153 SS=B	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on facility policy review and staff interview,	F 153	F153 SPECIFIC RESIDENT None OTHER RESIDENTS A Review of Current Residents requesting copies of medical record was completed to identify any other residents and ensure the cost of copies are reflective of community standard copy rates. SYSTEMIC CHANGES Specific Facility policy written with change of medical records cost of \$0.15 per page to reflect cost of local resources.	

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F 163	Continued From page 2 It was determined the facility failed to keep the cost of medical records at the community standard for photocopies. This failed practice could affect any resident or responsible party who requested medical record copies. Findings included: The facility's Health Information Management Policy and Procedure Manual dated 9/27/13, documented, "[Corporate Name]'s policy is for the facility to charge the rate of \$1 per page for the first 25 pages and \$0.25 per page thereafter for copying the medical record." On 12/2/15 at 4:40 pm, a local public library staff member at the circulation desk said black and white copies cost 15-cents per page. On 12/3/15 at 3:30 pm, the Health Information Management Director said she would charge the rate which was in the facility policy.	F 153	MONITOR Medical Records will ensure facility cost reflects the cost of local resources by verifying the cost of copies at local resources such as the Public Library monthly for 3 months and bi-annually thereafter. Medical Records will bring to the Quality Assurance Committee any requests for medical records monthly, including the cost charged any residents during that month. COMPLIANCE DATE: 1/11/16		
F 176 SS=B	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, it was determined the facility failed to ensure residents who wished to self-administer medications were safe to do so. This was true for two random residents (#s 25 and 26). This failure created the potential for medication errors if the	F 176	F176 SPECIFIC RESIDENT: Resident #25 Self Medication assessment was complete and resident not able to keep medications at bedside, so medications removed from room, Resident #26 Medications were removed from room OTHER RESIDENTS:		

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F 176	Continued From page 3 residents were not competent to self administer their medications. On 11/30/15, during the initial tour of the facility, the following were observed: *A tube of Pain Burst-R-It cream and eight lozenges were found on the overbed table of Random Resident #25. The resident said she applied the cream to her legs for pain and took the lozenges for a sorethroat. *A bottle of Tums was observed on the overbed table of Random Resident #26's room. On 12/01/15 at 9:20 am LN #1 was shown Random Resident #s 25 and 26 medications in their respective rooms. LN #1 said Random Resident #s 25 and 26 were not assessed to self administer medications safely.	F 176	Current and newly admitted Residents in facility who want to have medications at bedside will be assessed and educated regarding medications at bedside. Medication self-assessment will be completed, and lock box provided if applicable SYSTEMIC CHANGES: In-serviced Licensed Nurses, Department Heads, and CNA's that medications cannot be at bedside unless there is a self-medication assessment completed and resident is competent to keep meds at bedside and lock box is in place for the medications.		
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 staff and resident interview, it was determined the facility failed to ensure a resident was allowed to use a bedside commode instead of a bed pan as she requested. This affected 1 of 7 (#7) residents sampled for toileting needs. This	F 246	MONITOR: Department Heads to complete audits on 10% of residents weekly x8 and monthly x3 to ensure medications are not at bedside. These audits will be reviewed monthly in the QAPI committee to ensure system is effective and compliance is sustained. COMPLIANCE DATE: 1/11/16 F-246 SPECIFIC RESIDENT: Resident #7 will have her toileting preferences met.		

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F 246 Continued From page 4

had the potential to cause more than minimal psychosocial harm when the resident stated she did not want to "poop in bed."

Resident #7 was admitted to the facility with multiple diagnoses, including Parkinson's disease, Rheumatoid arthritis, and constipation.

The most recent ADL care plan documented the resident required extensive assistance of two staff for transfers using a Hoyer lift for toileting.

On 11/30/15 the resident stated she was "upset and disgusted" with nursing staff telling her she could no longer use the toilet and had to use a bed pan. When asked why she could not use the toilet, she stated, "Because they use a machine [Hoyer lift] to move me around and it won't fit in the bathroom. If they wouldn't come at me so fast and scare me, I'm sure I could stand." She stated she told nursing staff it was difficult for her to use the bed pan and she did not want to defecate in bed. The resident stated, "Since when do you have to poop lying down? My mom always told me, 'You don't poop in the bed.' I don't like it and they know about it."

On 12/3/15, CNA #4 stated some shower slings had an opening in the bottom and could be used when toileting a resident on a bedside commode. When asked if Resident #7 said she did not want to use the bed pan, CNA #4 stated, "The resident has told me and several other CNAs she does not like to use the bed pan because it is uncomfortable and she does not want to poop in bed." When asked how she and other CNAs responded to the resident's request, CNA #4 stated, "We tell her she can't use the toilet because she is a Hoyer lift," or "We don't provide

F 246

Therapy screen completed for Resident #7 for mobility to Bed Side Commode.

OTHER RESIDENTS:
Other residents that are in the facility who use a mechanical lift for transfers will be toileted per their preference

SYSTEMIC CHANGES:

Training provided to Nursing staff regarding the use of Bed Side Commode when doing hoyer transfers.

MONITOR:
Nurse Managers will interview 5 residents weekly who are hoyer lift to ensure their toileting needs are being maintained per their preference weekly x8 and monthly x3.

These interviews will be reviewed monthly in the QAPI committee to ensure system is effective and compliance is sustained.

COMPLIANCE DATE: 1/11/16

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F 246	Continued From page 5 an explanation and just put her on the bed pan." On 12/3/15, CNA #5 stated CNAs tell the resident "it is not possible for her to use the toilet because she is a Hoyer lift." On 12/3/15, the DNS and RNC stated the facility would accommodate the resident's preference by the using a Hoyer sling with an opening in the bottom and a bedside commode.	F 246		
F 248 SS-E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, resident group interview, and staff interview, it was determined the facility failed to provide an activities program consistent with residents' interests and needs. This was true for three of 25 residents sampled for activities (#s 3, 7, and 10), 9 of 13 residents in group interview, and any other resident utilizing the activity program in the facility. The deficient practice had the potential to decrease residents' level of physical, mental, and psychosocial well-being. Findings included: 1. Resident #3 was admitted to the facility on 10/9/15 with multiple diagnoses, including Parkinson's disease and dementia.	F 248	F248 SPECIFIC RESIDENT Residents #3, 7 and 10 will have activities assessment reviewed and will ensure activities important to the resident are on the care plan. OTHER RESIDENTS All resident's activity care plans will reflect important activity choices on activity evaluation and will be updated per MDS schedule SYSTEMIC CHANGES Identification of root cause analysis indicates that there was transition of Activities Director wherein training and education to ensure the resident activity choices from the evaluations are placed on the care plans was not effective.	

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F 248	<p>Continued From page 6</p> <p>On 12/1/15 at 9:30 am, the resident stated he enjoyed listening to music tapes, audiobooks, and singing for the other residents.</p> <p>The resident's Activity Evaluation, completed 10/12/15, documented the resident needed encouragement with activities and was interested in animals, bingo, cards, current events, exercise, family visits, group discussion, movies, music, reading, religious services, social events, sports, and television. It documented the resident's preference to participate in activities three times per week, morning or afternoon, and in his own room or activity room.</p> <p>The Activities of Daily Living care plan, initiated 10/9/15, documented all staff were to invite, encourage, remind, and escort Resident #3 to activities consistent with the resident's interests. Information documented on the Activity Evaluation was not reflected in the care plan.</p> <p>On 12/2/15 at 12:15 pm, the Activity Director stated there was no further information in the resident's care plan regarding activities.</p> <p>2. Resident #7 was admitted to the facility with multiple diagnoses, including depression.</p> <p>The Activities Evaluation form, dated 7/28/15, documented the following activities were important to the resident: arts and crafts; going to the beauty shop; cooking/baking; current events/news; family/friend visits; gardening; music; reading; religious services; and television. The evaluation documented the resident was interested in life/activities, was cooperative, needed encouragement/was willing to try. The evaluation did not include what encouragement</p>	F 248	<p>Activities Director trained on ensuring the residents activity choices from the evaluations are placed on the care plans. Competency of the Activities Director will be evaluated by Director of Nursing or Regional Director of Clinical Services monthly for 90 days after this training. Any New hired activities Director will have training provided upon hire and competency on ensuring choices from the evaluation are placed on the completed 90 days after hire.</p> <p>In-serviced Activity Staff to ensure important activity choices on evaluation reflect on residents care plans.</p> <p>In-service staff to ensure they are offering to take residents to activities</p> <p>An open poll has been given to residents for the purposes of compiling a list of potential activities on weekends.</p> <p>A revised calendar including a variety of activities from the list given by residents will be provided to residents.</p> <p>Monthly in resident council Activities will review with the residents the activities and solicit input as needed for upcoming activities calendars.</p>

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Continued From page 7
the facility would provide and/or what activities the resident was willing to try.

The most recent activity care plan, dated 7/1/14, documented the resident preferred to spend time in her room. Staff were to provide the resident with a current activity calendar to serve as a reminder of current activities; offer a daily activity memo each morning; assist the resident to group activities, including music events, newspaper readings, and gardening events; and respect her wishes "to be left alone on occasion." The resident's care plan was not updated in conjunction with the activity evaluation on 7/28/15, and did not reflect the resident's current activity preferences.

On 11/30/15, the resident stated she spent most of the day in her recliner watching television in her room. She stated she would like to participate in activities, but has a difficult time holding the chips for Bingo in her hands due to her limited dexterity and grip strength. She also stated staff used a mechanical lift to transfer her into a wheelchair, which was "more trouble than it's worth."

On 12/2/15, when asked why the current activity care plan did not include updated changes in residents' areas of interest from the Activities Evaluation, the Activity Director stated nurses look at the Evaluation for that information.

3. Resident #10 was admitted to the facility on 9/22/15, and readmitted on 10/26/15, with multiple diagnoses, including urinary tract infection.

The resident's 10/1/15 Activity Evaluation

F 248: MONITOR

Administrator to interview 10% of residents weekly to see if activity preferences are being met x8 and then monthly x3

Administrator to audit activity care plans per MDS schedule to ensure accuracy weekly x8 and monthly x3

These audits will be reviewed monthly in the QAPI committee to ensure system is effective and compliance is sustained.

COMPLIANCE DATE: 1/11/16

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F 248	Continued From page 8 documented the following activities were "somewhat important" to the resident: Community outings, current events/news, movies, music, religious services, sing-along, social parties, sports, and television. Resident #10's 9/22/15 Activities of Daily Living care plan documented all staff were "to invite, encourage, remind and escort to activity programs consistent with resident's interest." The resident's 10/14/15 Mood care plan documented all staff were to "encourage [Resident #10's] interest in diversional activities and interaction with peers and staff." There was no documentation of the resident's Activities evaluation found on the care plan. On 12/3/15, the resident said she enjoyed watching television inside her room. When asked if she participated in any group activities, the resident said, "Sometimes ... if they would take me." 4. On 12/1/15 at 11:15 am, 9 of 13 residents in a group interview stated there was a lack of activities on Saturdays after 2:00 pm, and nothing offered on Sundays besides church services. They also stated they would like more trivia for men, such as Wheel of Fortune, Jeopardy, horse racing, hangman, and more activities geared toward men's interests. On 12/3/15 at 2:00 pm, the Activity Director stated there was no activity staff present on Saturday evenings or Sundays. He stated residents played cards on Sundays. He was unaware of the other activities in which residents wished to participate.	F 248		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=C	<p>Continued From page 9 HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to perform dressing changes as ordered for 5 of 8 residents (#2, #4 and #15) reviewed for wound care. The facility also failed to ensure coordination and communication of care for a resident receiving hospice care was provided as care planned for 3 of 4 residents (#2, #5, and #6) reviewed for hospice care. These deficient practices created the potential for deterioration and infections of the residents' wounds, and missed and/or inadequate care by the facility and hospice provider. Findings included:</p> <p>1. Resident #15 was admitted to the facility on 3/8/15 for care and therapy following surgical repair of a fractured and dislocated right ankle. The resident left the facility against medical advice on 3/14/15.</p> <p>Review the resident's closed medical record revealed the orders from the referring hospital, dated 3/7/15, included a walking boot to the right lower extremity "at all times" and staple removal by the physician in two weeks. The orders did not include surgical wound care or dressing changes.</p>	F 309	<p>F309 Resident #15 Discharged Resident #4 Discharged Resident #2 will have dressing changed and documentation completed as ordered by MD. Hospice documentation requested for CNA visits/cares for Resident #2. Resident #6 is not on hospice. MD order clarified to reflect may have meds PO or per peg. Resident #5 hospice order obtained, coordinated plan of care and visit notes obtained.</p> <p>OTHER RESIDENTS: Residents who are on hospice will have MD orders obtained, coordinated plan of care and visit notes current.</p> <p>Residents who have wound care orders will have dressings changed and documented per MD order</p> <p>Residents who are on tube feedings with have route of medication clarified if needed</p> <p>SYSTEMIC CHANGES: In-serviced Nursing staff to ensure that wound care is completed and documented per MD order. If residents are on hospice to ensure we communicate to the RCM, HIM and SS so appropriate documentation can be provided. Also in-serviced nursing staff to ensure that medications are given by</p>	
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F 309	<p>Continued From page 10</p> <p>On 3/8/15, 90 minutes after the resident's admission to the facility, the orthopedic surgeon gave an order for twice daily and PRN wound care and dressing changes to the right ankle.</p> <p>On 3/10/15, the orthopedic surgeon changed the dressing changes to daily and on 3/11/15, during an office visit, the orthopedic surgeon changed the order to a "dry dressing" daily.</p> <p>The resident's Progress Notes and TAR for March 2015 documented the second dressing change was not completed on 3/8/15 and 3/9/15 as ordered. There was no evidence in the medical record that the resident refused or was not available for the dressing changes.</p> <p>On 12/3/15 at 3:40 pm, UM #1, reviewed the resident's clinical record and said the physician-ordered dressing changes were not completed twice on 3/8/15 and 3/9/15.</p> <p>2. Resident #4 was admitted to the facility on 11/11/15 with diagnoses of diverticulitis and perforated ileus.</p> <p>The November 2015 TAR documented staff was to "change colostomy pouch/wafer every 5-7 days/PRN." It was marked with a triangle on 11/18/15 and there was no documentation after 11/18/15 for the colostomy pouch/wafer change.</p> <p>On 12/3/15 at 3:38 pm, LN #1 said the triangle marked on 11/18/15 was a dressing change, but the nurse on duty did not initial it. When asked about the missed colostomy pouch/wafer change from 11/19/15 to 11/30/15, LN #1 said, "They</p>	F 309	<p>the correct route per MD order for residents with PEG tubes.</p> <p>Met with Hospice services to appropriate documentation is received</p> <p>MONITOR: Nurse Managers to review TARS to ensure wound care is provided and documented per MD order weekly x8 and monthly x3. Also review residents on tube feedings to ensure proper route of medication is followed weekly x8 and monthly x3</p> <p>HIM to request documentation from hospice weekly x8 and monthly x3</p> <p>Audits to be brought through Quality Assurance monthly and trends identified and education provided</p> <p>COMPLIANCE DATE: 1/11/16</p>

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F 309	<p>Continued From page 11 should be changing the colostomy pouch/wafer as per order but where they documented it, I don't know".</p> <p>3. Resident # 2 was admitted to the facility on 10/1/15 with multiple diagnoses, including dementia with behavioral disturbances and emphysema.</p> <p>The resident's 10/5/15 Physician's Telephone Order documented an order for staff to change the dressing on the R[ight] heel and to apply Abx ointment and Mepilex every 3-5 days/PRN.</p> <p>The resident's October and November 2015 TAR documented the dressing was changed on 10/5, 10/10, 10/17, 10/23 and 10/28. The resident refused the dressing change on 10/16/15, which was documented as having been completed on 10/17/15. The resident's wound dressing was not changed for 6 days after the 10/17/15 dressing and there was no dressing change performed for eight days, from 10/28/15 to 11/6/15. A 10/30/15 nursing note documented "skin lifted off and a small area remains, area measures 0.3 x 0.5". There was no documentation of resident refusal or why the dressing was not done on those days. The November TAR documented Resident #2's wound as Open to Air from 11/6/15 to 11/30/15. There was no physician's order to keep the resident's wound open-to-air.</p> <p>On 12/3/15 during an observation of wound care, LN #16 removed the resident's socks and the old dressing came off with the sock. LN #16 applied a new dressing after she cleaned the wound.</p> <p>*Resident #2 was admitted to the facility on 10/1/15 with multiple diagnoses, including</p>	F 309		

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F 309	Continued From page 12 dementia with behavioral disturbances. Hospice services were initiated on 10/2/15. Resident #2's 10/8/15 quarterly MDS assessment coded the resident received hospice care services. The hospice 10/2/15 Admission-Initial & Comprehensive Assessment documented the resident "shove[d] too much food into his mouth," and required extensive assistance to eat. The hospice's 10/27/15 Focused and Comprehensive Assessment documented the hospice aide was to provide unspecified cares for the resident twice daily. On 12/2/15 at 12:50 pm, a hospice CNA said he documented his visit electronically on his cell phone, which was then transmitted to the hospice system. He also said that there was no paperwork from the facility for him to document his visits. On 12/3/15 at 9:10 am, RN #8 was asked how hospice CNA visits were documented and communicated to the facility. She looked at the resident's record, found the hospice CNAs' October progress notes from 10/18 to 10/30, and confirmed there was no documentation from the hospice provider in the facility record. 4. Resident #6 was admitted to the facility on 2/6/15, and readmitted on 10/15/15, with diagnoses of hemiplegia following a stroke, dysphagia, and a PEG tube in place. The resident's recapitulated November and December 2015 Physician's Orders and MARs	F 309		
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F 309	<p>Continued From page 13</p> <p>documented 12 medications that were to be administered via PEG tube and 12 medications that were to be administered orally.</p> <p>On 12/1/15, LN #8 was observed crushing and administering via PEG tube several medications to Resident #8, including Methocarbamol, which was physician-ordered for oral administration and documented as an oral medication on the resident's MAR. LN #8 stated the resident had dysphagia and was to take all medications via PEG tube.</p> <p>On 12/2/15, LN #7 stated Resident #6 had just been administered three medications orally. The three medications were Zanaflex, Reglan, and Methocarbamol. The LN stated the resident could be administered all oral medications either by mouth or via PEG tube, except for one medication, which could not be crushed.</p> <p>On 12/3/15, LN #11 stated the resident could receive all oral medications either orally or via psg tube. LN #11 stated the resident's physician orders and MAR should reflect the appropriate routes for each medication.</p> <p>5. Resident #5 was readmitted to the facility on 6/5/15 with multiple diagnoses, including Alzheimer's Disease.</p> <p>The facility's Hospice Services Agreement, dated 8/26/13, documented: "Initial Plan of Care ... Hospice shall furnish facility with a copy of the Hospice Plan of Care within twenty-four (24) hours of its completion..." "Coordination ... The Hospice Plan of Care must identify the care and services that are needed</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>and specify which provider is responsible for performing the respective functions contained therein."</p> <p>*Physician Orders. All physician orders communicated to Facility on behalf of Hospice..."</p> <p>The resident's record included an 11/3/15 signed consent form for the resident's representative, and hospice and facility representatives. The chart did not contain a physician's order for hospice services, a hospice coordinated plan of care or hospice visit notes.</p> <p>The resident's 11/5/15 nurse progress notes documented, "Hospice admissions and request for hospice forms placed in chart ... Nursing will continue to monitor."</p> <p>On 12/2/15, at 11:25 am, the Health Information Management Director provided hospice progress notes, which she requested from the hospice agency because, she said, they were not found in the chart.</p> <p>On 12/2/15 at 12:05 am, CNA #19, with RCM #11 present, said the resident was on hospice and hospice provided all the resident's care when their staff were in the building. RCM #11 said hospice staff checked in with the floor nurse when they arrived to find out what services were needed for the resident. When asked where the plan of care for the resident was which directed facility and hospice staff on who was responsible for specific areas of the resident's care, RCM #11 said, "I don't see a hospice care plan."</p> <p>On 12/3/15 at 9:15 am, when asked to produce a physician order for hospice, RCM #11 said she could not find such an order in the resident's</p>	F 309	

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F 309	Continued From page 15 record. At 11:30 am, RCM #11 provided the order, which she said had just arrived from the physician's office that day. The order was dated 11/3/15.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the 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, staff interview, and record review, it was determined the facility failed to prevent the development of a pressure ulcer for 1 of 24 sampled residents (Resident #1). This failure resulted in harm when a resident developed an unstageable pressure ulcer to his right heel. Findings included: Resident #1 was admitted to the facility on 3/17/12, and readmitted on 7/18/15, with multiple diagnoses, including Diabetes Mellitus and aftercare for repair of a left hip fracture. On 7/18/15, a Foot Risk Assessment form, which instructed the assessor to examine both feet without shoes, documented both of Resident #1's heels were soft, without discoloration, and no sores present. Blanchable redness was noted to	F 314	SPECIFIC RESIDENT Resident #1 wound is improving and preventative interventions are in place OTHER RESIDENTS Residents recently admitted or readmitted will have a second skin check completed 24 hrs after admission and appropriate skin preventative interventions will be placed based on skin assessment SYSTEMIC CHANGES The root cause was identified as failure to follow the policy in place for Preventing Pressure Ulcers. In-servicing on Preventing Pressure Ulcers was provided to the wound nurse, RCM's, Admission nurse, Licensed nurses and CNAS. Accuracy of skin assessment upon admission and placing appropriate individualized interventions and care planning these interventions was also inserviced. Staff were inserviced to communicate new wounds or suspected skin issues on the 24 hour report.	

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F 314	<p>Continued From page 16</p> <p>the right great toe. The form documented the resident's heels were floated. The back of the form depicted a front and back body diagram with a notation of 1-plus edema to the right lower extremity.</p> <p>Resident #1's Risk for Pressure Ulcers care plan, Initiated 3/4/13, documented interventions of avoiding prolonged periods of skin-to-skin contact, encouraging the resident to use the trapeze over his bed to assist with repositioning, and encouraging the resident to float heels while in bed. The care plan also documented the use of a pressure reduction mattress. A new pressure ulcer care plan intervention, added on 7/18/15, was a warning the resident could bruise spontaneously from aspirin use. There was no documentation on the care plan regarding post surgery and readmission floating of the resident's heels or that the trapeze had been re-evaluated as an appropriate means of repositioning without causing the resident to experience additional friction, shear, or pressure to his heels.</p> <p>On 7/19/15 at 12:28 pm, a NN documented the resident used a wheelchair for mobility and his skin was warm and dry, with blanchable redness noted to the right great toe. At 1:29 pm, a NN documented the resident had been in bed all day and his heels were "soft" with 1-plus edema to the right leg.</p> <p>On 7/20/14 at 12:39 am, a NN documented the resident required 2-3 person maximum assistance for transfers, used a wheelchair for mobility, and had been up to take his evening meal in the dining room. He had trace edema noted in his right leg, and had worked with therapy that day. At 2:29 am, his skin was noted</p>	F 314	<p>Admission assessments will be completed by nurse manager or admission nurse who have a specific checklist to ensure treatments, notifications, interventions and follow up is completed. This check off list will be reviewed with the cart nurse to ensure the floor staff is aware of any skin issues and interventions placed. Both nurses will sign and date the form after going over it. This checklist will be given to the DON and wound nurse.</p> <p>In addition, to further assist the nursing staff with following Pressure Ulcer Prevention a Prevention checklist of standard interventions and who to notify was placed in the treatment book to be used a skin issue is discovered during their shift.</p> <p>MONITOR</p> <p>Nurse Managers to audit admit skin assessment and 24 hour skin assessments for completion as well as content. Nurse Managers to audit new admission charts to ensure skin interventions are care planned. Nurse managers to audit rooms to ensure ordered interventions are in place. This admission audit will be ongoing to ensure continued compliance with pressure ulcer prevention.</p>

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F 314	<p>Continued From page 17</p> <p>to be pink, warm, and dry. At 2:20 pm, his extremities were noted as dry and warm to the touch.</p> <p>On 7/20/15 at 11:04 pm, a NN documented the resident had spent most of the day in bed.</p> <p>On 7/21/15 at 3:43 am, a NN documented the resident was noted with skin that was pink, warm, dry, and with no edema. At 2:53 pm, compression stockings were applied to the resident's lower extremities. He had worked with therapy.</p> <p>On 7/21/15, a physician's progress note documented the resident had no sores, rashes, or lesions.</p> <p>On 7/22/15 at 12:34 am, a NN documentd the resident requirad 2-person extensive assistance with bed mobility and transfers. His skin was noted as pink, warm, and dry. At 2:38 pm, the resident was noted to have 1-plus edema to his lower extremities, with compression stockings in place. The resident was documented as using a wheelchair for mobility, but required someone to propel him to his destination.</p> <p>On 7/22/15 at 11:26 pm, a NN documented the resident's skin was warm to the touch and, "While staff was helping resident to bed staff noticed a blister-like area to right heel." The resident was noted with 2-plus edema to the right lower extremity.</p> <p>A 7/22/15 PUSR, untimed, documented Resident #1 had an unstageable pressure ulcer to his right heel, 8 cm long X 12 cm wide. The form documented the area was first observed on 7/22/15 and was present "on admit" with no</p>	F 314	<p>If a wound is present, Nurse Managers will audit to ensure appropriate individualized preventative interventions have been implemented and noted on 24 hr report, and care plan. These audits will be weekly X 8weeks and monthly X 3 months then reviewed at QA for ongoing audits. The nurse manager to give audits to the DON for review.</p> <p>Audits will be brought through Quality Assurance monthly by the DON and trends will be identified and education provided</p> <p>COMPLIANCE DATE: 1/11/16</p>

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F 314	<p>Continued From page 18 further explanation documented.</p> <p>On 7/23/15 at 4:39 PM, a Wound Note entry in Resident #1's NN documented, "Blister found to right posterior/plantar heel. Blister is fluid filled but does have some areas where blood is visible which would make it an SDTI. Redness with warmth surrounding the blister ..." The note documented wound treatments were initiated and "Sage" boots were applied and were to be worn at all times. The resident's care plan was updated at that time to reflect the use of "Prafo" boots at all times.</p> <p>On 7/25/15, Resident #1's Change of Condition MDS coded the resident was unable to participate in a cognitive assessment interview, but needed assistance with decisions in new or unfamiliar situations; required extensive assist of two staff for bed mobility and transfers; did not ambulate; relied on staff assistance for mobility in a wheelchair; experienced occasional pain as high as 7/10 on a 10-point pain scale; did not receive routine pain control, but used "as needed" medications; and had one unstageable pressure ulcer with SDTI "in evolution," which was not present on admission.</p> <p>On 7/25/15, Resident #1's Pressure Ulcer CAA documented the resident developed a facility-acquired SDTI.</p> <p>On 7/27/15, the Pressure Ulcer Status Record documented the blister had "deroofed."</p> <p>On 8/5/15 at 10:45 am, a Wound Note documented the blister had deroofed, extra skin had debrided off, and, "The wound bed appears superficial and red/pink but does have a few</p>	F 314	

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F 314	<p>Continued From page 19</p> <p>dispersed areas that are dark." The PUSR documented the wound was unstageable, and the appearance of the wound was granular.</p> <p>On 8/12/15 at 4:08 pm, a Wound Note documented the wound bed "appears superficial and is red with some areas that are dark." The PUSR documented the wound was unstageable, and the appearance of the wound as granular.</p> <p>On 8/18/15 at 1:52 pm, a Wound Note documented, "The blister de-roofed leaving an open wound ... The wound is now red with some yellow areas in the place of dark areas. All areas appear superficial at this time, but depth is unknown ... The wound was SDTI and is unstageable..." The PUSR documented the appearance of the wound as both granular and exhibiting slough.</p> <p>On 8/19/15 at 11:23 pm, a NN documented the resident reported pain to his right heel/foot approximately every 4 to 5 hours, and requested medication for relief.</p> <p>On 8/25/15 at 1:27 pm, a Wound Note documented the slough in the wound bed was softening and decreasing. The PUSR documented the appearance of the wound as both granular and with slough.</p> <p>On 12/1/15 at 4:09 pm, the resident's right heel pressure ulcer was observed during a dressing change with the WCN. The WCN assessed the wound as 3cm X 1cm with no measurable depth.</p> <p>On 12/3/15 at 8:45 am, RCM #11 said she was unsure if the resident developed a pressure ulcer before his admission to the facility on 7/18/15.</p>	F 314	

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F 314	Continued From page 20 After reviewing the Foot Risk Assessment form for that date, the RCM said the assessment documented the resident did not have a pressure ulcer present upon admission. She said the resident should have had a comprehensive skin assessment upon admission, and another skin assessment 24 hours later. RCM #11 stated the second skin assessment was not signed, and she could not see where the resident's heels were assessed again until 7/22/15. She said the interventions in place when the resident was admitted included a trapeze and a pressure relieving mattress. The RCM stated she recalled the resident had been transferred with a 2-person stand pivot assist to his wheelchair many times between 7/18/15 and 7/22/15. The RCM stated the resident was using foot pedals in his wheelchair to support his lower extremities while in the wheelchair. The RCM stated the resident had been wearing compression stockings and slipper socks, but no further measures were in place to protect his heels after readmission to the facility. The RCM stated the compression stockings would help with the resident's edema, but if there was indication that the resident was developing a pressure ulcer the compression stockings would further increase the risk. The RCM reviewed the NN from 7/18/15 through 7/22/15, and stated the nurses likely did not remove the residents socks when assessing his skin, before documenting the skin was pink, warm, and dry, and would not have necessarily noticed whether an SDTI was present. The RCM indicated there should have been more interventions at the time of admission. On 12/3/15, the facility provided the manufacturer's specifications for the resident's mattress, which was identified as pressure	F 314		
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F 314	Continued From page 21 redistributing foam surface, but not a pressure relieving surface. On 12/3/15 at 10:25 am, the WCN said she did not know what interventions were in place between 7/18/15 and 7/22/15, aside from the resident being encouraged to float his heels in bed. She did not know what interventions were in place to protect the resident's heels during transfers, or when he was sitting with his feet on the wheelchair foot pedals during that timeframe. The WCN said the application of Sage boots did not occur until after the pressure ulcer was identified on 7/22/15. The WCN indicated the intervention of "floating heels" was a standard intervention for all residents, and not necessarily an individualized intervention for Resident #1.	F 314		
F 318 SS=E	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 observation, interview, and record review, it was determined the facility failed to provide appropriate treatment and services to prevent a functional decline in ROM for 4 of 5 sampled residents (#3, #6, #7, & #13). This deficient practice had the potential to cause residents' range of motion to decline when	F 318	F 318 SPECIFIC RESIDENT Residents #3, 6, 7, have had a therapy screen completed to ensure there has not been a decline in ROM. Resident # 13 is receiving RNA services as well as therapy is overseeing hand splint. OTHER RESIDENTS Residents who have been on therapy will be assessed for a restorative program. SYSTEMIC CHANGES In-serviced Therapy staff and nursing staff to review process of the restorative program and who to contact for referrals and copy of referrals to DON. Competencies completed on two nurses to oversee RNA program and two CNAs to operate the RNA program. In-serviced nursing staff to ensure splints are in place as ordered and to notify therapy or DON if splint not available.	

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F 318

Continued From page 22
Resident #3 and #7 were discharged from physical therapy with no plan of care to maintain strength or range of motion; Resident #6 had no plan of care to prevent further decline or left arm/hand and leg/foot contractures; and, Resident #13 did not have a hand splint as ordered or plan of care to prevent decline of upper and lower extremity impairments.

1. Resident #3 was admitted to the facility on 10/9/15 with multiple diagnoses, including Parkinson's disease, history of falling, and muscle weakness.

The 10/16/15 admission MDS assessment documented the resident had no impairment of range of motion in the upper or lower extremities and was receiving physical therapy.

The Physical Therapy Daily Treatment Notes documented the resident started physical therapy on 10/10/15 and ended 11/25/15.

The Physical Therapy Progress Report for 11/5/15-11/20/15 documented upon discharge from physical therapy the resident demonstrated "good" muscle strength of the lower extremity.

The Physical Therapy Daily Treatment note of 11/25/15 documented the resident and caregiver were educated on a home exercise program and appropriate ways to progress the resident.

On 12/1/15 at 9:30 am, the resident stated he had just finished physical therapy a few days prior. He stated he would like to be able to move about his room independently, but needed assistance because his legs would quit working and "freeze."

F 318

Restorative program implemented. three times weekly the Director of Nursing and staffing Coordinator will evaluate the staffing in the restorative program. Each evaluation will include retention and recruitment as needed to ensure restorative program is adequately staffed.

MONITOR
DON or designee will audit referrals made from therapy to ensure restorative program has been assessed and implemented if indicated weekly x8 and monthly x3
DON to audit the Restorative Staffing to ensure staffing is adequate to provide restorative as ordered weekly times 8 and monthly times three.

Nurse Manager/Restorative Nurse to audit residents with splints to ensure splint is on as ordered, one time weekly times 8 weeks then monthly times 3 months.

Audits will be brought through Quality Assurance monthly and trends will be identified and education provided

COMPLIANCE DATE: 1/11/16

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F 318	<p>Continued From page 23</p> <p>On 12/1/15 at 11:45 am, the resident's POA stated there was no restorative nurse aide in the facility, and she did exercises Physical Therapy taught her with the resident everyday.</p> <p>On 12/1/15 at 2:20 pm, the resident's POA was observed with the resident providing aid with strengthening exercises.</p> <p>On 12/1/15 at 3:40 pm, the COTA stated residents discharged from therapies are placed on a walk-to-dine program, but there was no formal restorative program in the facility. She stated Occupational- or Physical Therapy would complete a communication order with restorative therapy orders then nursing would incorporate those orders into their care.</p> <p>On 12/2/15 at 11:15 am, the DNS stated there was no restorative program other than walk to dine.</p> <p>On 12/3/15 at 4:00 pm, the Physical Therapist stated the resident and his POA were taught strengthening exercises, but the exercises were not communicated to nursing staff in anticipation of the resident's discharge from the facility.</p> <p>2. Resident #13 was readmitted to the facility on 11/13/14 with multiple diagnoses, including hemiplegia (paralysis).</p> <p>The resident's 11/16/15 annual MDS assessment documented the resident: *Had upper and lower extremity ROM limitations to one side, and, *Was totally dependant on staff for bed mobility,</p>	F 318	

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F 318	<p>Continued From page 24</p> <p>dressing, toilet use, personal hygiene, and bathing.</p> <p>a. Physiolan's Telephone Orders, dated 8/12/13, documented the resident was to wear a splint on his right hand during the day, but not at night, for contractures.</p> <p>The resident's 10/27/15 ADL care plan documented the resident with right sided hemiplegia and the use of "R [Right] hand splint on in AM (the morning), off at night..."</p> <p>On 12/2/15 at 3:45 pm and 4:15 pm, and on 12/3/15 at 9:05 am and 9:55 am, the resident was observed without a hand splint to his right hand, which appeared to be contracted.</p> <p>On 12/3/15 at 9:48 am, CNA #9 said the resident's hand splint had been missing for over a month and he had not been wearing one during that time frame.</p> <p>On 12/3/15 at 9:55 am, the resident said the splint had been missing for "quite a while" and he did not know when he would receive another one. He was asked if he could move his fingers on his right hand and he reached with his left hand, took hold of his right hand and opened the first two digits of his right hand.</p> <p>On 12/3/15 at 5:20 pm, RCM #11 said the resident should have been wearing the splint, which she did not know had been missing. She said she would have expected staff to inform her so the therapy department could re-evaluate the resident for a new hand splint.</p> <p>b. The resident's November 2015 Physician</p>	F 318	
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F 318	<p>Continued From page 25</p> <p>Orders, dated 1/13/15, documented, "Restorative program 2x/wk [times a week] x 9 wk. Goal: prevent functional decline" and "1# [pound] theraband, UE [upper extremity] strength."</p> <p>The resident's care plan did not document the resident participated in an RNA program.</p> <p>On 12/2/15 at 3:45 pm, the resident said staff did not provide any exercise or RNA program for him.</p> <p>On 12/3/15 at 2:45 pm, Occupational Therapist #10 said the resident would benefit from an RNA program, but the facility did not have an RNA program.</p> <p>On 12/3/15 at 5:20 pm, RCM #11 was asked about the RNA and theraband orders. She said both orders should have been discontinued because the facility did not have an RNA program.</p> <p>3. Resident #7 was admitted to the facility 6/24/14 with multiple diagnoses including Parkinson's disease, Rheumatoid Arthritis, osteoarthritis, and peripheral neuropathy.</p> <p>Quarterly MDS assessments, dated 7/17/15 and 10/16/15, documented the resident had not received Occupational Therapy or Restorative Nursing for the previous 7 days.</p> <p>The ADL care plan, dated 6/24/14, documented the resident had degenerative joint disease, spinal stenosis, and Rheumatoid Arthritis. Interventions included: Escort to activity programs consistent with resident's interest to enhance</p>	F 318	

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F 318	<p>Continued From page 26</p> <p>physical strengthening needs; provide environmental adaptations; and report changes in ADL self performance to nurse. On 7/17/15, decreased strength, endurance, and impaired mobility were added to the care plan. On 8/4/15 the Hoyer lift for transfers was added as an intervention.</p> <p>On 11/30/15, the resident stated she ate most meals in her room. The resident stated, "I have to position my plate right in front of my mouth so I can shovel the food in. It is so discouraging and embarrassing." The resident was then observed to open and close her hands and fingers with difficulty. When asked if she had told anyone about her hands, she stated, "They know about it."</p> <p>On 12/3/15, the Licensed Occupational Therapist stated the resident would be able to tolerate hand dexterity and strength therapy. The therapist stated a Restorative Nursing Program would be beneficial for the resident and she would recommend a program if the facility had a program, but it did not.</p> <p>On 12/3/15, the DNS stated the facility was "re-vamping" the Restorative Nursing Program which it currently did not provide. He stated the facility offered walk-to-dine for residents and Activities offered an informal group exercise program.</p> <p>4. Resident #8 was admitted to the facility on 2/6/15, and readmitted on 10/15/15, with diagnoses of hemiplegia following a stroke.</p> <p>The Quarterly MDS, dated 10/22/15, documented :</p>	F 318	

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F 318	<p>Continued From page 27</p> <p>the resident was cognitively intact, did not reject cares, and had bilateral upper and lower extremity impairment.</p> <p>The Physician's 10/16/15 visit notes documented the resident with chronic left hemiparesis, left sided contractures, spasticity, and discomfort associated with these issues.</p> <p>Resident #6's current Care Plan documented ADL self care deficits with left-sided weakness and contractures, but there were no interventions that addressed concerns with range of motion, left-sided weakness, or the contractures, other than staff assistance with ADLs.</p> <p>The August, September, and October 2015 recapitulated Physician's Orders documented the resident could participate in RNP as appropriate and Physical and Occupational Therapy were to evaluate and treat, but there were no RNP orders for November and December 2015.</p> <p>On 12/1/15 at 8:00 am Resident #6 was observed in the dining room and at 2:15 pm in her bed. The resident's left arm was resting across her abdomen, hand was contracted, and there was no splint or brace in place. The resident leaned to the right in the Broda chair and struggled to eat independently, though the wedge supports were in place. Resident #6 stated she was unable to use her left arm and leg. The resident said neither Occupational Therapy, Physical Therapy, nor nursing provided range-of-motion exercises. The resident stated she did not have a left arm/hand or a left leg/foot splint now, but remembered wearing a hand splint in the past. Resident #6 stated she was unaware of what happened to the splint.</p>	F 318		
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	<p>On 12/3/15 at 10:25 am, PTA #9 stated Physical Therapy had not worked with the resident for over a year, other than a screening about three weeks prior to determine if she needed a mechanical lift for transfers and 1 or 2 staff assistance.</p> <p>On 12/3/15 at 2:40 pm, OT #10 stated Occupational Therapy worked with Resident #8 in July 2015 for left arm and hand placement. OT #10 said Occupational Therapy advised nursing staff provide the resident with a left hand splint and arm trough, however nursing had not complied with those recommendations and the resident was left without the assistive devices. OT worked again with Resident #8 in October 2015, for trunk support with wheelchair positioning because the resident leaned to the right, which impaired right upper extremity function during ADLs. The OT said Resident #8's wheelchair positioning continued to be a concern and the resident would have benefited from a RNP to ensure prevention of ADL decline, worsening contractures, and trunk strengthening.</p>		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	
	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p>		<p>F-323</p> <p>SPECIFIC RESIDENT Resident #1 will be reassessed for toileting plan and fall interventions will be reviewed for appropriateness and care plan updated</p> <p>Resident #6 transfer status has been clarified for accuracy and care plan updated and therapy currently working with resident</p>

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F 323 Continued From page 29

Based on observation, interview and record review, it was determined the facility failed to adequately supervise and assist residents to prevent falls and injury. This was true for 2 of 24 sampled residents (#1 and #6). This failed practice resulted in harm when Resident #1 fell and sustained a left hip fracture requiring surgical repair. Resident #6 was at risk for more than minimal harm when he/she was transferred in a manner inconsistent with the comprehensive assessment and care plan. Findings included:

1. Resident #1 was admitted to the facility on 3/17/12, and readmitted on 7/18/15, with multiple diagnoses, including lower extremity weakness, chronic vertigo, hypertension, and fracture.

The resident's Annual MDS assessment, dated 6/16/15, documented the resident was cognitively intact; required limited assistance of one staff for toileting and transfers; had not ambulated in his room for the previous 7 days; required limited assistance of one staff to ambulate in the corridor; and required balance assistance when moving from a seated- to a standing position, walking, or turning.

Mild cognitive impairment was also noted in a 5/15/15 physician's progress note.

An 11/7/14 incident/Accident Report documented Resident #1 fell at 1:05 pm while attempting to go to the bathroom. No new interventions were added to the resident's care plan at that time regarding changes in the resident's toileting cares or level of assistance provided.

A physician progress note, dated 5/15/15, documented the resident "cannot ambulate due

F 323

OTHER RESIDENTS

Residents who have falls will have interventions implemented and followed as care planned and Residents who need 1-2 transfer assist will be transferred per care plan and gait belts will be used

SYSTEMIC CHANGES:

Fall Huddles were inserviced and implemented as part of Grand Rounds where staff and managers gather to look at scene of fall, the documented description of the fall by the staff, the residents statements if able, and witness statements to determine root cause of fall to ensure that individualized meaningful interventions are put in place for the resident. The intent of the fall huddle was inserviced to the staff and it gives the staff more insight into their role in preventing falls and the importance of ensuring that all interventions are in place and followed. It also shows the staff the importance of noticing all the details so a true picture of what may have contributed to the fall is found so risk of future falls can be minimized. Fall huddles gives managers more information on interventions that work and the need for changing those interventions and or adding increased supervision.

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F 323	<p>Continued From page 30</p> <p>to lower extremity weakness, and also some chronic vertigo."</p> <p>A 6/1/15 a physclan's order documented the resident was to be evaluated and treated by PT.</p> <p>On 6/5/15, a Berg Balance Scale documented the resident was at high risk for falls. A Fall Risk Evaluation, and a second Berg Balance Scale, dated 8/18/15, documented the resident remained at high risk for falls.</p> <p>On 6/19/15, a Rehabilitation Services Multidisciplinary Screening Tool documented the resident had experienced two episodes of incontinence. The form documented the resident said he was having increased difficulty controlling his bowel and bladder. The form documented the resident was to have a urinal placed close to him, but the resident's cere plan was not updated with this information.</p> <p>On 7/1/15, a PT progress note documented the resident "continues to demonstrate significant balance deficits and is at risk for falling according to all the outcome measures."</p> <p>On 7/10/15, PT documented the resident refused ambulation due to lower extremity weakness and concern with his left knee buckling.</p> <p>On 7/13/15 at 12:34 pm, PT documented the resident had a Berg evaluation which showed some improvement in standing balance, however the resident's score indicated he continued to be at risk for falls.</p> <p>A 7/13/15 Incident/Accident Report documented Resident #1 fell at 2:45 pm, when he stood up</p>	F 323	<p>Nursing staff inserviced on mandatory use of gait belts with transfers and on transferring per careplan, Mandatory gait belt use to be covered in orientation and staff to sign Mandatory Gait belt form for their personel file.</p> <p>Nurse Managers will follow up and complete audit on all fall huddles to ensure careplan and resident or residents room have current interventions (which may include increased supervision) in place and these interventions are careplanned. The fall huddle, careplan and intervention in place audit will be after each fall ongoing. These will be turned into the DON for review.</p> <p>Nurse managers to observe 5 transfers weekly to ensure proper gait belt use and transfer status are being followed. Nurse Managers or designees will audit 5 random residents per week to ensure that careplanned fall interventions are in place. These Audits to be done weekly x8 and monthly x3 and turned into the DON for review.</p> <p>Audits will be brought through Quality Assurance monthly and trends will be identified and education provided. Trends of falls will be brought thru QA monthly looking at times of day, need for changing process or routines, and need for increasing supervision on a hall or resident.</p> <p>COMPLIANCE DATE: 1/11/16</p>

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F 323	<p>Continued From page 31</p> <p>from bed to void, could not find his urinal, and was attempting to urinate into a pink basin. The I/A Report documented Resident #1 "lost his balance when he stood up resulting in falling to the floor landing on his left side." According to the Report, Resident #1 was to be toileted every two hours, but was last toileted at noon. The Report did not document where the urinal was located at the time of the fall. The resident complained of pain to his left hip that was "10 out of 10" on a 10-point pain scale.</p> <p>Nursing Progress notes from 7/13/15 to 7/15/15 documented the resident continued to complain of left hip pain prior to being transferred to a hospital and diagnosed with a left hip fracture.</p> <p>On 12/1/15 at 4:09 pm, the wound care nurse and surveyor entered Resident #1's room. The resident reported he was incontinent of urine, which had "run down my leg." The resident's pants were observed to be wet with urine. The wound care nurse and CNA #20 assisted the resident to the bathroom, removed his pants, provided peri-care, and changed his adult brief. The resident's urinal was at his bedside during the observation.</p> <p>On 12/3/15 at 3:45 pm, RCM #1 said Resident #1 preferred to have his urinal on his bedside table, as it was important to him to take care of his personal needs as independently as possible. She was aware of the rehab recommendation from 6/19/15 to place the urinal at bedside, but did not know why that intervention had not been added to the care plan. She stated for infection control purposes, the urinal typically sat in a large pink basin, rather than directly on the table surface. She said at the time of the fall the</p>	F 323	

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F 323	Continued From page 32 resident should have been tolleted every two hours because he was not able to toilet independent of staff assistance. On the day of the fall, the RCM stated, the urinal had been taken to the bathroom to be rinsed out, but was not returned to the bedside. When the resident needed the urinal and could not find it, he tried to stand and maneuver to urinate into the pink basin where the urinal usually sat, lost his balance, and fell. 2. Resident #6 was admitted to the facility on 2/6/15, and readmitted on 10/15/15, with diagnoses of left sided hemiplegia following a stroke. The current ADL Care Plan documented the resident required extensive- to total assistance of 1-2 staff for ADLs and a mechanical lift with 2 staff assisting for transfers. Resident #6's Quarterly MDS, dated 10/22/15, documented the resident was cognitively intact, had bilateral upper and lower extremity impalment, and required the total assistance of two staff for transfers. On 12/1/15 at 4:40 pm, CNAs #17 and #18 were observed transferring Resident #6 from a Broda chair without the use of a mechanical Hoyer lift; LN #8 was present during the transfer. Each CNA supported the resident under either arm, instructed the resident to help, lifted her to a standing position, and quickly pivoted her onto the bed. The resident was not provided with a gait belt during the transfer. LN #8 asked the two CNAs why the resident did not have a gait belt on during the transfer and explained the gait belt was needed for safety with Resident #6. CNA #18 stated she had a gait belt with her, but had failed	F 323		
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F 323	Continued From page 33 to place the belt on the resident. On 12/3/15 at 9:20 am, RCM #11 stated the resident was "extremely weak" upon admission to the facility and required the mechanical lift for transfers. RCM #11 said the resident was recently assessed by Physical Therapy and was determined to be capable of helping with transfers with the assistance of one-to-two staff. The RCM stated the facility's transfer policy required 1-to-2 staff and use of a gait belt.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interview, and record review, it was determined the facility failed to administer oxygen per physician order for 1 of 5 sampled residents (#10). This failure created the potential for the resident to experience unmet respiratory needs. Findings Included: Resident #10 was admitted to the facility on	F 328	F328 SPECIFIC RESIDENT Resident #10 oxygen order clarified and being administered as ordered OTHER RESIDENTS: Residents who have orders for oxygen will ensure that it is on as ordered SYSTEMIC CHANGES: In-serviced nursing staff to ensure oxygen is on as ordered MONITOR: Nurse managers will audit 10% of residents on oxygen weekly x8 and monthly x3 to ensure it is on as ordered Audits will be brought through Quality Assurance monthly and trends will be identified and education provided. COMPLIANCE DATE: 1/11/16	

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F 328	<p>Continued From page 34 9/22/15, and readmitted on 10/26/15, with multiple diagnoses, including COPD.</p> <p>The September 2015 care plan documented the resident had the potential for difficulty breathing related to COPD and CHF.</p> <p>The 10/26/15 2015 Physician's Orders documented Resident #10 was to receive continuous oxygen at 2 liters per minute via nasal cannula for COPD.</p> <p>On 12/1/15 at 9:20 am, the resident was observed sitting in a wheelchair without oxygen. When asked why she was not equipped with her oxygen, the resident said, "I don't know."</p> <p>On 12/1/15 at 9:40 am, LN #1 checked the resident's oxygen saturation level, which was 92%. She then placed the nasal cannula and adjusted the flow to 2 liters per minute. LN #1 stated the resident was supposed to receive continuous-flow oxygen.</p>	F 328	<p>F-329</p> <p>SPECIFIC RESIDENT Resident #2 and #10 have medication orders documented on MAR for the correct length of time that the MD has ordered.</p> <p>F 329 Resident #7 GDR of Seroquel was attempted.</p> <p>Resident #8 Will have behavior meeting and review medications and behavior monitor for appropriateness.</p> <p>OTHER RESIDENTS: Residents who are on antipsychotic medications have been assessed for appropriateness and also residents who are on a medication that has a stop date have been assessed</p>
F 329 SS=E	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents</p>	F 329	

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F 329 Continued From page 35
who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, it was determined the facility failed to:

- * Ensure an antipsychotic medication had an applicable diagnosis and clinical indication for use; and
- * Ensure medications were not administered beyond the discontinue date.

This deficient practice created the potential for harm due to unnecessary and duplicate medication being administered. This was true for 4 of 10 sampled residents (#2, 7, 8, and 10). Findings included:

1. Resident #7 was admitted to the facility with multiple diagnoses, including depression.

December 2015 Physician Orders documented the resident was to receive Seroquel 60 mg tablet daily for psychosis. The order was initiated on 7/31/15.

The Psychosocial Well-being care plan, dated

F 329 SYSTEMIC CHANGES:

Behavior management Team will meet monthly to review residents on psychotropic medications. All residents currently on an antipsychotic or who are admitted with an antipsychotic will have their medication listed on Antipsychotic Medication Quarterly Evaluation (this form will be used monthly not quarterly) during their entire stay at BVE or until we are able to GDR the antipsychotic and d/c it. All new admits who are an antipsychotic will be brought through The Behavior Management Team and they will ensure that all new admits and anyone previously brought through the meeting with any follow up, will be done by that time. Prior to the meeting all resident on an antipsychotic medication will have an audit filled out to ensure there is an appropriate indication for us, a applicable diagnosis and when the last GDR was attempted, which is to be reflected on the Antipsychotic Medication Quarterly Evaluation. DON or RCM to ensure that monthly behavior summary matches the current audit that indications of use with an applicable diagnosis present and that if there are zeros on the behavior monitor or it is time for a dose reduction this is put in place or the clinical reason why not is explained by the MD. This will be an ongoing system monthly in the Behavior Meeting. In addition, the LSW

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F 329	<p>Continued From page 36</p> <p>7/1/15, documented the resident had episodes of auditory and visual hallucinations which were "annoying," but did not frighten her. Staff were to determine whether there was any validity to the resident's suspicion; allow the resident to express her feelings and concerns; provide reassurance to her that staff were there for her and she was safe; and not to argue with her or tell her that she was "seeing things."</p> <p>The PN, BMFS, and MBS for June 2015 through December 3, 2015 documented:</p> <ul style="list-style-type: none"> * The resident experienced hallucinations on 8 of 155 days. Non-pharmacological interventions of reassurance and redirection were implemented with positive results. * The resident told nursing staff she was experiencing auditory and visual hallucinations. Non-pharmacological interventions of reassurance and redirection were implemented with positive results. * The resident said she felt like a hypochondriac and asked the nurse if he/she thought it was possible the resident fabricated these stories (hallucinations) or saw things on television that became real to her. The PN documented the nurse told the resident, "There was a very good chance she had lost touch with the world. The resident agreed and seemed to be okay after that." * "Visual hallucinations and paranoia have been present for approximately 6 months. [The resident verbalizes] mild distress at night and requests reassurance that there is no one in the closet. The resident reports she thinks things are better this week." * New order (7/16/15) for Seroquel 12.5 mg for ten days, increased to 25 mg for one week, and then increased to 60 mg for night psychosis 	F 329	<p>consultant will audit the antipsychotics each quarter she is here and make recommendations as needed. Any physicians that are not complying with the standards related to antipsychotics, their dose or attempting a GDR, will be brought to the attention of the Medical Director in a timely manner, either verbally by DON or through the Medical Director Oversight Committee which is held the last week of every month.</p> <p>In-serviced nursing staff and social services on indication for use of antipsychotic medication and accurate behavior monitors reflecting reason for use. Also in-serviced the need to look at non-pharmacological interventions to look for effectiveness before making medication adjustments and to document indication for use of each medication. Quarterly in-services will be presented on behavior monitors, clinical indication for use and GDR requirements. A copy of "Guidance for Antipsychotics in the LTC Setting" issued by Omnicare pharmacies has been laminated and placed in the front of all MAR's, given to our Medical Director, out on-site physician, as well as our Behavior Management Team to help use as a guide for antipsychotic is in our setting.</p>	

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F 329	<p>Continued From page 37</p> <p>manifested by auditory hallucinations. * The resident stated she was still having hallucinations, but they were not harmful to her. * "The resident does see or hear people at times, however the resident stated, "They don't scare me, [they are] more of an annoyance." (Social Service Note 8/11/15) * The resident continued to have hallucinations, but of a less disturbing and intrusive nature. * The resident's visual and auditory hallucinations decreased.</p> <p>On 12/4/15 the RSD stated she was unable to describe how the facility determined the resident's hallucinations were distressing and harmful. The RSD stated non-pharmacological interventions, reassurance, and redirection resulted in a positive outcome for the resident. The RSD stated she could not explain why an antipsychotic medication was initiated when non-pharmacological interventions resulted in a positive outcome.</p> <p>2. Resident #8 was admitted to the facility on 5/15/15 with multiple diagnoses, including bipolar disorder, anxiety, and insomnia.</p> <p>A quarterly MDS assessment, dated 11/20/15, documented the resident had no behaviors, minimal depression, and no difficulty with sleeping patterns.</p> <p>The November 2015 recapitulated physician order documented the resident was to receive Amitriptyline 150 mg (5/1/15) daily at bedtime for sleep, and Xanax 0.5 mg (8/25/15), as needed, for insomnia.</p> <p>On 12/4/15 at 9:20 am, the RCM stated</p>	F 329	<p>Nursing also in-serviced on ensuring that orders with stop dates are adequately transcribed on MAR to ensure MD order is followed</p> <p>Review of orders written by nursing staff indicates a need for continued education as new nurses come into the facility. Education on how to write and note a physician order will be done on orientation and quarterly on going.</p> <p>MONITOR Nurse Manager to audit all orders that have a stop date to ensure the orders are transcribed and documented on MAR as ordered weekly x8 and monthly x3</p> <p>Members of the BMT to audit all residents on antipsychotic medications to ensure proper indication for use and diagnosis is in place and GDR is timely.</p> <p>Audits will be brought through Quality Assurance monthly and trends will be identified and education provided as needed.</p> <p>COMPLIANCE DATE: 1/11/16</p>	

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F 329	<p>Continued From page 38</p> <p>Amitriptyline and Xanax were being used to promote sleep. A November 2015 sleep monitor documented Resident #8 slept 7 hours each evening. The RCM was unable to explain how it had been determined those medications were indicated as appropriate to help this resident sleep.</p> <p>3. Resident #2 was admitted to the facility on 10/1/15 with multiple diagnoses, including dementia with behavioral disturbances and emphysema.</p> <p>The 11/10/15 Physician's Telephone Orders documented the resident was to receive Levaquin 750 mg daily for 10 days, Duoneb SVN TID for 10 days, and Floraster Probiotic BID for 7 days.</p> <p>The November 2015 MAR documented Levaquin was administered daily for 12 days, from 11/9/15 through 11/20/15, rather than 10 days as ordered. Duoneb was administered daily for 13 days, from 11/11/15 through 11/25/15, rather than 10 days as ordered. The MAR documented the Levaquin was administered once on 11/23/15 and 11/25/15; and twice on 11/24/15. Probiotic was administered for 18 days, from 11/11/15 through 11/28/15, rather than 7 days as ordered.</p> <p>4. Resident #10 was admitted to the facility on 9/22/15, and readmitted on 10/26/15, with multiple diagnoses, including urinary tract infection and colitis.</p> <p>The 9/22/15 Physician's Order documented the resident was to receive Levaquin 750 mg tablet daily for a diagnosis of aspiration pneumonia. The final dose was to be administered on 9/24/15.</p>	F 329		
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F 329	Continued From page 39	F 329		
F 353 SS=E	<p>The September 2015 MAR documented the first dose of Levaquin was administered on 8/23/15 and the last dose was given on 8/29/15. The MAR documented the resident received four extra doses of Levaquin.</p> <p>On 12/2/15 at 4:30 pm LN #1 said there was no order in the resident's chart to administer the medication for five more days.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (o) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 353	<p>F-353 SPECIFIC RESIDENT Residents #3,6,7,13 have been screened by therapy and have had no functional decline</p> <p>OTHER RESIDENTS Residents who could benefit from restorative could be affected</p> <p>SYSTEMIC CHANGES Competencies completed on two nurses to oversee RNA program and two CNAs to operate the RNA program. 3 times weekly the Director of Nursing and Staffing Coordinator will evaluate the staffing in the restorative program. Each evaluation will include the appropriate discussion of retention and recruitment as needed to ensure that adequate staffing is available and allocated in the restorative program.</p> <p>In-service staff regarding implementation of the restorative program</p> <p>In-service Restorative nurse and aides on requirements of the restorative program</p>	

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F 353	<p>Continued From page 40</p> <p>Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of residents who required a restorative nursing program. This affected 4 of 14 (#s 3, 6, 7, & 13) sampled residents and had the potential to affect all residents who were at risk for developing a functional decline. This failure created the potential for physical decline if residents did not receive restorative services. Findings included:</p> <p>On 12/2/15 at 9:05 am, CNA #9 said she formerly assisted residents with the Restorative Nursing Assistant (RNA) program, but had been reassigned several months prior to perform other duties due to lack of staff.</p> <p>On 12/3/15 at 10:25 am, PTA #9 said he would refer residents to the RNA program if one would have been one in place.</p> <p>On 12/3/15 at 2:45 pm, Occupational Therapist #10 said she would recommend several residents to the RNA program, but the facility did not have an RNA program due to lack of staffing.</p> <p>On 12/3/15 at 4:50 PM, the Administrator said the RNA program was discontinued around or about January of 2015 due to lack of CNA staff and RNA staff were reassigned other duties. He said the RNA program had not been started yet and the facility was in the process of implementing it again.</p> <p>Please refer to F318 for details related to the lack of restorative nursing services for Resident #s 3, 6, 7, and 13.</p>	F 353	<p>MONITOR DON to audit the Restorative Staffing to ensure staffing is adequate to provide restorative as ordered weekly x8 and monthly x3</p> <p>Monthly the DON will bring the Audits and the staffing evaluations through Quality Assurance Committee to monitor the system.</p> <p>COMPLIANCE DATE: 1/11/16</p>	

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F 364 F 364 SS=E	Continued From page 41 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on the Resident Council Meeting minutes, Resident Group Interview, individual interview, test tray evaluation and staff interview, it was determined the facility failed to serve food at a palatable temperature. This affected 1 of 14 (#7) sampled residents, 2 random residents (#s 28 & 29) and 6 of 14 residents who attended the Resident Group interview, and had the potential to affect all residents who dined in the facility. This failed practice created the potential to negatively affect residents' nutritional status and psychosocial well-being related to unpalatable food. Findings included: Resident Council Meeting minutes documented: -8/25/15-"All residents c/o their food being cold in the dining rooms." -9/1/15-"One resident c/o the food being cold in the Twin Falls dining room." and, -9/29/15-"Meals are cold at times." * On 11/30/15 at 3:10 pm, Resident #7 said food was cold, especially the oatmeal, * On 12/1/15 at 9:40 am, Resident #29 said the eggs and oatmeal were cold, and * On 12/2/15 at 4:15 pm, Resident #28 said the food was served cold.	F-364 F 364 F 364	SPECIFIC RESIDENT: Resident #7, 28 and 29 Dietary Services individually interviewed them on palatability of food OTHER RESIDENTS: Any resident receiving meals can be affected SYSTEMIC CHANGES: Identified that the timing between the time the dietary staff plates the food and the time it is served to the residents was root cause for food temperatures not adequate. System implemented that when the dietary dept is complete with plating the food they will quickly deliver the food to the appropriate location and notify the charge nurse who will then utilize the walkie talkies to notify the CNA's who will then pass out the food to the appropriate location of the building. In-serviced dietary and nursing staff on the importance of utilizing the system and getting trays passed timely to ensure food is served hot and also improve palatability. MONITOR: Director of Dining services will complete audits weekly x3 months asking 10% of residents specifically about the palatability of foods	

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F 364	Continued From page 42 On 12/1/15 at 11:15 am, during the Resident Group Interview, 6 of 14 residents said the food was not served hot and was unpalatable. On 12/3/15 at 8:50 am, a breakfast meal test tray was evaluated by the survey team and CDM #2. The test tray included oatmeal with a temperature of 78-degrees F. CDM #2 said the oatmeal was, "ice cold." The scrambled eggs had a temperature of 95 F and CDM #2 said, "it's not hot."	F 364	Director of Dining Services will hold a monthly menu meeting with the residents and ask for feedback on palatability of foods monthly x3 Dietician will audit processes by doing a weekly test tray audit and evaluate the delivered tray for palatability x3 months Audits will be brought through Quality Assurance monthly and trends will be identified and education provided	
F 371 66=E	463.36(l) 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 failed to ensure food was prepared and served under sanitary conditions when 2 of 2 quaternary sanitizing solution buckets tested at zero. This had the potential to affect 12 of 14 (#s 1-5, 7-12 & 14) sampled residents and all residents who dined in the facility. This failure created the potential of cross contamination from inadequate concentration of cleaning solution used on food preparation and non-food	F 371	COMPLIANCE DATE: 1/11/16 F-371 SPECIFIC AND OTHER RESIDENTS: Resident #1 -5, 7-12 and 14 All residents who dine in facility could be affected and will have food prepared and served under sanitary conditions. SYSTEMIC CHANGES: All Kitchen staff in-serviced on preparation of sanitizer buckets and documenting PPM throughout the shift MONITOR Clinical Dietary Manager will review the sanitizer logs daily x 3months to ensure food is prepared and served under sanitary conditions. The consultant RD will audit by randomly checking rag bucket PPM x3months	

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F 371	Continued From page 43 preparation surfaces. Findings included: On 11/30/15 at 12:00 pm, CDM #2 tested two of two quaternary sanitizing solution buckets with cleaning cloths in them. CDM #2 said the solution tested at "zero," which meant the solution was at an ineffective level.	F 371	Audits will be brought through Quality Assurance monthly and trends will be identified and education provided COMPLIANCE DATE: 1/11/16	
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. 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	F 431	SPECIFIC RESIDENT: Heparin Lock Flush solution and IV solutions removed from Med room and discarded #14 Expired cream removed from room and discarded OTHER RESIDENTS: Residents in facility who utilize medications from medication rooms and bring medications from home may be affected SYSTEMIC CHANGES: Identified that the nursing staff routine checks of expired medications was not adequately covering the IV Fluid and heparin flushes and other medications that may be at bedside because they are stored/located in a different area than where the majority of the medications are located. System changes include a list of locations for Resident Care Managers and other nursing staff to identify expired medications. Every other week Nursing staff will use that location list and check	

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F 431	<p>Continued From page 44</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure expired IV fluids and heparin flushes were removed from the medication rooms. This was true for 2 of 3 medication rooms checked for expired medications and for 2 of 14 sampled residents (#s 1 and 14). This failed practice created the potential for decreased efficacy for any resident who could receive the expired IV fluid and heparin flushes.</p> <p>1. On 12/2/15 at 11:30 am, the Sawtooth Medication Room had 13 Heparin Lock Flush Solution 5 ml syringes with an expiration date of 10/2015 and seven bags of 1000 ml 5% Dextrose and 0.9% Sodium Chloride IV solution with an expiration date of 10/2015. The Thousand Springs Medication Room had seven bags of 1000 ml 5% Dextrose and 0.9% Sodium Chloride IV solution with an expiration date of 10/2015. RCM #1 stated the expired medications were available for administration to residents and would be disposed of properly.</p> <p>2. On 11/30/15 at 11:30 am and 12/02/15 at 10:00 am, a tube of Bidrozil (Nistatinal Triamcinolone) cream was on the bedside table of Resident #14. The cream label documented it expired November 2014.</p>	F 431	<p>those areas and remove medications prior to expiration.</p> <p>In-serviced nursing staff to ensure expired medications are removed from medication room before they expire and admission nurse in-serviced to educate residents and families upon admission to not bring in medications from home.</p> <p>MONITOR:</p> <p>Nurse managers will audit 10% of resident rooms and medication rooms weekly x8 and monthly x3 to ensure expired medications are not at bedside or in medication room.</p> <p>Location list and routine checks for outdated medications along with the Audits will be brought through Quality Assurance monthly and trends will be identified and education provided</p> <p>COMPLIANCE DATE: 1/11/16</p>

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F 431	Continued From page 45	F 431		
	On 12/02/15 at 12:25 pm, LN #11 stated the medication should not be stored in the resident's room.		F441 SPECIFIC RESIDENT Resident #24 catheter tubing is not on floor	
F 441 SS=D	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 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	F 441	OTHER RESIDENTS Residents who have catheters could be affected and tubing will not drag on the floor. SYSTEMIC CHANGES In-serviced nursing staff to ensure that catheter tubing is not on the floor and if catheter tubing comes apart and staff touches any surface including floor, they must change gloves prior to cleaning and putting tubing back together. MONITOR Nurse Managers to audit residents with catheters weekly x8 and monthly x3 to ensure that tubing is not on the floor. 5 CNA's will be randomly questioned on proper procedure if catheter tubing comes apart and touches the floor. Audit will be weekly x8 then x3 monthly. Audits will be brought through Quality Assurance monthly and trends will be identified and education provided COMPLIANCE DATE:1/11/16	

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F 441	Continued From page 46 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to prevent the spread of infection for 1 of 24 sampled residents (#24). This deficient practice had the potential for infection when Resident #24's catheter tubing dragged on the floor. Findings included: Resident #24 was admitted to the facility 4/26/10 with multiple diagnoses, including overactive bladder. The December 2015 physician recapitulation orders documented the resident had an indwelling suprapubic catheter. On 12/2/15 at 11:00 am, the resident's catheter tubing was observed dragging on the floor. CNA #14 picked up the tubing, and two connections came apart on the tube. The two connections lay on the floor while the CNA put on gloves. The CNA was observed placing both gloved hands on the floor before picking up the two connections, swabbing them with alcohol, hooking them together, and placing the catheter tubing back into the bag. CNA #14 stated the catheter tubing should not have been on the floor.	F 441		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency	F 518	F518 SPECIFIC RESIDENT: No specific resident identified OTHER RESIDENTS: All residents in facility	

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F 518	<p>Continued From page 47</p> <p>procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of emergency policies and procedures, it was determined the facility failed to ensure 2 of 3 interviewed staff members were trained to respond in emergency situations. The failure placed residents' safety at risk if the untrained staff were to respond inappropriately in a natural disaster, fire, and missing person situation. Findings included:</p> <p>The facility's General Fire Procedures documented staff discovering a fire, were to remove anyone in the room, call out "code red," close the door to the fire room, activate the fire alarm, close all doors and windows in the fire zone, and evacuate as directed by the person in charge. The team would then attempt to extinguish the fire if possible, mark the fire room door, and turn off the oxygen supply.</p> <p>a) On 12/2/15 at 3:45 pm, Dietary Aide #21 stated during the event of a fire in the kitchen, staff were to push the hallway cart away, make sure there were no residents in the vicinity, and call for help. He was unable to recall procedures to contain and evacuate. When asked about natural disaster, he stated he got a policy and procedure about it but did not read it.</p> <p>On 12/2/15 at 4:15 pm, the Maintenance Director approached the surveyor and said the staff</p>	F 518	<p>SYSTEMIC CHANGES: In-serviced staff regarding protocols to follow in case of a natural disaster, fire and missing person situation</p> <p>MONITOR: Maintenance Director to interview 10% of employees weekly x8 and monthly x3 to ensure they know how to follow emergency protocols</p> <p>Audits will be brought through Quality Assurance monthly and trends will be identified and education provided</p> <p>COMPLIANCE DATE: 1/11/16</p>	

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F 518	Continued From page 48 member was new and provided staff training records for emergency procedures, including the identified staff member, dated August 2015. b) On 12/3/15 at 11:07 am, CNA #4 said in the event of a fire she would call a code red, protect the resident, and she did not know what else to do. The CNA said she did not know what to do if an aggressive person entered the building. She said she would call the charge nurse for a missing resident. She said she did not know where to report if there was a natural disaster.	F 518		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 520	F-520 SPECIFIC RESIDENT Resident #3,6,7,13 have been screened by therapy and have been assessed for a RNA program OTHER RESIDENTS Residents who could benefit from restorative program SYSTEMIC CHANGES: Identified that in the facility that there was not a clear delineation of duties to assure QAA committee was sufficiently monitoring and planning. The process of ensuring the Administrator is responsible for establishing meeting times and having the committee members responsible for collecting data, and the committee monitoring and planning was established.	

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F 520	<p>Continued From page 49 a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility's QAA failed to take actions that identified and resolved systemic problems for 4 of 14 (#s 3, 6, 7, & 13) sampled residents, with the potential to affect any resident who required RNA. This failure resulted in the QAA committee providing insufficient monitoring and planning to ensure residents' care needs were met. Findings included:</p> <p>The QAA committee failed to address the lack of an RNA program, identify a root cause, plan to correct the lack of programming and re-establish an RNA program from January 2015 until 10/29/15, when it was noted as an item in the meeting minutes. There were no new action plans following the 10/29/15 QAA meeting.</p> <p>On 12/3/15 at 5:55 pm, the Administrator said the QAA committee had not been involved in the re-establishment of an RNA program.</p>	F 520	<p>Administrator and DON have been in-serviced on the QAA this process and to ensure appropriate follow up is completed</p> <p>.MONITOR: Regional Director of Clinical Services will review the QAA process to ensure the delineation of duties are clear and the committee has met, monitored and planned accordingly monthly x3</p> <p>Audits will be brought through Quality Assurance monthly and trends will be identified and education provided</p> <p>COMPLIANCE DATE: 1/11/16</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/04/2015
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NAME OF PROVIDER OR SUPPLIER
BRIDGEVIEW ESTATES

STREET ADDRESS, CITY, STATE, ZIP CODE
**1828 BRIDGEVIEW BOULEVARD
TWIN FALLS, ID 83301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state licensure and complaint survey conducted at the facility from November 30, 2015 to December 4, 2015.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Kendra Deines, RN, BSN Brad Perry, LSW Linda Hukilli-Neil, RN Linda Kelly, RN Angela Morgan, RN, BSN Preslie Billington, RN</p> <p>Definitions included: ICN = Infection Control Nurse</p>	C 000	<p><i>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</i></p>	
C 666	<p>02.150.02,c Quarterly Committee Meetings</p> <p>c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson. This Rule is not met as evidenced by: Based on review of the Infection Control Meeting Minutes and staff interview, it was determined the facility failed to ensure a representative from each department was included and signed in at the Infection Control Meetings. This failure had the potential to affect all residents, staff and visitors to the facility. Findings included:</p> <p>On 12/3/15 at 10:38 am, during the review of the Infection Control Protocol with the former and newly appointed ICNs, sign-in sheets from monthly Infection Control Meetings revealed the Medical Director did not attend any of the monthly</p>	C 666	<p>STATE CITATIONS</p> <p>C-666</p> <p>SPECIFIC RESIDENT</p> <p>None.</p> <p>OTHER RESIDENTS</p> <p>All Residents have the potential to be affected and medical director will attend infection control meeting quarterly.</p> <p>SYSTEMIC CHANGES</p> <p>Training provided to Infection Control Committee on ensuring the Medical</p>	

RECEIVED
JAN 22 2016
FACILITY STANDARDS

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

TITLE

(X6) DATE

STATE FORM

22GZ11

If continuation sheet 1 of 2

[Handwritten Signature]

Executive Director

12-31-15

Executive Director *1-20-16*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/04/2015
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NAME OF PROVIDER OR SUPPLIER BRIDGEVIEW ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1828 BRIDGEVIEW BOULEVARD TWIN FALLS, ID 83301
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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) COMPLETE DATE
C 666	Continued From page 1 meetings for May through November. The former ICN said he would conduct individual briefings of the meetings for those who were not present and then asked those committee members to sign the minutes.	C 666	Director attends the Infection control meeting quarterly in accordance to regulation. Medical Director will coordinate his schedule to assure compliance. MONITOR Director of Nursing will bring the Infection Control sign in sheet to the QAPI meeting monthly for review and monitoring. Audits will be brought through Quality Assurance monthly and trends will be identified and education provided COMPLIANCE DATE: 1/11/16	



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
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January 5, 2016

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On **December 4, 2015**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006548

The complaint was investigated in conjunction with the facility's Federal Recertification and Complaint Investigation survey conducted November 30, 2015 to December 4, 2015.

Observations of interactions between staff and residents were completed during the survey. Accommodation of needs and cares provided to the identified residents and fourteen other residents were also completed. The identified resident was also observed on night shift for accommodation.

Records reviewed included July 2014 grievances, July 2014 Incident and Accident reports, July 2014 daily care documentation for the identified residents, and abuse investigations from June to November 2015. Interviews were also completed during the survey, including identified staff members regarding administration notification of the incident. The identified resident and four other residents were interviewed regarding accommodation of needs and past occurrences of neglect. Finally, nine staff members were interviewed regarding identification of abuse or neglect, and the corresponding reporting requirements.

Jeffrey Corriher, Administrator
January 5, 2016
Page 2 of 2

Allegation #1: The complainant reported a certified nursing assistant did not check on two identified residents for an entire night shift; one resident was left in a wheelchair all night.

Findings #1: Interactions between staff and residents were appropriate throughout the survey; residents' needs and cares were accommodated across all shifts. The identified residents' daily cares and needs were documented as complete in July 2014. One of the identified residents interviewed revealed no problems with neglect in the past and across all shifts; four other interviews with sampled residents revealed no issues with being provided care or neglect. July 2014 daily care documentation for the identified residents was complete with no days of missing cares.

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

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The complainant reported the allegation of neglect of was not reported to administration after being reported to three different staff members.

Findings #2: No grievances or Incident and Accident reports documented the allegation of neglect in July 2014. Identified staff members could not recall the incident or if it was reported to facility administration. Other suspected abuse investigations from June to November 2015 were thorough, complete, and reported appropriately. Staff interviewed regarding identification of abuse or neglect knew the reporting requirements and what to report to whom.

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

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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December 31, 2015

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On **December 4, 2015**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006574

The complaint was investigated in conjunction with the facility's Federal Recertification and Complaint Investigation survey conducted from November 30, 2015 to December 4, 2015.

Observations during the medication pass task were made, including observations of nurses destroying controlled medications, storage of controlled medications, and distribution of medications (with count). The treatment nurse was observed performing ordered treatments and staff interactions were observed across all shifts.

Facility documents reviewed included the destruction policy for controlled medications and past investigations of suspected narcotic diversions. The Treatment Administration Records of three identified residents and fourteen additional residents were reviewed. Grievances for July 2014 were reviewed, as well as June to November 2015. Abuse and neglect investigations from June to November 2015 were reviewed.

Five nurses were interviewed regarding the procedure for destroying narcotic medications. In addition, thirteen residents were interviewed regarding staff's facial expressions at night, and nine staff members regarding identification of abuse and reporting requirements were interviewed.

Allegation #1: The complainant reported a nurse was destroying narcotics alone in a room, while two other nurses stood outside the door then signed as witness to the destruction of the medications.

Findings #1: No observations of inappropriate destruction of controlled medications were made; narcotic medications were distributed as ordered and counts were accurate. Nurses interviewed described the procedure for destruction and were consistent with the documented policy and procedure. Investigations of past instances of narcotic discrepancies were complete and included the required investigative components. Law enforcement was notified and involved appropriately in all instances.

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

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The complainant reported the treatment nurse did not complete treatments on three residents as ordered.

Findings #2: The treatment nurse completed treatments as ordered. The Treatment Administration Records of seventeen residents were complete and accurate. There were no grievances regarding treatments not being completed by the treatment nurse.

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

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The complainant reported a staff member went into residents' rooms, turned on the lights at night, and made faces at the residents.

Findings #3: Staff interactions with residents were appropriate. Grievances and Incidents and Accident reports did not document inappropriate facial expressions by staff. All thirteen residents interviewed denied any staff making faces at them on the night shift. Abuse and neglect investigations from June to November 2015 were complete and contained the appropriate investigative elements. Nine staff members and the administrator reported the appropriate ways to identify abuse or neglect, and proper reporting procedures.

Based on observations, record review, and interviews, the allegation could not be substantiated due to lack of evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Jeffrey Corriher, Administrator
December 31, 2015
Page 3 of 3

Allegation #4: The complainant reported a staff member's name was forged in a narcotic count book.

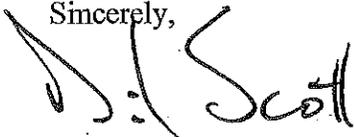
Findings #4: The reported allegation was not cited as there is no regulation related to this issue.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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.

Sincerely,

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

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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December 31, 2015

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On **December 4, 2015**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006751

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from November 30, 2015 to December 4, 2015

Fall precautions were observed for six residents during the survey. The medical record of the identified resident and 10 other residents were reviewed for falls and/or delay of treatment concerns. The facility policy for medical records release was reviewed along with the facility's admission agreement related to medical records release. The facility's grievance file and Incident and Accident reports for March to July 2014 and June to November 2015 were reviewed. The Resident Council minutes from September to November 2015 were also reviewed.

During the survey six individual residents, 14 residents in the Resident Group meeting and two family members were interviewed. The Director of Nursing and Resident Care Manager were interviewed regarding Quality of Care concerns and the Health Information Management Director was interviewed regarding the medical record request procedure.

Allegation #1: The complainant stated an identified resident was not protected and the resident fell and fractured his/her back.

Findings #1: Fall precautions were observed for six residents. The medical record of the identified resident and six other residents were reviewed for falls. The Resident Care Manager and Director of Nursing were interviewed regarding falls and fall prevention.

Based on record review 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 another resident regarding falls with injury and the facility was cited at F323. Please refer to the survey report for the detailed findings.

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: An identified resident experienced a delay in treatment following two separate falls and the physician was not notified following one of the falls.

Findings #2: The medical record of the identified resident and 10 other residents were reviewed for delay of treatment and physician notification without concerns. Interviews with six residents and two family members did not express a concern with delay of treatment. The Resident Care Manager and Director of Nursing said when a resident falls, they do not experience a delay in treatment and the physician is notified.

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

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: An identified resident experienced a functional decline when he/she was restrained by alarms placed near or on the resident.

Findings #3: Fall precautions were observed for six residents and none of the residents had alarms as a fall prevention measure. The medical record of the identified resident and six other residents were reviewed for fall prevention and restraints. The Resident Care Manager and Director of Nursing said the identified resident received adequate fall prevention measures without affecting functional decline and the facility no longer used alarms.

Since the time of the complaint, the facility has implemented an alarm free policy for the entire facility.

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

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Jeffrey Corriher, Administrator
December 31, 2015
Page 3 of 3

Allegation #4: The medical records department would not provide copies of records to a Power of Attorney without the appropriate paperwork. A legal representative was also denied access to a resident's medical records.

Findings #4: The facility's grievance file for March to July 2014 and June to November 2015 did not document a concern regarding medical records requests. The facility's admission agreement was reviewed and it documented the legally responsible party can ask for medical records either verbally or in writing. One resident in the group interview said he/she requested and received medical records without any concerns. The Health Information Management Director said the resident or legal representative would be given access to the record either by verbal or written request.

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

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Medical record copies costs too much at \$1.00 per page.

Findings #5: The facility's policy for medical records release documented the first 25 pages were \$1.00 a piece and the rest of the copies were \$0.25 each. The Health Information Management Director said she would follow the policy and charge the fees indicated.

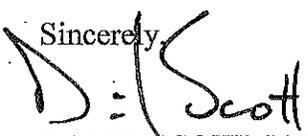
Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F153. Please refer to the survey report for the detailed findings.

Conclusion #5: Substantiated. Federal deficiencies related to the allegation are cited

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

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

Sincerely,


DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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January 5, 2016

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On **December 4, 2015**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006905

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from November 30 to December 4, 2015.

Nursing care and staff interactions were observed with the identified resident. Four licensed staff were observed during the Medication Pass task as they administered five residents and the identified resident prescribed medications. One resident who received medications through a peripheral intravenous central catheter was observed during the survey.

The medical record of the identified resident and 13 other residents were reviewed for quality of care concerns. The facility's grievance file and Incident and Accident reports for June to November 2015 were reviewed. The Resident Council minutes from September to November 2015 were reviewed.

The identified resident, six other individual residents, 14 residents in the Resident Group meeting, and two residents' family members were interviewed about quality of care and quality of life concerns, including the reporting party. Two licensed nurses were interviewed about the facility process of notification for residents with change of condition, the need of an invasive procedures, and/or changes in treatment.

Jeffrey Corriher, Administrator
January 5, 2016
Page 2 of 3

Allegation #1: The reporting party stated the identified resident had to go to the hospital for an invasive procedure without the reporting party's knowledge. The reporting party had reported his/her phone was disconnected for two days in March 2015, about the time when the resident's procedure took place. The reporting party reported the facility had tried to reach him/her because of the need to have someone with the resident, but the facility had found someone to go with the resident for the procedure.

Findings #1: The identified resident was observed while staff provided care and interacted with him/her. The staff were aware of the resident's limitations and handled these appropriately.

The identified resident was interviewed about quality of care and quality of life concerns, and any reported concerns were adequately addressed by the facility. The resident was able to activate the call light and make his/her needs known.

The resident's medical record was reviewed for contact information and quality of care and quality of life concerns. The resident had two emergency contacts documented with correct information. The resident's record documented the reporting party was called when the resident was in need of an immediate physician ordered procedure. The reporting party's phone had been disconnected and the facility called the second emergency contact. This interested party was able to facilitate someone to be present for the resident's procedure.

Based on observation, record review, and interviews, this complaint was determined to be unsubstantiated due to the lack of supporting evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The reporting party stated a peripheral intravenous central catheter (PICC) had been placed sometime in February and the facility had removed the PICC. The reporting party reported the identified resident had to go to the hospital to have another PICC placed in March 2015. The reporting party was unclear on why the facility would discontinue the PICC, only to have the resident go to the hospital and have a new one placed.

Findings #2: During the survey, four nurses were observed to administer medications to six residents, including the identified resident. The facility was not cited with any deficient practices related to medication administration. Observations were also made of a resident with a PICC line. There were no identified care concerns identified with the facility's practice regarding PICC lines.

The identified resident was observed and he/she did not have a PICC at the time of survey.

The identified resident's medical record was reviewed. The resident had a PICC during his/her hospital stay. The resident's PICC was no longer needed and was discontinued at the hospital, prior to admittance to the facility.

Jeffrey Corriher, Administrator
January 5, 2016
Page 3 of 3

After moving to the facility the resident had an emergent need arise and the physician ordered the placement of a PICC. The resident's PICC was placed, used for the emergent need, and then was discontinued by licensed staff per the physician's orders.

The investigation into this allegation did not show the facility acted inappropriately with the placement and/or discontinuation of the PICC. This complaint was determined to be unsubstantiated due to the lack of supporting evidence.

Conclusion #2: Unsubstantiated: Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script, appearing to read "Nina Sanderson".

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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December 31, 2015

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On **December 4, 2015**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006909

The complaint was investigated during the facility's Recertification survey on November 30, 2015 through December 4, 2015.

The medical records of the identified resident and six other residents, with orders for dressing changes were reviewed. Observations of dressing changes for four residents were conducted.

Three Licensed nurses were interviewed about dressing changes and orders for dressing changes.

The medical records staff and resident services staff were also interviewed.

Allegation #1: Facility has been changing the identified resident's surgical dressing twice daily, disregarding the surgeon's order of not changing the dressing until he changes it in seven days from date of surgery March 6, 2015.

Jeffrey Corriher, Administrator
December 31, 2015
Page 2 of 2

Findings #1: RP not sure if communications failed at hospital discharge orders or at facility. Review of the medical records revealed that physician's orders for dressing changes were not followed for three residents. The deficient practice was cited at F 309.

Conclusion #1: Substantiated. Federal deficiencies related to allegation are cited.

Allegation #2: A copy of the identified resident's discharge orders was requested during a Plan of Care meeting and so far have not been received.

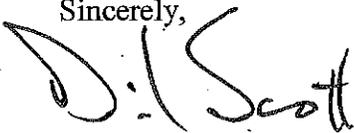
Findings #2: Per interview with the medical records and resident services staff and in conjunction with review of the identified resident's medical record, the requested medical information originated at a hospital and the requesting party was directed to that hospital to obtain the information. The allegation was not substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

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

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pint



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

March 14, 2016

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On **December 4, 2015**, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007164

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from November 30, 2015 to December 4, 2015.

Observations of interactions between staff and residents were completed during the survey. The identified resident had been discharged from the facility prior to the survey process, so the accommodation of needs and cares provided to fourteen other residents were observed.

Call light response times were observed on different shifts throughout the survey.

Six residents with foley bags were observed for appropriate needs being met.

Four licensed staff were observed as they administered six residents their prescribed medications.

Residents' rooms and common areas were observed for cleanliness and housekeeping staff were observed while completing their duties. The facility was observed for provision of a homelike environment.

The medical record of the identified resident and thirteen other residents were reviewed for quality of care concerns. The facility's grievance file and Incident and Accident reports for June 2015 to November 2015 were reviewed. The Resident Council minutes from September 2015 to November 2015 were reviewed for quality of care and quality of life concerns and to ensure those concerns were addressed.

Six individual residents, fourteen residents in the Resident Group meeting, and two residents' family members were interviewed about quality of care and quality of life concerns. There were nine staff members interviewed regarding identification of abuse or neglect and the corresponding investigations and regulatory reporting requirements.

Allegation #1: The interested party stated an identified resident had his/her call light on and staff did not respond for over an hour. The resident's foley bag had broke and saturated the bedding. The resident's family changed the bedding without the staff offering assistance.

Findings #1: The staff and residents' interactions were observed throughout the survey and were appropriate; residents' daily needs and cares, including emptying foley bags, were accommodated; and, the facility's grievances and Resident Group documented issues were addressed with resolutions and appropriate reporting requirements. The identified resident's clinical record documented daily cares and needs as complete while he/she was a resident. Six individual residents, fourteen residents in the Resident Group meeting, and two residents' family members interviewed revealed no problems with abuse or neglect in the past.

Based on observations, record review, and interviews, this allegation was unsubstantiated due to the lack of supporting evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The resident had his/her call light on for long periods of time on numerous occasions and when staff would answer the call light they would at times turn the light off without providing or offering assistance.

Findings #2: Six individual residents and fourteen residents in Resident Group did not voice any concerns regarding call light response times and quality of care. Staff and residents' interactions were appropriate. The staff attending to the residents' daily cares and needs throughout the survey were observed to be appropriate and timely. Call light response times were observed on all shifts and was determined to be appropriate.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The interested party reported the floor in an identified resident's room had a sticky substance present for a few days before it was cleaned.

Findings #3: During the survey process, there were observations of the housekeeping staff cleaning residents' rooms and common areas appropriately. There were no identified housekeeping areas of concerns identified by the surveyors. The facility was observed as providing a homelike environment for the residents. The resident' interviews did not reveal any concerns with the facility's cleanliness or identify a housekeeping problem.

Based on observation and interviews this complaint was determined to be unsubstantiated due to the lack of supporting evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The reporting party felt an identified resident was not having pain concerns and pain medication administration dealt with timely and appropriately.

Findings #4: During the survey, four nurses were observed administering medications to six residents. The facility was not cited with any deficient practices related to medication administration. There were eight residents who were observed for pain concerns and there were no identified areas of concern. The residents who were interviewed did not express any problems with having their pain concerns addressed and pain medications administered appropriately.

Clinical records of eight residents, including the identified resident, were reviewed for pain needs being met and there were no identified areas of concern.

Based on observation, interviews, and medical record review, this allegation could not be substantiated based on the lack of supporting evidence.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The interested party reported the dietary department would not provide an identified resident with any ice or juice and it was almost lunch time, nor would staff provide an alternative for the resident.

There was a form in the room for staff to document every time they checked and provided care on an identified resident. The interested party stated the staff had not filled out the form for fourteen days.

Jeffrey Corriher, Administrator
March 14, 2016
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The facility had white boards in each resident's room and the boards were not updated daily with the date nor the nursing staff providing care. This allegation was substantiated, but does not fall under any regulatory requirement and could not be cited by the survey team.

Findings #5: Accommodation of needs and cares were observed for fourteen residents without any identified areas of concern. The staff were observed providing ice, water, and drinks at varying times and shifts throughout the survey process. The facility was observed to have a refreshment room readily accessible for staff to ensure residents were provided ice, drinks, and snacks appropriately when requested.

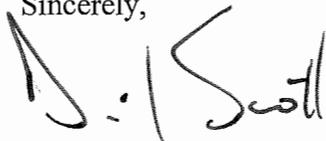
The identified resident's medical record was reviewed for documentation of daily cares. The resident's Plan of Care addressed the documentation and how the resident and nursing staff were implementing this documentation. The documentation of care details were reviewed and there were no missing days of nursing documentation.

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

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 14, 2016

Jeffrey Corriher, Administrator
Bridgeview Estates
1828 Bridgeview Boulevard,
Twin Falls, ID 83301-3051

Provider #: 135113

Dear Mr. Corriher:

On December 4, 2015, an unannounced on-site complaint survey was conducted at Bridgeview Estates. The complaint allegation, findings and conclusion are as follows:

Complaint #ID00007198

This complaint was investigated in conjunction with the facility's Federal Recertification and Complaint Survey conducted from November 30, 2015 to December 4, 2015.

The resident was admitted to the skilled side of the facility on 4/7/15 and discharged to the assisted living side on 6/9/15.

The resident's History and Physical, Care Plan, Nurses Notes, Physician Progress notes, Social Service notes, and Power or Attorney information was reviewed.

The resident was estranged from his family and Social Services had contacted the Board of Guardianship to start the guardian process. The resident's next door neighbors from the community asked to take the resident out of the facility for some "fresh air" and were informed the resident was not medically stable, however they were more than welcome to visit the resident in the facility. The neighbors had been very vocal with the facility and social services regarding the resident's assets going to them if something should happen to the resident. The resident became visibly upset after his friends left.

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The facility worked directly with the Director of the Guardianship program, the office on aging, the physician, and an attorney appointed to represent the resident. The police became involved after the resident's neighbors removed belongings from his house.

The following allegation was investigated and unsubstantiated by the Residential Assisted Living Team on November 19, 2015:

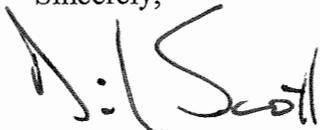
Allegation: The facility denied family to visit a resident.

Findings: The resident was admitted to the Skilled nursing facility on 4/7/15 and discharged to assisted living on 6/9/15.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As the allegation was unsubstantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

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

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt