



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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March 4, 2016

Richard Ord, Administrator
Bennett Hills Center
1220 Montana Street
Gooding, ID 83330-1856

Provider #: 135134

Dear Mr. Ord:

On **February 19, 2016**, a survey was conducted at Bennett Hills Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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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 **March 17, 2016**. Failure to submit an acceptable PoC by **March 17, 2016**, may result in the imposition of civil monetary penalties by **April 6, 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 **March 25, 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 **March 25, 2016**. A change in the seriousness of the deficiencies on **March 25, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **March 25, 2016** includes the following:

Denial of payment for new admissions effective **May 19, 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 **August 19, 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 **February 19, 2016** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **March 17, 2016**. If your request for informal dispute resolution is received after **March 17, 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,

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

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt
Enclosures

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

PRINTED: 04/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2016
NAME OF PROVIDER OR SUPPLIER BENNETT HILLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1220 MONTANA STREET GOODING, ID 83330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An Annual Recertification survey was conducted from February 16, 2016 to February 19, 2016. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Linda Kelly, RN Nina Sanderson, LSW Evelyn Floyd, RN, MSN Definitions: ADON = Assistant Director of Nursing BOM = Business Office Manager bpm = beats per minute CAA= Care Area Assessment DON = Director of Nursing IDT = Interdisciplinary Team LPN= Licensed Practical Nurse LSW = Licensed Social Worker MDS= Minimum Data Set PCC= Point Click Care QAPI = Quality Assurance Quality Improvement RN= Registered Nurse RNC = Regional Nurse Consultant SNF = Skilled Nursing Facility	F 000			
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and	F 156		3/25/16	

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

TITLE

(X6) DATE

Electronically Signed

03/14/2016

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

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F 156	<p>Continued From page 1 any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available</p>	F 156			

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F 156	<p>Continued From page 2 for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide 2 of 2 residents (#9 and # 12) reviewed for the end of Medicare Part A coverage, information how to</p>	F 156	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Bennett Hills Center does not admit that</p>		

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F 156	<p>Continued From page 3</p> <p>appeal the termination of coverage for their stay in the SNF. This failure created the potential for residents to experience financial distress when they were not informed of their right or of the process to appeal the facility's determination that the resident no longer qualified for Medicare coverage in the nursing home Findings included:</p> <p>On 2/17/16, the "SNF Determination on Continued Stay" letters, which informed the residents of the facility's intent to stop billing Medicare for services provided in the SNF, were reviewed for Resident #s 9 and 12. Resident #9's letter documented Medicare coverage would end 11/9/15 and Resident #12's letter documented Medicare coverage would end 9/23/15. Neither letter contained contact information as to how to appeal the facility's billing decision, or about the option for an expedited review.</p> <p>The findings were presented to the BOM on 2/18/16 at 10:45 am. The BOM stated, "Yes, we forgot to give them the appeal information."</p>	F 156	<p>the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F 156</p> <p>Affected Residents</p> <p>On or before 3/25/2016, the Administrator or designee will provide information to resident #9 and/or POA, regarding their Medicare rights and appeal/contact information.</p> <p>Resident # 12 was discharged from the facility on 2/14/2016.</p> <p>Potential Residents</p> <p>On or before 3/25/2016, the Administrator or designee will review current residents to identify those with Medicare Part A payer source and whose coverage may be ending.</p> <p>Identified residents will be provided information regarding their right to appeal, including the appeal contact information.</p> <p>Systemic</p> <p>Beginning the week of 3/25/2016 the Clinical Reimbursement Coordinator or</p>		

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F 156	Continued From page 4	F 156	designee will report on residents <input type="checkbox"/> coverage status and notification of termination of coverage at the weekly utilization review. The Administrator is responsible for monitoring and follow-up. Monitoring - QA Audit Effective 3/25/2016 the Administrator or designee, will review 3 Medicare A residents to identify those with coverage ending to ensure appeal rights/contact information has been provided. Results will be reviewed with Regional Clinical Reimbursement Coordinator. Audits will be completed weekly X 4 then Monthly X 2. Results will be reviewed by IDT during the QAPI meeting for 3 months or until substantial compliance is achieved. The Administrator is responsible for monitoring and follow-up. Compliance date 3/25/2016		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review it was determined the facility failed to	F 250	F 250	3/25/16	

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F 250	<p>Continued From page 5</p> <p>effectively communicate and pursue resolution of issues regarding dental care in a timely manner for 1 of 12 sample residents (#6). The deficient practice created the potential for more than minimal harm by delayed consistent and timely dental treatment. Findings included:</p> <p>Resident #6 was admitted to the facility on 10/27/09 with diagnoses which include Type II diabetes, hypertension, chronic pain, and anxiety.</p> <p>Social Service assessment notes, dated 5/1/15, documented the resident had "dental issues and goes to the dentist often and according to the dentist, nothing could be done to prevent the resident's teeth from falling out."</p> <p>Progress Notes, dated 10/12/15, documented the resident's "right front tooth fell out ..."</p> <p>CAA Worksheet, dated 10/13/15, documented dental problems and indicated the resident and family was aware of the resident's oral status.</p> <p>Care Planning meeting notes, dated 10/16/15, documented the resident's teeth were "discussed ... and the resident is aware the dentist cannot do anything to prevent them from falling out."</p> <p>Physician progress notes, dated 12/17/15, documented a chewing problem due to poor dentition, and noted, "Expedite eval[uation]."</p> <p>Progress Notes, dated 12/29/15, documented, "Tooth decay: Facility trying to coordinate with [family member] and dentist to get her teeth pulled."</p>	F 250	<p>Affected Residents</p> <p>On 2/19/2016 the Licensed Social Worker reviewed resident # 6's dental history, dental visits, & dental plan of care with the resident / resident's daughter. The resident's daughter did report satisfaction with the facilities attempts to resolve dental concerns. Resident #6's daughter also declined any further dental follow up at that time.</p> <p>On or before 3/25/2016 the Licensed Social Worker or designee will update the Medical Provider with the resident's current dental status including timeline of dental events and decline for further follow up.</p> <p>Potential Residents</p> <p>On or before 3/25/2016 Current residents and/or resident responsible parties will be interviewed by the Licensed Social Worker or designee regarding unresolved concerns or needed follow up related to medically related social services provided. Any identified concerns will be addressed by the Licensed Social Worker on or before 3/25/2016.</p> <p>Systemic</p> <p>On or before 3/25/2016 the Licensed Social Worker or designee will receive education provided by the Divisional quality of life specialist related to the provision of medically related social</p>		

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F 250	Continued From page 6 A Change of Condition MDS assessment, dated 1/13/16, documented the resident had cavities or broken teeth. Social Service notes, dated 2/3/15, documented the resident went to the dentist for a loose tooth. The possibility that the resident would need dentures was discussed with the [family member], but the resident's insurance carrier notified the facility of a six-month waiting period. The clinical record did not document the resident had been placed on the waiting list or that the insurance issue had been pursued further to determine if an expedited resolution could be reached due to the condition of the resident's teeth. Social Service assessment notes, dated 2/12/15, documented the resident's teeth were "falling out" and she was going to the dentist for dental care, but the dentist could not pull her teeth or the remaining roots due to her fragile jaw. Care plan meeting notes, dated 2/16/15, documented, "Resident reports her teeth and jaw are feeling much better." On 2/18/16, the resident's teeth and gums were observed with darkened areas. On 2/18/16, the LSW stated the resident's teeth had been an issue for 3-4 years, but she was unaware it was still an issue. She stated the resident could not have her teeth pulled because of a fragile jaw, the resident's insurance would not pay for the procedure or for dentures, there was a six month waiting list for the only oral	F 250	services. On or before 3/25/2016, residents with medically related social service concerns, which may be unresolved, will be reviewed in weekly Customers at Risk meeting by the IDT including the Licensed Social Worker. Beginning 3/25/2016 resident's and/or resident's responsible parties will be interviewed by the Licensed Social Worker related to any unresolved concerns or medically related social services provided, at the regularly scheduled quarterly care plan conference. Follow-up will be completed as indicated. Monitoring - QA Audit Effective 3/25/2016, the Licensed Social Worker or designee will review 3 residents for unresolved medically related social service concerns. These audits are to be compiled by the Director of Nursing and reported to the QAPI committee for review and remedial intervention for 3 months or until resolved. Audits will be completed weekly X 4 then Monthly X 2. Results will be reviewed by IDT during the QAPI meeting for three months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and follow-up. Compliance Date: 3/25/2016		

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F 250	Continued From page 7 surgeon accepting the resident's insurance plan, and the surgeon practiced outside of the area. On 2/18/16, a family member stated she was involved in care planning, and although the resident's teeth had been discussed for the previous four years the issue was still unresolved. She stated the resident's meals had been changed to a soft diet and the resident could no longer enjoy a regular meal. The family member noted she could not afford dentures, or the cost to extract the resident's teeth, and that she was "not sure what the plan is" for resolving the resident's dental needs. On 2/18/16, the resident stated her primary concern was her mouth and teeth. She stated, "They grind my food, [but my] gums [are] sore and irritated. One tooth is really sore. I just wish it would come out. I try to loosen it. [My teeth] just keep falling out." She stated she had regularly voiced her discomfort and had spoken about her concerns with the LSW.	F 250			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and recognized standards of practice, it was determined the facility failed to identify and respond to significant changes of condition, or notify residents' physicians when a significant change occurred. This was true for 1 of 12	F 281	F 281 Affected Residents On 2/18/2016 resident # 6 was assessed by the primary care provider for	3/25/16	

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F 281	<p>Continued From page 8</p> <p>sampled residents (#6) reviewed for quality of care and created the potential for harm if declines in residents' health were not detected, addressed, and/or communicated to physicians. Findings include:</p> <p>Resident #6 was admitted on 10/27/09 with diagnoses which include Type II diabetes, hypertension, chronic pain, and anxiety.</p> <p>The resident's clinical record from 10/3/15 to 2/18/16 documented four episodes of heart rates below 50 beats per minute:</p> <ul style="list-style-type: none"> · 12/16/15 at 11:29 pm - 46 bpm "regular" · 2/6/16 at 4:25 pm - 36 bpm "irregular" · 2/6/16 at 11:45 pm - 40 "irregular" · 2/17/16 at 1:32 pm - 34 " regular " <p>The resident's clinical record documented vital signs were not taken, a physical assessment was not conducted, and the physician was not notified of the bradycardia episode on 12/16/15 or the two bradycardia episodes on 2/6/16. The bradycardia episode on 2/17/16 was not documented in the resident ' s electronic health record and there were no vital signs or physical assessment in response to the incident and resident statements.</p> <p>The facility's 24 hour Shift Report Policy documented the 24 report was to be "completed ... to monitor and communicate on a shift-to-shift basis the changes in [resident] status and unit activity and to guide follow-up by nursing staff." Documentation was required on a change of condition/reportable event, which was classified as a "High Risk Alerts." Staff did not initiate this report on Resident #6 in response to the</p>	F 281	<p>Bradycardic episode. The resident's order for metoprolol was discontinued and orders received to increase monitoring of residents pulse & blood pressure daily. Provider was notified of results. On 2/19/2016 Resident # 6 was re-assessed by the Director of Nursing and noted with pulse of 54, B/P of 150/72 and no associated symptoms. Resident #6 was found free of cardiac or respiratory distress. Resident # 6, the resident's daughter, and the medical provider were updated with resident's current status.</p> <p>On or before 3/25/2016, the Director of Nursing or designee will update the medical provider with the resident's history of bradycardic episodes and any associated symptoms. Resident # 6's care plan will be updated to reflect the resident's current cardiac status.</p> <p>Potential Residents</p> <p>On or before 3/25/2016 a review of current residents medical records for the last 30 days will be completed by the Director of Nursing or designee, to identify residents with changes in condition which were not reported to the medical provider and/or without nursing follow-up. Follow-up will be completed as indicated for residents with identified concerns. Respective resident care plans will be updated to reflect residents' current status by the Director of Nursing or designee on or before 3/25/2016.</p>		

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F 281	<p>Continued From page 9 bradycardiac events and the DON stated she "had never seen this policy."</p> <p>The facility's Nursing Documentation Policy documented the purpose of documentation was "to communicate patient's status and provide accurate accounting of care and monitoring provided."</p> <p>The facility's Physician Notification Policy documented physician notification was indicated "upon identification of a patient who has a change of condition ... a licensed nurse will perform appropriate clinical observations and data collections and report to physician/mid-level provider." The purpose of the policy was to communicate a change of condition "and initiate interventions as needed/ordered."</p> <p>The resident's Care Plan identified interventions for cardiovascular symptoms or complications related to hypertension, but did not identify a history of bradycardia or interventions when the resident experienced bradycardia.</p> <p>According to Standards of Professional Nursing Practice, failure to assess properly or in a timely fashion, follow appropriate nursing measures, communicate information, adhere to facility policy or procedure, and document appropriate information are departures from the Standards of Nursing Care (Lippincott, Williams & Wilkins, 9th ed. 2010).</p> <p>Nursing progress notes, dated 2/17/16 at 10:56 am, documented the resident stated she was not feeling well and that her "head feels like its swimming ... maybe a little dizzy, but not really."</p>	F 281	<p>Systemic</p> <p>On or before 3/25/2016, Licensed Nursing will receive education by the Director of Nursing or designee, regarding guidelines for reporting and monitoring resident changes in condition.</p> <p>On or before 3/25/2016, Licensed Nursing competencies related to response to resident changes in condition will be validated with a post-test. Identified concerns will receive follow up as indicated. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Monitoring - QA Audit</p> <p>Effective 3/25/2016 the Director of Nursing or designee will review 3 residents to ensure resident changes in condition are reported to the medical provider and are being monitored by nursing as indicated.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reviewed by IDT during the QAPI meeting for 3 months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Compliance Date: 3/25/2016</p>		

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F 281	<p>Continued From page 10</p> <p>The progress note documented the resident's apical pulse was 34 bpm and that the physician was notified. At 1:32 pm, the progress notes documented the resident "did not feel right in the head," and stated she was, "fuzzy." The bradycardia episode on 2/17/16 was not documented in the resident's electronic health record and there were no vital signs or physical assessment in response to the 2/17/16 bradycardia and statements.</p> <p>On 2/18/16 at 11:35 am, the resident was observed sitting on edge of the bed. She appeared unsteady and stated she was "tired and weak." The resident's family member, who was present at the time of the observation, stated she was concerned about the resident's decreased heart rate and increased weakness.</p> <p>On 2/18/16 at 12:43 pm, LPN #1 stated the resident's heart rate was "34" on 2/17/16 at 11:00 am.</p> <p>On 2/18/16 at 3:15 pm, the DON stated she was unaware of any policy related to changes in a resident's vital signs, such as an apical heart rate of 34 bpm. She stated that vital signs are different for each person and that a heart rate of 34 bpm would not necessarily warrant further action.</p> <p>On 2/18/16 at 4:35 pm, the RNC stated a heart rate of 34 bpm would be a significant change that would trigger a 72 hour protocol of monitoring on every shift, documented on the nursing progress notes, and warrant physician notification. She stated the care plan should address episodes of bradycardia.</p>	F 281			

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F 281	Continued From page 11	F 281			
F 520 SS=E	<p>On 2/18/16 at 5:00 pm, the DON, with the RNC present, stated she was unclear as to whether a heart rate of 34 bpm would initiate additional monitoring policies, such as the 24 hour report. The DON state she would follow doctor's orders for monitoring and frequency of vital signs. They stated that although the resident had a history of bradycardia, the bradycardia events were significant enough to warrant notification of the physician.</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p>	F 520		3/25/16	

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F 520	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility's Quality Assurance Performance Improvement Committee failed to identify and resolve medication administration errors for five residents between September 2015 and January 2016. This failure and had the potential to affect all residents in the facility who experienced increased pain related to missed doses of routine pain medication. Findings include: 1. Review of the facility's Occurrence Reports from September 2015 to January 2016 documented six medication errors during scheduled medication administrations by the ADON, RN/House Supervisor, LN#2, and twice by LN#3. The following errors, conclusions, and interventions were documented: a. On 9/2/15 at 8:00 pm, the nurse pre-signed administration of a pain medication, however, after reconciliation of the medication it was determined the medication had not been administered. The investigation did not document a conclusion or corrective action. b. On 11/2/15 at bed time, a resident should have received two doses of a pain medication and received one dose. The LN read the MAR incorrectly. The LN was re-educated. c. On 11/18/15 at 6:00 am, a scheduled morning dose of an anxiety medication was "overlooked" by the nurse. The nurse failed to double check the MAR when preparing the resident's medications. The nurse was re-educated to follow the Five Rights of Medication	F 520	F 520 Affected Residents On or before 3/25/2016 the Director of Nursing will review incidence of medication errors that occurred over that past 6 months. Review will include identification of any trends in staff, time, date or other concern. On or before 3/25/2016 the Director of Nursing will interview licensed nurses related to any barriers or issues that may contribute to the centers rate of medication errors. On or before 3/25/2016 the Director of Nursing will compile the results of completed reviews and report to the QAPI committee for review and intervention. A plan will be developed by the QAPI team that will include a licensed nurse who is responsible for medication administration. Medication error rate will continue with ongoing review by the QAPI committee until concern is resolved as evidenced by no medication errors for a 6 month period. Potential On or before 3/25/2016 the Director of Nursing will review current clinical systems utilizing a key clinical process	

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F 520	<p>Continued From page 13</p> <p>Administration and double check the MAR.</p> <p>d. On 11/29/15 at 8:00 am and 12:00 pm, two scheduled doses of a resident's pain medication were missed. The nurse failed to thoroughly review the full page of the MAR. The Five Rights of Medication Administration were reviewed with the nurse.</p> <p>e. On 1/26/16 at 12:00 pm, a pain medication, of a lesser dose than ordered, was administered to a resident from another resident's medications. The nurse failed to verify the medication label to the MAR. The nurse was re-educatated on the Five Rights of Medication Administration.</p> <p>On 2/18/16 at 6:30 pm, the Administrator and DNS stated they had not identified medication errors as a quality or system deficiency, and were not aware 6 of 7 errors had the same conclusion and corrective action. The Administrator stated the QAPI committee met monthly and discussed medication errors made during the month. He stated the facility had not, but should have tracked and trended the errors. The Administrator and DNS stated the identified concern would be discussed in the next QAPI meeting and would include the physician and IDT.</p>	F 520	<p>monitor. Any identified system issues will be reported to the QAPI committee for review and remedial intervention.</p> <p>Systemic</p> <p>On or before 3/25/2016 the Regional Vice President will educate the centers QAPI committee on running a comprehensive PI program including the reports, tools, location of policy and procedures and how to reference them, root cause analysis, and metrics that are available to the committee in real time. The training will also include conducting productive monthly QAPI meetings.</p> <p>Monitoring - QA Audit</p> <p>Effective 3/25/2016 the Administrator will chair the Performance Improvement Committee meeting and review the resources brought to meeting by committee members along with the compliance audits from this survey and resident council meeting minutes to ensure recommendations, audit results, and metric trends are acted upon.</p> <p>Results of recommendations and audits will be discussed by team members to include but not limited to cause identification with systematic reviews for necessary changes. The QAPI meeting will occur monthly with regional support available as needed. The Administrator is responsible for monitoring and follow-up.</p>		

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