



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

April 8, 2016

Sherrie Nunez, Administrator
Trinity Mission Health & Rehab Of Midland
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

On **April 1, 2016**, a survey was conducted at Trinity Mission Health & Rehab Of Midland 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.

Sherrie Nunez, Administrator
April 8, 2016
Page 2 of 4

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 **April 21, 2016**. Failure to submit an acceptable PoC by **April 21, 2016**, may result in the imposition of penalties by **May 16, 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 **June 30, 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 **June 30, 2016**. A change in the seriousness of the deficiencies on **May 16, 2016**, may result in a change in the remedy.

Sherrie Nunez, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **June 30, 2016** includes the following:

Denial of payment for new admissions effective **June 30, 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 **September 28, 2016**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 30, 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 **April 21, 2016**. If your request for informal dispute resolution is received after **April 21, 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 cursive script that reads "Nina Sanderson".

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/pmt
Enclosures



**Trinity Mission Health & Rehab
of Midland**

4/20/2016

Nina Sanderson
Idaho State Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720

Re: Plan of Correction for Trinity Mission Health & Rehab of Midland
Credible Allegation of Compliance

Dear, Nina Sanderson:

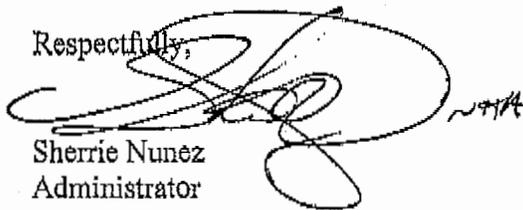
Enclosed you will find the Statement of Deficiencies completed, with the facility's Plan of Correction for the deficiencies identified in the survey dated for April 1, 2016.

Please consider this letter and the Plan of Correction to be the facility's credible allegation of compliance. The facility asserts substantial compliance with the applicable certification requirements on April 30, 2016.

This letter is also the facility's request for a re-survey, if one is necessary, to verify that the facility has achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.

Thank you for your assistance in this matter.

Respectfully,


Sherrie Nunez
Administrator

RECEIVED

APR 20 2016

FACILITY STANDARDS

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

PRINTED: 04/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2016
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF MIDLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from 3/28/16 - 4/1/16.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD, Team Coordinator Michael Case, LSW Sharon Whitehead, BSN, RN</p> <p>Abbreviations included:</p> <p>ABD = Abdomen ADLs = Activities of Daily Living ARD = Assessment Reference Date CNA = Certified Nursing Assistant DON = Director of Nursing DX = Diagnosis GDR = Gradual Dose Reduction HHA = Hospice Health Aide IDG/IDT = Interdisciplinary Group/Team LPN/LN = Licensed Practical Nurse/Licensed Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set MG = Milligrams MS = Maintenance Supervisor NC = Nasal Cannula O2 = Oxygen PRN = As needed basis RN = Registered Nurse SDC = Staff Development Coordinator</p>	F 000	<p>Preparation and submission of this plan of correction by, <i>Trinity Mission Health & Rehab of Midland LLC</i>, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.</p>	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a</p>	F 241		

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APR 20 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE N/A (X8) DATE 4/20/16

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

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F 241	<p>Continued From page 1</p> <p>manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</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 maintain resident dignity for 1 of 13 residents (#5) reviewed whose dining experience was observed. This resulted in the potential for a negative effect on their self-esteem. Findings included:</p> <p>1. Resident #5 was readmitted to the facility on 5/28/15 with diagnoses which included profound intellectual disability and dysphagia - oropharyngeal phase. Resident #5 was non-verbal and required full physical assistance to complete all ADLs.</p> <p>Resident #5's 6/5/15 care plan was reviewed and included the following: - Mechanically altered diet with pudding thick liquids. - Speak clearly and simply.</p> <p>a. Resident #5 was observed in the dining room on 3/28/16 from 5:50 - 6:30 pm At 5:57 pm, CNA #2 sat at the table to the resident's right. CNA #2 spoke Resident #5's name, then began to spoon pureed food from one of the bowls into the resident's mouth.</p> <p>CNA #2 did not tell Resident #5 what food item she was eating, and waited until each food item was consumed before uncovering and starting the next, including fluids (water and milk). Additionally, CNA #2 was observed to turn and</p>	F 241	<p>F 241</p> <p>1. On 4/6/2016, Resident # 5 was assessed by the Social Service Director with no psychosocial needs noted related to her dining experience.</p> <p>2. On 4/15/2016 an observation was completed by the Social Service Director and nurse managers of each dining room to include the breakfast, lunch and a dinner meal to ensure staff were interacting in conversation with the residents individually and explained to residents which food item was being offered as needed as staff assisted residents with their dining services; concerns were addressed at that time.</p> <p>3. Root cause: Root cause analysis was completed by Interdisciplinary (IDT) team on 4/18/2016. It was determined that staff members did not verbally communicate to this resident, as resident responds better with nonverbal cues due to her cognitive level.</p>	

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F 241	<p>Continued From page 2</p> <p>encourage 2 other residents to eat. However, other than stating the resident's name when she sat down, CNA #2 was not observed to verbally interact with Resident #5 throughout the course of the meal.</p> <p>b. Resident #5 was observed in the dining room on 3/30/16 from 6:40 - 6:30 pm At 5:52 pm, CNA #3 sat at the table to the resident's right and began spoon feeding pureed food to the resident. CNA #3 did not inform Resident #5 of what food items she was eating. Additionally, CNA #3 was observed to talk to other residents seated at the table, but did not verbally interact with Resident #5.</p> <p>At 6:03 pm, CNA #3 was called out of the dining area. CNA #4 assumed the task of feeding Resident #5. CNA #4 was observed to spoon feed the resident food items and wipe her face with a damp cloth, but did not inform the resident what she was eating or verbally interact with the resident.</p> <p>At 6:19 pm, CNA #3 left the dining area and CNA #2 assumed the task of feeding Resident #5. CNA #3 was not observed to tell the resident what she was eating, or to verbally interact with Resident #5. At 6:30 pm, the observation ended.</p> <p>During an interview on 3/31/16 at 2:40 pm, LN #1, who was the Nursing Manager, stated staff should be offering Resident #5 choices of what she was eating and verbally interacting with her during the dining process. LN #1 stated staff should not be talking over Resident #5 to other residents.</p> <p>The facility failed to ensure Resident #5 dining</p>	F 241	<p>4. Beginning the week of 4/30/2016 the Social Service Director or designee will conduct observations of each meal in the dining rooms weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure staff are interacting/ conversing with the residents individually as they assisted them with their dining services, explaining food items being offered, not talking over the resident that they are assisting, and not to have several staff members feed one resident during dining room services. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations, and determine continued monitoring. The Administrator will be responsible for monitoring and follow-up.</p>		

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NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF MIDLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 48 NORTH MIDLAND BOULEVARD NAMPA, ID 83661		
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F 241 F 253 SS=E	<p>Continued From page 3</p> <p>tasks were completed in a manner that would maintain or enhance her dignity.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to perform maintenance services necessary to ensure ice machine floor drains were kept sanitary for 1 of 2 ice machines, which resulted in potential for contaminated ice. This failure had the potential to impact any resident served ice from the machine. Findings included:</p> <p>On 3/28/16 at 2:24 pm, the floor drain behind the ice machine in the Big Band Cafe was observed. The drain had a cross-hatched insert to prevent large items from falling into the drain. Approximately 80 percent of the cross-hatched surface was covered with a brown colored sludge-like substance.</p> <p>The overflow drainpipe for the ice machine ended less than 1 inch above the sludge-like substance and had a black substance covering the end of the pipe. A smaller red overflow pipe from the water filter was submerged into the drain through the sludge-like substance.</p> <p>During an interview on 3/28/16 at 5:39 pm, the MS stated the ice machines were disassembled</p>	F 241 F 253	<p>Systemic change will include that an IDT member will observe a meal in each dining room daily to ensure staff are interacting in conversation with the residents individually, explain food items being offered as needed, Residents will have one staff member feed them without changing staff members unnecessarily, and to ensure that staff are not talking over resident to another resident or staff during their dining services.</p> <p>Beginning on 4/11/2016 the facility staff was re-educated by the Staff Development Coordinator regarding staff interaction, explaining food items being offered, not talking over the resident that they are assisting and not to have several staff members feed one resident as they assist residents with their dining services to ensure each resident is provided with dignity and respect during dining room services.</p>	4/30/2016

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F 253	Continued From page 4 and cleaned monthly and the drains were not part of the cleaning routine, but should be. The facility failed to ensure the floor drain for the ice machine in the Big Band Cafe was maintained in a sanitary manner.	F 253	2. On 3/28/16 the drain for the ice machine located in the Big Band Dining room was cleaned by the Maintenance Director.	
F 275	483.20(b)(2)(III) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to complete a comprehensive annual assessment within 366 days for 1 of 9 (#3) sampled residents. This failure could potentially affect the resident's clinical condition if care area triggers on the assessment were not identified and care planned accordingly. Findings included: Resident #3 was readmitted to the facility on 10/4/14 with diagnoses including dementia with behavioral disturbances and recurrent major depressive disorder. On 2/26/15 a significant change MDS was completed. On 5/29/15, 8/28/15, 11/28/15, and 2/27/16 quarterly MDS assessments were completed. However, the resident's record did not contain an annual assessment within 366 days from 2/26/15.	F 275	On 4/11/2016 an audit was completed by the Maintenance Director of the facility ice machine drains to ensure they were clean; concerns were addressed at that time. Beginning on 4/15/2016, the Social Service Director and nursing management followed up with residents who dine in the Big Band dining room for concerns regarding equipment and environmental concerns; no concerns were noted. 3. Root cause analysis was completed by the IDT team on 4/18/2016 It was determined that during the monthly cleaning of the facility ice machines the back drain was not included in the monthly inspections. Systemic change: The instructions on the monthly maintenance monitoring system will include the maintenance and cleaning of the drain pipes.	

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F 275	<p>Continued From page 5</p> <p>When asked during an interview on 3/31/16 at 10:25 am, the DON said an annual assessment should have been completed on 2/27/16, not a quarterly.</p> <p>F 278 483.20(g) - (j) ASSESSMENT SS=D ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 275	<p>Beginning on 4/11/2015 the Maintenance Director was reeducated by the Administrator on the monthly inspection and cleaning of the ice machine drain pipes per the monthly ice machine cleaning schedule.</p> <p>4. Beginning the week of 4/30/2016 the Administrator or designee will conduct audits of the facility ice machine drains, weekly for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure the ice machine drains are clean. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations and determine continued monitoring. The Administrator will be responsible for monitoring and follow-up.</p> <p>F 275</p> <p>1. On 4/8/2016, Resident # 3's comprehensive assessment was completed on by the MDS coordinator.</p> <p>2. On 4/11/2016 an audit of other residents MDS assessments was completed by MDS coordinators to ensure residents have been reviewed for a comprehensive assessment per requirements of the Resident Assessment Instrument (RAI); no other concerns were noted.</p>	4/30/2016

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F 278	<p>Continued From page 6</p> <p>Based on observation, record review, and interview, it was determined the facility's assessment of 1 of 9 residents (#7) whose assessments were reviewed, did not accurately reflect the resident's use of O2. The failure created the potential for interventions to not be implemented, placing resident at risk for incorrect oxygen therapy. Findings included:</p> <p>Resident #7 was admitted to the facility with multiple diagnoses including dementia, major depressive disorder, and generalized anxiety disorder.</p> <p>The resident's 1/8/16 quarterly MDS did not code for O2 therapy.</p> <p>On 3/28/16 at 2:25 pm, the resident was observed in bed with NC connected to a concentrator at 2 liters per minute.</p> <p>The resident's 2/2016 Physician Orders (recapitulation) contained a 3/28/15 order for O2 at 2 liters per NC to keep O2 saturations above 90 percent.</p> <p>The resident's 10/21/15 O2 care plan approaches included administer O2 as ordered.</p> <p>The resident's 1/2016 - 3/2016 MARs documented the resident was administered O2 at 2 liters every day.</p> <p>When asked during an interview on 3/31/16 at 10:08 am, the DON reviewed the quarterly MDSs and immediately made a correction to the 1/8/16 MDS in the facility's database.</p>	F 278	<p>3. Root cause analysis was completed by IDT team on 4/18/2016 it was determined that the facility MDS coordinator completed a quarterly assessment in lieu of the annual comprehensive assessment.</p> <p>Systemic change: The Director of Nursing or designee will review resident's MDS monthly to ensure each resident has been comprehensively assessed per the state RAI guidelines within the regulatory time frames as necessary.</p> <p>Beginning on 4/11/2016, the MDS Coordinator was re-educated by the Director of Nursing regarding resident assessments per the RAI and completion of the compressive assessment within required timeframes.</p> <p>4. Beginning the week of 4/30/2016 the Director of Nursing or designee will conduct audits of MDS assessments weekly for 4 weeks then monthly for 2 months and quarterly thereafter, to ensure comprehensive assessments are completed per the requirements of the RAI. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations and determine continued monitoring. The Director of Nursing will be responsible for monitoring and follow-up.</p>	4/30/2016
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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PRINTED: 04/08/2016
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF MIDLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651		
(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 309 SS=D	Continued From page 7 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure coordination and communication of care was established for 1 of 3 residents (#11) and the agreed upon coordinated plans of care identified the care and services provided for 2 of 3 residents (#s 7 and 10) reviewed for hospice care. The failure created the potential for the residents' unique needs and expressed desires for hospice care to be unmet. Findings included: 1. Resident #11 was admitted to the facility on 1/22/16 with diagnoses which included chronic systolic congestive heart failure. Resident #11's record included a Physician Verbal Order from a hospice agency, dated 1/22/16, stating the resident was to be admitted to the facility for a 5 day respite stay. The respite stay was changed to long term following the 5 day period. Resident #11's care plan contained 14 identified needs dated 1/22/16. The need titled "ADL's" stated "Resident received assistance with ADLs in collaboration with hospice personnel."	F 309	F 278 1. On 3/31/2016, Resident # 7's MDS was modified by the Director of Nursing to ensure oxygen was coded to reflect the resident's status. 2. On 4/11/2016 an audit of other resident's MDS assessments was completed by MDS nurses to ensure that resident receiving special treatments or procedures was coded to reflect the resident's current status on the MDS; concerns were address at that time. 3. Root cause analysis was completed by Interdisciplinary team (IDT) on 4/18/2016. It was determined that the MDS coordinator did not code the oxygen use on the MDS. Systemic change: The Director of Nursing or designee will review residents MDS prior to submission monthly to ensure residents receiving special treatments or procedures are coded and captured on MDS to reflect the residents status. On 4/11/2016 the MDS Coordinator was re-educated by the Director of Nursing on coding oxygen and other special treatment, procedures, and programs on the MDS to ensure that the MDS is coded to reflect the resident's current status.		

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F 309	Continued From page 8 However, the resident's care plan did not include how frequently and when the hospice personnel would provide services related to his ADL needs. During an interview on 4/1/16 at 10:15 am, the DON stated hospice care was not sufficiently incorporated into Resident #11's plan and the plan would be updated. The facility failed to develop a coordinated plan of care with the resident's hospice agency which specified the care and services provided to the resident by the facility and those care and services provided to the resident by the hospice personnel. 2. Resident #7 was admitted to the facility with multiple diagnoses including dementia, major depressive disorder, and generalized anxiety disorder. Resident #7 was certified for hospice on 12/15/15. The resident's care plan contained 18 identified needs with different dates. Three of the identified needs contained hospice interventions, as follows: - hospice, 12/15/15, changed hospice company, coordinate care with hospice team, and provide resident and family with grief and spiritual counselling if desired. - ADLs, 10/9/14, coordinate care with hospice. - End of life, 10/9/14, on hospice care related to end stage dementia. The resident's care plan did not include how	F 309	4. Beginning the week of 4/30/2016 the Director of Nursing or designee will conduct audits of the MDS coding for special treatment, procedures, and programs weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure resident assessments is coded per the RAI manual to reflect the residents status. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI committee will make recommendations and determine continued monitoring. The Director of Nursing will be responsible for monitoring and follow-up. F 309 1. On 4/7/2016, Resident's # 7, 10, and 11's Individual care plans were updated by the IDT to reflect the coordinated care and services which the facility and hospice will provide for the Individual resident needs. 2. On 4/11/2016 an audit of other residents receiving hospice services was completed by the Social Service Director to ensure Individual plans of care were updated to reflect the care and services which the facility and hospice will provide for the Individual resident needs; concerns were addressed at that time.	4/30/2016	

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F 309	<p>Continued From page 9</p> <p>frequently and when the hospice would provide services and how the resident's care needs would be met related to skilled nursing, HHA, MSW, and Chaplain.</p> <p>During an interview on 3/31/16 at 10:08 am, LN #1 reviewed the resident's care plan and said the care plan would be updated for each hospice discipline.</p> <p>The facility failed to develop a coordinated plan of care with the resident's hospice agency which specified the care and services provided to the resident by the facility and those care and services provided to the resident by the hospice personnel.</p> <p>3. Review of Resident #10's March 2016 "Physician Orders" indicated the resident had diagnoses that included saddle embolus of pulmonary artery without acute cor pulmonale (a blood clot in the lungs that did not cause heart complications), other Alzheimer's disease, generalized anxiety disorder, chronic pain, and restlessness and agitation.</p> <p>Review of a hospice "Rapid Referral" form, dated 3/4/16, indicated the hospice admitted the resident to its services on 3/5/16 due to Alzheimer's dementia and overall decline.</p> <p>Review of the facility's plan of care for Resident #10, reviewed by the facility staff on 3/25/16, indicated the following problem and interventions: "Problem Onset: 3/5/16 I have chosen to receive hospice care dx of senile degeneration of the brain." The interventions included: a. "Hospice services thru (sic) [hospice name and phone number]";</p>	F 309	<p>3. Root cause analysis was completed by IDT team on 4/18/2016. It was determined that the facility did not include in the plan of care for each individuals receiving hospice services to reflect unique services and coordination of care provided by the facility and by hospice.</p> <p>Systemic change: The facility IDT will review and update the plan of care for each individual receiving hospice services to reflect unique services provided by the facility and by hospice during the quarterly care conferences and as changes occur for each resident.</p> <p>Beginning on 4/11/2016 the Social Service Director and IDT were re-educated by the Director of Nursing regarding the revision and updates of individuals receiving hospice services to reflect unique services provided by the facility and by hospice during the quarterly care conferences and as changes occur for each resident on hospice services.</p> <p>4. Beginning the week of 4/30/2016 the Social Service Director will conduct audits of residents' care plan who are receiving hospice services weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure the plan of care for each individual receiving hospice services reflect the unique services provided by the facility and by hospice. A report will be submitted to the Quality Assurance</p>	

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F 309	Continued From page 10 b. "Coordinate my care with my Hospice Team"; c. "Coordinate with the Hospice Team to assure I experience as little pain as possible"; and d. "Provide me and my family with grief and spiritual counseling if desired." The staff failed to develop a coordinated plan of care with the resident's hospice agency which specified the care and services provided to the resident by the facility and those care and services provided to the resident by the hospice personnel.	F 309	Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations for and determine continued monitoring. The Social Service Director will be responsible for monitoring and follow-up. 4/30/2015	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the staff performed a mechanical lift transfer in a safe and professionally-accepted manner for 1 of 13 (Resident #4) residents. This deficient practice had the potential to cause more than minimal harm from possible falls for residents that required the use of a mechanical lift for transfers. Findings included: Review of Resident #4's March 2016 "Physician's Orders" indicated the facility admitted the resident	F 323	F 323 1. On 4/5/16, Resident #4 was re-assessed for concerns regarding the transfer with the Hoyer lift, by the Social Service Director, and the nurse manager; with no physical or psychosocial concerns noted. 2. Beginning 4/11/2016 observations were completed by the Staff Development Coordinator and nurse manager of each certified nursing assistant (C.N.A.) to ensure safety procedures were followed for handling of residents during a mechanical lift transfer; concerns were addressed at that time.	

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F 323	<p>Continued From page 11</p> <p>on 1/9/15 with diagnoses that included dementia without behavioral disturbance, type II diabetes mellitus with diabetic peripheral neuropathy (nerve pain in the extremities), pain in the left and right knees, rheumatoid arthritis and generalized osteoarthritis, other chronic pain, and systemic lupus (an autoimmune disorder).</p> <p>Review of the resident's 1/13/16 quarterly MDS coded Resident #4 had severe cognitive impairment, limited range of motion to both lower extremities and required total assistance of two or more persons for transfer. The assessment indicated the resident stood 67 inches tall and weighed 273 pounds.</p> <p>Review of the resident's plan of care, last reviewed/ revised on 1/14/16, a problem statement with an onset date of 1/13/15, that read: "...ADL's: I require staff assistance for all ADL's related to dementia, impaired mobility, pain, (and) impaired vision." The plan of care directed the staff to, "...Transfer (the resident) with 2 (two) assist to and from bed - Hoyer."</p> <p>Observation on 3/28/16, beginning at 4:40 pm, revealed Resident #4 lying in bed on her back. CNA #4 elevated the resident's bed and completed incontinent care for the resident. While observed by the surveyor and the facility's SDC, CNA #4 placed a mechanical lift sling under the resident. CNA #4, along with CNA #5, then attached the loops of the sling to the mechanical lift cross bar and CNA #5 operated the mechanical lift to raise the resident into the air. While CNA #4 steadied the resident in the sling, CNA #5 backed the lift away from the bed and turned the lift around in preparation for lowering the resident into her wheelchair. CNA #4 then</p>	F 323	<p>3 Beginning on 4/6/2016 a root cause analysis was completed by IDT team. It was determined that per manufacturers guidelines it is routine to transfer from the front, but it is possible to transfer from the side, depending on the resident's specific needs. The facility reevaluated residents who require a mechanical lift to determine the need for transferring from the side and that it did not place the resident at risk for accidental hazard. Specific interventions were reflected in the plan of care.</p> <p>Systemic change: The Certified Nursing Assistants will be observed quarterly by the Staff Development Coordinator or designee to ensure the standard of practice for transferring resident with a mechanical lift are adhered to.</p> <p>Beginning on 4/11/2016 the facility licensed staff and certified nursing assistance were reeducated on the standard of practice for transferring resident with a mechanical lift.</p>	

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F 323	Continued From page 12 rolled the resident's wheelchair into the "V"-shaped space created by the fully opened base legs of the lift. Continued observation revealed that because CNA #4 failed to remove the wheelchair pedals from the wheelchair, the wheelchair could not roll far enough into the "V" of the base legs to allow CNA #5 to lower the resident into the wheelchair. While the resident remained suspended in the air, CNA #4 then rolled the wheelchair back out of the "V" and maneuvered the wheelchair over the lift's right leg base. CNA #5 then attempted to lower the resident into the wheelchair but found the wheelchair sat too far back to position the resident in the seat of the wheelchair. CNA #5 raised the resident back up and CNA #4 removed the wheelchair sideways off of the lift's right base leg, mildly jostling the lift in the process. CNA #4 then maneuvered the wheelchair over the lift's left leg base and pulled the wheelchair back far enough to allow the resident to be lowered into the seat of the wheelchair. As CNA #4 stood behind the wheelchair and guided the resident, CNA #5 lowered the resident into the seat of the wheelchair. During the lowering process, the resident's back caused the wheelchair to tilt backwards slightly. Continued observation revealed that as the resident's full weight settled on the seat of the wheelchair, a bolt on the right front wheel of the wheelchair caught on, and then slipped off of the lift's left base leg causing the front of the wheelchair to jolt to the floor. The resident vocalized "Oh!" during the jolt. With the resident fully seated in the wheelchair, CNA #5 then removed the lift from underneath the wheelchair. During an interview on 3/28/16 at 5:05 pm, CNA #4 stated she had been a CNA for one year and	F 323	4. Beginning the week of 4/30/2016 the Staff Development Coordinator or designee will conduct audits of mechanical lift transfers weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure that staff are demonstrating knowledge of safe transfers involving the Hoyer lift. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations, and determine continued monitoring. The Administrator will be responsible for monitoring and follow-up.	4/30/2016	

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F 323	<p>Continued From page 13</p> <p>had worked at the facility for two to three months. The CNA stated that during her orientation she received instruction on using the Hoyer lift. The CNA stated she watched a long-term facility CNA perform a resident transfer with the mechanical lift and then she performed a resident transfer along with the other CNA. CNA #4 stated there should always be two staff to perform a resident transfer with the mechanical lift and that the lift's base legs should be opened to their fullest position during the procedure. The CNA did not indicate that she knew the manner in which she placed the wheelchair over the lift's base legs was incorrect and could pose a safety risk.</p> <p>During an interview on 3/30/16 at 11:30 am, the SDC stated that CNA #4 had not been retrained on the use of the mechanical lift. The SDC asked the surveyor about the concerns with the mechanical lift transfer that CNA #4 and CNA #5 performed with Resident #4. When the surveyor explained the potential safety issue with placing the wheelchair over the base legs of the mechanical lift, the SDC stated that CNA #4 would receive retraining on mechanical lift use that day.</p> <p>During an interview on 3/30/16 at 5:40 pm, CNA #4 stated she had not yet received additional training on the use of the mechanical lift. CNA #4 stated that she had been scheduled to work with a more experienced CNA that shift and would receive additional training on mechanical lift use and transfers in general that evening.</p> <p>During an interview on 3/31/16 at 10:00 am, the Administrator stated that she had found information on the internet regarding the sideways use of a mechanical lift for transferring</p>	F 323		

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F 323	Continued From page 14 residents into cars and that CNA #4 may have mistakenly used that information to transfer Resident #4. During an interview on 3/31/16 at 3:00 pm, lead CNA #6 stated she restrained CNA #4 on the use of the mechanical lift and observed the CNA safely transfer two residents on 3/29/16 and an additional three residents on 3/30/16. A review on 3/31/16 of an undated "Safety Guide" for "Patient Lifts" on the U.S. Food and Drug Administration website revealed the following information: "... Move (the) lift base legs near or around patient's device. Base legs are usually more stable in full open position." A review of the facility's documentation for a "C.N.A. Staff Meeting" held in February 2016 revealed the facility provided education to the CNA staff regarding, "Hoyer Lift Transfers Competencies Observed by Nursing." The information provided during the education directed the CNAs to, "...Ensure the legs are open on (the) Hoyer lift..." but did not address the placement of residents' wheelchairs within the "V"-shaped space between the base legs of the mechanical lift and not over the base legs.	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;	F 328 F 328	1. On 4/6/2016 Resident #7 was re assessed by the licensed nurse manager with no concern related to her oxygen use.	

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F 328	<p>Continued From page 15</p> <p>Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to administer oxygen as ordered for 1 of 2 residents (#7) reviewed for oxygen. The failure created the potential for the resident to receive unnecessary oxygen therapy. Findings included:</p> <p>Resident #7 was admitted to the facility with multiple diagnoses including dementia, major depressive disorder, and generalized anxiety disorder.</p> <p>On 3/28/16 at 2:25 pm, the resident was observed in bed with NC connected to a concentrator at 2 liters per minute. The resident was not administered O2 at any other observation timeframes during the survey process.</p> <p>The resident's 2/2016 Physician Orders contained a 3/28/15 order for O2 at 2 liters per NC to keep O2 saturations above 90% (percent) and staff were to obtain oxygen saturations every shift.</p> <p>The resident's 10/21/15 O2 care plan approaches included administer O2 as ordered and monitor O2 saturations.</p> <p>The resident's 1/2016 to 3/2016 MARs documented the resident was administered O2 at 2 liters every day on the night shift and saturations ranged from a low of 92% to a high of</p>	F 328	<p>2. On 4/11/2016, an audit of residents who are receiving oxygen was conducted by the nurse manager to ensure the residents are receiving the physician ordered oxygen and documentation is recorded; concerns were addressed at that time.</p> <p>3. Root cause analysis was completed by IDT team on 4/18/2016. It was determined that this resident had an order for PRN oxygen to keep her sats above 90%, and staff were applying it routinely at night per this residents needs without obtaining an MD order to support the administration.</p> <p>Systemic change: The Licensed Nurse manager will review physician's orders monthly of residents who are receiving oxygen, to ensure they are receiving oxygen per physician orders and it is documented as required.</p> <p>Beginning on 4/11/2016 the facility licensed staff were reeducated by the Staff Development Coordinator related to residents receiving oxygen and ensuring they receive the treatment and care as ordered by the physician and documentation supports the need.</p>	

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F 328	<p>Continued From page 16 96%.</p> <p>The resident's Vital Signs & Weight Flow Sheet documented on 2/1/16 the resident's O2 saturations were 90%.</p> <p>The resident's Nurses Notes and MARs did not contain documentation that the resident's O2 saturations were determined at or below 90 percent from 1/2016 to 3/2016 to warrant the use of O2 at 2 liters every day on the night shift.</p> <p>When asked during an interview on 3/31/16 at 5:06 pm, the Administrator provided the original 3/28/15 O2 order to Initiate O2 therapy at 2 liters per minute to keep saturations above 90 percent.</p> <p>However, the physician did not order the O2 therapy to be administered as was documented on the reviewed MARs.</p>	F 328	<p>4. Beginning the week of 4/30/2016 the Staff Development Coordinator or designee will conduct audits of residents who receive oxygen weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure residents are receiving care and needs related to the oxygen use as ordered by the physician. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations and determine continued monitoring. The Director of nursing will be responsible for monitoring and follow-up.</p>	4/30/2016
F 329 SS-D	<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 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition</p>	F 329	<p>1. On 4/7/2016, Resident #2 was re-assessed by the licensed nurse manager with no concern related to Seroquel use. Resident #2 was also re-assessed by the Social Service Director with no psychosocial needs noted related to Seroquel use.</p> <p>2. On 4/11/2016 an audit of residents who are receiving Antipsychotic medication was completed by the IDT to ensure the drug therapy is necessary to treat a specific condition as diagnosed and documentation is present in the clinical record to support the need to increase or continued use; Concerns were</p>	addressed at that time.

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F 329	<p>Continued From page 17</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure drugs used to control behavior considered to be maladaptive were adequately indicated and appropriately monitored for 1 of 6 residents (#2) reviewed who received behavior modifying drugs. This failure had the potential for harm if the resident received drugs not needed to treat a specific medical condition, or experienced adverse side effects of those drugs. Findings included:</p> <p>Resident #2 was admitted to the facility on 3/20/14 with diagnoses which included dementia with behavioral disturbances and anxiety disorder unspecified. The most recent annual MDS assessment, dated 3/4/16, documented moderate cognitive impairment and the use of antipsychotic, anti-anxiety, and anti-depressive drug use.</p> <p>Resident #2's care plan, dated 3/6/16, included an entry dated 4/20/15 which stated "MD decline GDR of antipsychotic dose reduction is contraindicated because benefits outweigh risk, reduction is likely to impair [patient] function</p>	F 329	<p>3. Root cause analysis was completed by IDT team on 4/18/2016. It was determined that this resident had a gradual dose reduction to resident's Seroquel on 12/12/2015. This resident went without any documented behaviors for 60 days, and began to display behaviors to include, physical and verbal aggression, delusions, and hallucinations, intrusive wandering, paranoia, changes in appetite, and also was easily angered. The documentation was placed on her behavior monitor per her displayed behaviors, but there were no nursing notes documented in regards to how often or long did resident's outburst last throughout the day the behavior was documented on the monitor. The facility set up an appointment with this resident's mental health provider, who increased this residents Seroquel based on the information that was documented on the February Behavior Monitor and resident's current medication regime.</p> <p>Systemic change: The Psychotropic committee will review residents who are on an Antipsychotic medication to ensure the drug therapy is necessary and documentation is present in the clinical record to support the new medication order, increase and or continued use.</p>	

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F 329	Continued From page 18 [and/or] cause psychiatric instability." Resident #2's drug regime and behavior monitors documented reductions and subsequent increases were made to behavior modifying drugs without sufficient indications being present, as follows: Resident #2's Psychoactive Medication Quarterly Evaluation for Seroquel, dated 8/11/14, stated she received 100 mg daily for verbal and physical aggression, and for verbal disruption in the resident environment. A subsequent entry, dated 9/8/15, stated Seroquel was reduced to 50 mg on 8/18/15. Resident #2's Psychoactive Medication Quarterly Evaluation for Ativan, dated 8/11/15, stated she received 0.5 mg three times daily for irritability, being easily angered, and being restless. A subsequent entry, dated 9/8/15, stated the drug was decreased on 8/19/15 to 0.5 mg at noon and HS, and 0.25 mg at 4:00 pm Both evaluation forms documented no change in Resident #2's target behaviors from the date of the decrease to the date of the review. Resident #2's November 2015 MAR documented Zoloff had been decreased from 200 mg daily to 150 mg on 9/18/15. Resident #2's behavior monitors for November 2015 were reviewed and documented the following: - 11/14: A "2" was present on the record indicating physical aggression (defined as hitting, kicking, or slapping). A "1, 2" was present under	F 329	Beginning on 4/11/2016 the facility licensed staff were reeducated by the Staff Development Coordinator related to residents receiving Antipsychotic medication to ensure the documentation is present in the clinical record to support the new medication order, increase and or continued use. 4. Beginning the week of 4/30/2016 the Director of Nursing or designee will conduct audits of residents receive psychotropic medications weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure residents receiving Antipsychotic medication have supporting documentation present in the clinical record to support the need of a new medication order, increase and or continued use. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations and determine continued monitoring. The Director of Nursing will be responsible for monitoring and follow-up.	4/30/2016	

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F 329	<p>Continued From page 19</p> <p>interventions, indicating "engage in conversation" and "Reapproach 10-15 minutes, ensure safety." Outcome was marked "+" indicating "improved."</p> <p>- 11/23: A "1" was present in the record indicating verbal aggression (defined as yelling or screaming). No interventions were documented.</p> <p>No indicators of depressive symptoms or anxiety symptoms were documented.</p> <p>Resident #2's November 2016 MAR documented Zolof was decreased to 100 mg on 11/20/15.</p> <p>Resident #2's behavior monitors for December 2015 were reviewed and documented no behaviors were exhibited. The December 2015 MAR documented Seroquel was further decreased to 25 mg daily on 12/10/15.</p> <p>Resident #2's behavior monitors for January 2016 were reviewed and documented no behaviors were exhibited.</p> <p>Resident #2's behavior monitors for February 2016 documented intrusive wandering and being verbally disruptive in the resident environment on 4 days, and verbal and physical aggression on 4 days, between 2/19 and 2/26. Anxiety behaviors of being easily irritated or angered were documented on 5 days from 2/19 to 2/23, and depressive symptoms of having a sad/pained/worried facial expressing, being tearful/crying, and making derogatory statements about self were documented on 2/19. Interventions were documented as unsuccessful.</p> <p>Resident #2's behavior monitors for March 2016 documented intrusive wandering and being</p>	F 329		

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F 329	<p>Continued From page 20</p> <p>verbally disruptive in the resident environment on 3/3. No other behavioral issues were documented for February or March 2016.</p> <p>A "Resident Social Progress Notes," dated 3/4/16, stated Resident #2 "has been noted to have episodes of verbal/physical abuse toward staff, easily irritated/angered see behavior sheet. Staff [at] this time will give her space and this help [decrease] behaviors."</p> <p>No additional documentation related to the behavioral spike, documented between 2/19/16 and 3/3/16, was present in the record (e.g., who the behaviors were directed towards, intensity of the behaviors, duration of the behaviors, etc.). Additionally, no information indicating the potential cause of the behavior spike (environmental factors, new staff on the unit, staffing patterns, etc.) had been investigated or assessed was documented in the record.</p> <p>Resident #2's psychiatric Progress Note, dated 3/9/16, stated "Pt [Patient] is here with [van driver]. She has been having some trouble in the afternoon. Lashing out. Getting agitated, throwing things at nurses." The note stated "She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous ... Mood presents as normal with no signs of either depression or mood elevation. Affect is appropriate, full range, and congruent with mood. Behavior suggests that hallucinations are being experienced. Delusional ideas are expressed. Her thoughts are so disorganized that only words are intelligible."</p> <p>The "Recommendations" section stated "Increase Zoloft to 150 mg and Seroquel to 50 mg." On</p>	F 329			

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F 329	Continued From page 21 3/9/16, Resident #2's Seroquel was increased to 50 mg dally and Zoloft was increased to 150 mg dally. Resident #2's record documented Seroquel was decreased on 8/18/15 and 12/10/15, Zoloft was decreased on 9/18/15 and 11/20/15, and Ativan was decreased on 8/19/15. With the exception of two days in November 2015 (11/14 and 11/23), no behaviors were documented during the reduction period until 2/19/16, more than 2 months after the last reduction. Additionally, no documentation related to the intensity, duration, impact, or potential causes of the behavioral spike, documented from 2/19/16 - 2/23/16, could be found in the record to justify the increase to both Seroquel and Zoloft on 3/9/16. During an interview on 3/31/16 at 1:45 pm, LN #1 stated narrative information related to the intensity and duration of Resident #2's behaviors should be documented in the Nursing Notes. However, Nursing Notes for Resident #2 from 1/6/16 - 3/3/16 were not present in the record. LN #1 stated the 9 days of behavior documented between 2/19/16 - 3/3/16 was sufficient to demonstrate a failed drug reduction. The facility failed to ensure Resident #2's record documented comprehensive information indicating the need to increase her Zoloft and Seroquel.	F 329			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F 332 1. On 4/7/2016, Resident #12 was re-assessed by the licensed nurse manager with no concerns related to the administration of the prescription eye medication.		

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F 332	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents were free of medication errors exceeding a rate of 5-percent. This was true for 2 of 28 medication administrations observed between 3/28/16 and 4/1/16. This 7.14-percent medication error rate created the potential for residents to receive the wrong medications, wrong time of administration, wrong dosage, and/or wrong route of administration. Findings included: Observation on 3/29/16 at 7:21 am with the SDC present revealed LPN #8 shook Resident #12's bottle of prednisolone 1% eye drops to mix the solution. The LPN then instilled one drop of the medication into the resident's left eye and instructed the resident to close her eyes. The LPN applied light finger pressure to the resident's left lacrimal sac for approximately three seconds. The LPN then instilled one drop of the medication into the resident's right eye and again instructed the resident to close her eyes. The LPN applied light finger pressure to the resident's right lacrimal sac for three seconds. LPN #8 then waited five minutes before the administration of the resident's Combigan eye drops. Continued observation revealed LPN #8 shook Resident #12's bottle of Combigan eye drops to mix the solution. The LPN then instilled one drop of the medication into the resident's left eye and instructed the resident to close her eyes. The LPN applied light finger pressure to the resident's left lacrimal sac for four seconds. The LPN then	F 332	2. On 4/11/2016, an audit of residents who are receiving eye medication was completed by the nurse manager to ensure the instructions per the manufacture guidelines are placed on the medication administration record and that eye medications are administered as directed; concerns were addressed at that time. 3. Root cause analysis was completed by IDT team on 4/18/2016. It was determined that the facility LN applied pressure to the eye for 3 seconds; the manufacturer guidelines recommended for holding pressure for 1 minute to avoid systemic absorption. Systemic change: The facility will place the manufacturers guidelines per eye medication administration on the medication administration record (MAR) to ensure the licensed nurses are aware of the specifications per eye drop administration. Beginning on 4/11/2016 the facility licensed staff were reeducated by the Staff Development Coordinator related to the administration of eye medications and the referencing of the manufacturer guidelines per each medication. On 4/13/16 the Administrator contacted the pharmacists regarding the request of re-education for facilities licensed nurses on eye medication administration per manufacturer's guidelines.		

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F 332	<p>Continued From page 23</p> <p>Instilled one drop of the medication into the resident's right eye and again instructed the resident to close her eyes. The LPN applied light finger pressure to the resident's right lacrimal sac for three seconds.</p> <p>During an interview on 3/29/16 at 7:30 am, LPN #8 stated the administration technique and precautions for the resident's prednisolone eye drops included to hold pressure on the resident's inner canthus (inner aspect of the eye lid) "...for a couple of seconds and wait five minutes between (eye) drops if different (eye) drops are administered." LPN #8 then stated that the resident's Combigan eye drops contained a beta-blocker medication and the administration technique and precautions for these eye drops included to hold pressure on the resident's inner canthus of each eye and to monitor the resident for a drop in blood pressure, which would indicate systemic absorption of the medication.</p> <p>Review of medication information for prednisolone 0.1% eye drops and Combigan eye drops contained in "Nursing 2015 Drug Handbook," 35th Edition, indicated that for both medications the staff should, "Apply light finger pressure on (the) lacrimal sac (the tear duct located on the inner aspect of the eye socket) for one minute after instillation..." In order to minimize the potential for systemic absorption of the eye drops.</p> <p>Review of the facility's drug administration book for the "C" hall (the hall on which Resident #12 resides) entitled, "PharMerica C/R 2015-2016," under the drug information for prednisolone 1% eye drops and Combigan eye drops indicated the manual did not contain information regarding the</p>	F 332	<p>4. Beginning the week of 4/30/2016 the Director of Nursing or designee will conduct audits of residents receiving eye medication weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure the specific manufacturer guidelines are being followed with the administration of the eye medication by the licensed nurse. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations and determine continued monitoring. The Director of Nursing will be responsible for monitoring and follow-up.</p>	4/30/16

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F 332	Continued From page 24 application of light finger pressure to the lacrimal sac for one minute after the instillation of drops for either of these eye medications. Review of the facility's policy and procedure entitled, "Medication Administration (for) Eye Drops," 2007, by PharMerica Corp. indicated the policy directed the staff to, "...11. If necessary, press tissue finger (sic) on the lacrimal duct for about one (1) minute to avoid systemic absorption." During an interview on 3/31/16 at 3:40 pm, the DON stated the staff should administer the eye drops per physician's orders and wait either one minute or five minutes depending on the medication administered before applying different eye drops. The DON did not indicate that staff should also apply light finger pressure to the lacrimal glands for one minute to minimize the risk of systemic absorption of eye medications.	F 332			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the staff administered eye drop medications according to instructions specific to the eye medications and per facility policy for 1 of 28 residents (#12) observed during medication administration. This deficient practice had the potential to cause more than minimal harm due to the possibility of	F 333	F 333 1. On 4/7/16, Resident #12 was re-assessed by the licensed nurse manager with no concern related to the administration of the prescription eye medication. 2. On 4/11/2016 an audit of residents who are receiving eye medication was completed by the nurse manager to ensure the instructions per the manufacture guidelines are placed on the medication administration record and that eye medications are administered as directed; concerns were addressed at that time.		

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F 333	Continued From page 25 systemic absorption of the medications and potential for adverse side effects. Findings Included: Review of Resident #12's March 2016 "Physician's Orders" indicated the resident had diagnoses that included glaucoma (an eye disorder that causes increased pressure within the eye and can lead to blindness) and congestive heart failure. The resident's medications included: A. Prednisolone 0.1% (a steroid medication used to decrease inflammation), one drop to both eyes twice daily; and B. Brimonidine-timolol 0.2%-0.5% (Combigan- a combination eye medication used to decrease pressure in the eye), one drop to both eyes twice daily. Review of the manufacturer's package insert for Combigan eye drops, dated 2015, indicated the following precautionary statement: "Combigan contains timolol maleate (a beta-blocker medication); and although administered topically can be absorbed systemically....severe respiratory reactions and cardiac reactions including death due to bronchospasm (spastic narrowing of the airway) in patients with asthma, and rarely death in association with cardiac failure have been reported following systemic or ophthalmic administration of timolol maleate..." Review of medication information for prednisolone 0.1% eye drops and Combigan eye drops contained in "Nursing 2015 Drug Handbook," 35th Edition, indicated that for both medications the staff should, "Apply light finger pressure on (the) lacrimal sac (the tear duct located on the inner aspect of the eye socket) for	F 333	3. Root cause analysis was completed by IDT team on 4/18/2016 It was determined that the facility LN applied pressure to the eye for 3 seconds; the manufacturer guidelines recommended for holding pressure for 1 minute to avoid systemic absorption. Systemic change: The facility will place the manufacturer's guidelines per eye medication administration on the MAR to ensure the licensed nurses are aware of the specifications per eye drop administration. Beginning on 4/11/2016, the facility licensed staff were reeducated by the Staff Development Coordinator related to the administration of eye medications and the referencing of the manufacturer guidelines for medication administration. The facility licensed staff will also be re-educated by the Nurse Consultant on 5/3/2016 through the facilities contracted Pharmacy related to administration of eye medications and the referencing of the manufacturer guidelines for medication administration.	

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F 333	Continued From page 26 one minute after instillation..." In order to minimize the potential for systemic absorption of the eye drops. Observation on 3/29/16 at 7:21 am with the SDC present revealed LPN #8 cleansed her hands with an alcohol-based hand cleanser and put on a clean pair of gloves. The LPN shook Resident #12's bottle of prednisolone 1% eye drops to mix the solution. The LPN then instilled one drop of the medication into the resident's left eye and instructed the resident to close her eyes. The LPN applied light finger pressure to the resident's left lacrimal sac for approximately three seconds. The LPN then instilled one drop of the medication into the resident's right eye and again instructed the resident to close her eyes. The LPN applied light finger pressure to the resident's right lacrimal sac for three seconds. LPN #8 then dabbed away the excess medication from the resident's eyes and waited five minutes before the administration of the resident's Combigan eye drops. Continued observation revealed LPN #8 shook Resident #12's bottle of Combigan eye drops to mix the solution. The LPN then instilled one drop of the medication into the resident's left eye and instructed the resident to close her eyes. The LPN applied light finger pressure to the resident's left lacrimal sac for four seconds. The LPN then instilled one drop of the medication into the resident's right eye and again instructed the resident to close her eyes. The LPN applied light finger pressure to the resident's right lacrimal sac for three seconds. LPN #8 then dabbed away the excess medication from the resident's eyes, returned the medications to the medication cart, removed her gloves, and cleansed her hands.	F 333	4. Beginning the week of 4/30/2016, the Director of Nursing or designee will conduct audits of residents receiving eye medication weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure the specific manufacturer guidelines are being followed with the administration of the eye medication by the licensed nurse. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations, and determine continued monitoring. The Director of Nursing will be responsible for monitoring and follow-up.	4/30/2016	

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PRINTED: 04/08/2016
FORM APPROVED
OMB NO. 0938-0391

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F 333	<p>Continued From page 27</p> <p>During an interview on 3/29/16 at 7:30 am, LPN #8 stated the administration technique and precautions for the resident's prednisolone eye drops included to hold pressure on the resident's inner canthus (inner aspect of the eye lid) "...for a couple of seconds and wait five minutes between (eye) drops if different (eye) drops are administered." LPN #8 then stated that the resident's Combigan eye drops contained a beta-blocker medication and the administration technique and precautions for these eye drops included to hold pressure on the resident's inner canthus of each eye and to monitor the resident for a drop in blood pressure, which would indicate systemic absorption of the medication.</p> <p>During an interview on 3/31/16 at 3:40 pm, the DON stated the staff should assure they have the right medication and the right resident and provide for privacy if the requested by the resident. The staff should then wash their hands, apply gloves and administer the eye drops per physician's orders. The staff should wait either one minute or five minutes depending on the medication administered before applying different eye drops. The DON did not indicate that staff should also apply light finger pressure to the lacrimal glands for one minute to minimize the risk of systemic absorption of eye medications.</p> <p>Review of the facility's drug administration book for the "C" hall (the hall on which Resident #12 resides) entitled, "PharMerica C/R 2015-2016," under the drug information for prednisolone 1% eye drops and Combigan eye drops indicated the manual did not contain information regarding the application of light finger pressure to the lacrimal sac for one minute after the instillation of drops for either of these eye medications.</p>	F 333		

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F 333	Continued From page 28 Review of the facility's policy and procedure entitled, "Medication Administration (for) Eye Drops," 2007, by PharMerica Corp. indicated the policy directed the staff to, "...11. If necessary, press tissue finger (sic) on the lacrimal duct for about one (1) minute to avoid systemic absorption."	F 333			
F 431 SS=D	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	F 431	F 431 1.On 3/31/16 the mentioned medication was immediately discarded from the refrigerator and reordered as indicated. The temperature was also adjusted at that time by the Director of Nursing to ensure the temperature controls were in accordance to the state and federal requirements. The refrigerator temperature log was also updated on 4/1/2016 by the Director of Nursing to reflect the "normal temperature range of the refrigerator" as well as instructions for what to do if concerns of out of range temperatures occur. No residents were noted to be affected. 2.On 4/11/2016 an audit of other medication storage refrigerators was completed by the Director of Nursing to ensure the temperature controls were in accordance to state and federal requirements; concerns were corrected at that time.		

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F 431	<p>Continued From page 29</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility staff failed to maintain the temperature inside one of two medication refrigerators ("C" hall) within the appropriate temperature range for the medications stored within the refrigerator. This deficient practice had the potential to alter the effectiveness of the residents' medications. Findings Included:</p> <p>Review of the storage information listed on the package inserts for the following disposable prefilled insulin pens: Levemir FlexTouch Pens (insert revised on 3/2013), Lantus SoloSTAR pens (date of insert: 2/2015), NovoLog FlexTouch Pens (date of insert: 2/25/15), and Humalog Pens (date of insert: 11/2015) and for Novolin N insulin vials (date of insert: 3/9/13), indicated that the unopened insulin pens and insulin vials must be stored in the refrigerator with a temperature range of 36 degrees F to 46 degrees F and must not be allowed to freeze.</p> <p>Observation and review of the "C" hall medication "Refridgerator (sic)/Freezer Temperature Record" for March 2016 on 3/31/16 at 11:23 am revealed the form listed the "Acceptable Refridgerator (sic) Ranges" as "32 - 40 F (Fahrenheit)." The temperature record also included a directive to the staff that read, "If temperatures are unacceptable, the number is circled and the</p>	F 431	<p>3. Root cause analysis was completed by IDT team on 4/18/2016 It was determined that the medication refrigerator temperature gage was adjusted following the defrosting of the refrigerator and was not re-adjusted to the required temperature following the defrosting of the refrigerator.</p> <p>Systemic change: The Staff Development Coordinator will conduct weekly observations of the daily recorded temperatures of the medication refrigerator with a separate thermometer to ensure the settings are adjusted accordingly and that the temperatures are in accordance to the State and Federal requirements, ranging from 36-46 degrees. Beginning on 4/11/2016 the facility licensed nurses were reeducated on the storage of drugs and biologicals in accordance to the State and Federal requirements regarding the temperature range of the refrigerator of 36-46 degrees, and ensuring that medication refrigerator temperature gauges are adjusted accordingly to ensure the required temperature following the defrosting of the refrigerator.</p>		

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F 431	<p>Continued From page 30</p> <p>supervisor is notified immediately."</p> <p>Further review of the temperature record indicated the temperature inside the refrigerator fell below 36 degrees F on the following dates and times:</p> <ul style="list-style-type: none"> a. 3/6/16 at 12:00 am: 34 degrees F; b. 3/7/16 at 12:00 am: 32 degrees F; c. 3/8/16 at 12:00 am: 34 degrees F; d. 3/22/16: no temperature entered on the record; e. 3/29/16: no temperature entered on the record. <p>Observation of resident medications inside the "C" hall refrigerator on 3/31/16 beginning at 11:23 am revealed the medications included, but were not limited to:</p> <ul style="list-style-type: none"> a. Four unopened Levemir FlexTouch insulin pens; b. Two unopened Lantus SoloSTAR insulin pens; c. Six unopened NovoLog FlexTouch insulin pens; d. Five unopened Humalog insulin pens; and e. One unopened vial of Novolin N. <p>Review of the facility's policy and procedure entitled, "Medication Storage" dated 10/07, indicated, "11. Medications requiring "refrigeration" or "temperatures between 2 degrees C (Celsius) (36 degrees F) and 8 degrees C (46 degrees F) are kept in a refrigerator with a thermometer to allow temperature monitoring."</p> <p>During an interview 3/31/16 at 1:47 pm, with the Administrator, DON, and the MS, the MS stated he did not perform calibration or verification checks on the thermometers kept in the medication refrigerator and that the facility had no procedure in place to ensure accurate</p>	F 431	<p>4. Beginning the week of 4/30/2016, the Staff Development Coordinator or designee, will conduct weekly audits of the medication refrigerator temperatures and settings weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure the temperatures are in accordance to the State and Federal requirements ranging from 36-46 degrees. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations, and determine continued monitoring. The Director of Nursing will be responsible for monitoring and follow-up.</p>	4/30/2016

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F 431	Continued From page 31 temperature readings.	F 431			
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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F 441 1. On 4/6/2016 Resident #4 was re-assessed by the licensed nurse manager with no signs or symptoms of infection. 2. Beginning on 4/11/2016, observations were completed by the Staff Development Coordinator and nurse manager of each Licensed Nurse providing wound care to ensure infection control practices for treatments and wound care were followed; concerns were addressed at that time. Beginning on 4/11/2016, observations were completed by the Staff Development Coordinator and nurse manager of each Certified Nursing Assistant providing perineal care to ensure the standard of practice for infection control was followed to include hand hygiene and ensuring gloves are changed between clean and dirty tasks while providing cares to residents; concerns were addressed at that time.		

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F 441	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the staff changed gloves and washed their hands, and performed wound care per professionally-accepted standards of practice for 1 of 9 residents (#4) reviewed for incontinent care and skin concerns. This deficient practice had the potential to cause more than minimal harm from the possible development of infection due to cross-contamination. Findings included: 1. Review of Resident #4's March 2016 "Physician's Orders" indicated the facility admitted the resident on 1/9/16 with diagnoses that included dementia without behavioral disturbance and cellulitis of the trunk (an infection of the skin). The "Physician's Orders" directed the staff to apply mupirocin (an antibiotic ointment) to affected areas twice daily. Review of the resident's plan of care, reviewed by the staff on 1/14/16, indicated a problem statement with an onset date of 1/13/15 that read: "...I am incontinent of urine..." The plan of care directed the staff to, "...Provide incontinent care each episode..." Further review of the plan of care indicated the staff added a problem statement on 1/29/16, which read, "Cellulitis to abd." The interventions included: "...Ensure wound care is given as ordered by my physician..." The facility's undated handwashing during pericare procedure stated, "1. Wash hands and put on gloves...5. Have two staff. 1 clean/1	F 441	3. Root cause analysis was completed by IDT team on 4/16/2016. It was determined that both the licensed nurse and Certified Nursing assistant did not follow the facility standards of practice for infection control when providing cares to residents. Systemic change: The Licensed Nurses will be observed quarterly and as needed, by the Staff Development Coordinator or designee to ensure that infection control practices are followed for treatments and wound care. The Certified Nursing Assistance (CNA) will be observed quarterly by the Staff Development Coordinator or designee to ensure the standard of practice for infection control is followed to include hand hygiene and ensuring gloves are changed between clean and dirty tasks while providing cares to residents. Beginning on 4/11/2016 both the licensed nurses and certified nursing assistance (to include LN #10, and C.N.A. #), were re-educated by the Staff Development Coordinator in regards to infection control practices related to treatments, wound care, and perineal care.	

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F 441	Continued From page 33 dirty...8. Clean CNA to hand clean supplies to Dirty CNA...9. CNA cleans peri-area from front to back...12. Clean CNA replaces attends and wet linen if needed...16. Remove gloves and wash hands..." a. Observation on 3/28/16 at 4:40 pm, with the facility's SDC present, revealed CNA #4 provided incontinent care for Resident #4. The CNA washed her hands and applied a clean pair of gloves. The CNA completed cleansing of the resident's front genital area. Without first removing her gloves, washing her hands, and applying clean gloves, the CNA used her now contaminated gloved hands to assist the resident to roll to the left side by touching the right shoulder of the resident's shirt and the resident's right outer thigh to pull the resident toward her. The CNA walked to the other side of the resident's bed and cleansed the resident's right buttock. The CNA then used her contaminated gloves to assist the resident to roll to the right side by touching the left shoulder of the resident's shirt and the resident's outer left thigh to pull the resident toward her. CNA #4 walked back to the other side of the resident's bed and cleansed the resident's left buttock. CNA #4 then left the resident's bedside and used her contaminated gloves to open the resident's closet and retrieve a clean draw sheet and placed the sheet and a clean brief under the resident's right hip. The CNA then used her contaminated gloves to pick up and open the resident's tube of barrier cream and applied the cream to the resident's buttocks. After applying the barrier cream, the CNA removed her gloves and applied a clean pair of gloves without first washing her hands. CNA #4 then assisted the resident to roll toward her, straightened the resident's clean brief and the	F 441	4. Beginning the week of 4/30/2016 the Staff Development Coordinator or designee will conduct audits of both wound care and perineal care weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure that infection control practices related to treatments of wound care and perineal care are followed. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations, and determine continued monitoring. The Director of Nursing will be responsible for monitoring and follow-up.	4/30/2016	

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F 441	<p>Continued From page 34</p> <p>resident rolled back to a supine position. The CNA then redressed the resident, placed the mechanical lift sling under the resident and assisted with transferring the resident to a wheelchair. CNA #4 then removed her gloves, gathered the trash and soiled linen bags and exited the resident's room without first washing her hands.</p> <p>During an interview on 3/28/16 at 5:05 pm CNA #4 stated she began work at the facility two to three months prior. The CNA stated that she received education on incontinent care and glove use upon orientation. CNA #4 stated that she should have changed her gloves before she placed the clean brief and sheet under the resident and applied barrier cream to the resident's buttocks.</p> <p>During an interview on 3/30/16 at 11:30 am the facility's SDC stated that CNA #4 received retraining on handwashing, gloving and perineal care on the evening of 3/28/16 after the observation of incontinent care for Resident #4.</p> <p>Review of a copy of a paper entitled, "Infection Control" dated 3/28/16, indicated the facility retrained CNA #4 on handwashing, glove use and perineal care. The paper included the signatures of both CNA #4 and the facility's Administrator.</p> <p>During an interview on 3/31/16 at 3:40 pm the Administrator and the DON stated they would expect the staff to remove their gloves, wash their hands, and re-glove when going from dirty to clean during Incontinent care and prior to leaving a resident's room.</p> <p>b. Observation on 3/30/16 at 11:15 am, LPN #10</p>	F 441			

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F 441	<p>Continued From page 35</p> <p>prepared supplies to perform wound care for Resident #4. The supplies included a pair of clean gloves, a tube of mupirocin ointment, and a tube of skin repair cream. LPN #10 entered the resident's room and placed the supplies including the pair of clean gloves, on top of the resident's over-the-bed table without first disinfecting the tabletop or placing a clean barrier on the tabletop. After the LPN washed her hands, she applied the now potentially contaminated pair of gloves. The resident raised her shirt to reveal four circular wound areas on the front of her abdomen. One of the four wounds appeared closed with new pink skin covering the wound site. LPN #10 used the potentially contaminated gloves to open the tube of mupirocin ointment and applied a small amount of the ointment to the tips of her gloved index and middle fingers of her right hand. The LPN then used her middle finger to apply ointment to one of the three wounds and used her index finger to apply the ointment to the other two wounds potentially cross-contaminating the third wound. LPN #10 then removed her gloves, washed her hands and applied a clean pair of gloves retrieved from a glove supply box in the room, and applied the skin repair cream to the resident's arms.</p> <p>During an interview on 3/30/16 at 11:25 am LPN #10 stated she should have placed the wound care supplies and clean gloves on a clean barrier and acknowledged that she used one fingertip to apply antibiotic ointment to two of the resident's wounds.</p> <p>During an interview on 3/31/16 at 3:40 pm, the Administrator stated she expected the staff to use a clean Chux pad (a disposable pad also used to protect surfaces from incontinence) or clean</p>	F 441			

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F 441	Continued From page 36 towel as a barrier for supplies and to use sterile Q-Tips or different fingertips to apply medication to different wounds on the resident's skin.	F 441			