



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
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May 11, 2016

Chuck Williams, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Williams:

On **April 28, 2016**, a survey was conducted at Riverview Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

After each deficiency has been answered and dated, the administrator should sign the Form

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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 **May 21, 2016**. Failure to submit an acceptable PoC by **May 21, 2016**, may result in the imposition of civil monetary penalties by **June 13, 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.

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

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

Civil money penalty, effective **April 28, 2016**. 42 CFR §488.430

Denial of payment for new admissions effective **July 28, 2016**. 42 CFR §488.417(a)

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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 **October 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.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **May 21, 2016**. If your request for informal dispute resolution is received after **May 21, 2016**, the request will not be granted. An incomplete informal dispute

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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, appearing to read "David Scott for".

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/28/2016
NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706		
(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 annual federal recertification survey and complaint investigation of your facility from April 25, 2016 to April 28, 2016.</p> <p>The surveyors conducting the survey were: Evelyn Floyd, JD, MS, RN, Team Coordinator Amy Barkley, BSN, RN Linda Kelly, RN</p> <p>Abbreviations: ADL= Activities of Daily Living BG = Blood glucose BIPAP = Bi-level Positive Airway Pressure CCA - Corporate Compliance Auditor CPAP = Continuous Positive Airway Pressure CNA = Certified Nursing Assistant COTA = Certified Occupational Therapy Assistant CVA = Cerebrovascular accident DON = Director of Nursing DME = Device and Medical Equipment ER = Emergency Room I & A = Incident and Accident report IDT=Interdisciplinary Team IV = Intravenous NP = Nurse Practitioner LN = Licensed Nurse LSW= Licensed Social Worker MAR = Medication Administration Record MDS= Minimum Data Set Assessment mg = Milligram(s) OT= Occupational Therapy prn = As needed PCC = Point Click Care PT= Physical Therapy POA = Power of Attorney RCO = Regional Compliance Officer</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

05/20/2016

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

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F 000	Continued From page 1 ROM = Range of motion POST = Physician Orders for Scope of Treatment Pyxis = Medication Dispensing Machine pt= patient q = every rehab=Rehabilitation r/t= related to sub-q = Subcutaneously TAR = Treatment Administration Record w/c = Wheelchair < = less than or equal to	F 000			
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to	F 156		5/21/16	

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F 156	<p>Continued From page 2</p> <p>the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance</p>	F 156			

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F 156	<p>Continued From page 3 directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, family, and staff interviews, and policy review, it was determined the facility failed to ensure 4 of 9 sample residents (#s 2, 4, 5, and 6) were informed of their rights in writing prior to or upon admission to the facility and/or that the clinical records documented a reason for the delay. The deficient practice created the potential for more than minimal harm when residents did not have written information about exercising their rights and out-of-pocket costs before or at the time of admission to the facility. Findings included:</p> <p>The facility's Admission Agreement included "Resident Rights" and "General Information" regarding financial responsibility, bed hold, transfer or discharge, medical treatment, self-medication, visitation, access to personal medical records, rules and regulations, and advance directives, and other pertinent information.</p>	F 156	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverview Rehabilitation does not admit that the deficiencies listed on the CMS 2567 exists, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies.</p> <p>I. a. Resident #2 signed the admission agreement on 4/23/2016 and readmission 5/6/2016. b. Resident #4 signed the admission agreement on 4/25/2016. c. Resident #5 signed the admission agreement on 4/23/2016. d. Resident #6 signed the admission agreement on 4/25/2006. II. All newly admitted residents have the potential to be affected. The admission</p>		

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F 156	<p>Continued From page 4</p> <p>On 4/26/16 at 8:25 am, review of the Admission Agreement documented, "At the time of admission, the resident (or his/her representative) must sign an Admission Agreement (contract)..."</p> <p>On 4/27/16 at 3:00 pm, the facility's Community Liaison said she was responsible for getting admission agreements signed. The Liaison said that she visited patients in the hospital and verbally reviewed the facility's admission process, costs, and resident rights with them prior to their discharge. She said the admission agreement was usually printed and ready for signature when residents arrived at the facility but sometimes the insurance information may not be ready. The Liaison said she tried to get the Admission Agreement signed when a resident was admitted to the facility but sometimes they refused, were in therapy, had visitors, or were asleep. The Liaison said she would go back every 30 minutes, if necessary, until the agreement was signed.</p> <p>On 4/27/16 at 8:05 am, LN #2, who identified herself as the Unit Manager, said she sometimes admitted new residents. The LN said she would have the new resident sign a consent for treatment, side rail consent, and consents for anti-psychotic medications, if ordered. The LN said she could not think of anything else the resident would sign, other than a POST, and that the Community Liaison took care of the Admission Agreement.</p> <p>On 4/27/16 at 8:15 am, LN #1 said she did admit new residents to the facility and the first consent they were asked to sign was a consent for treatment. The LN said the new resident also signed consents for side rails and bed bolsters,</p>	F 156	<p>coordinator/designee will have the admission agreement presented to, and signed by the resident and/or the responsible party/POA at or before the time of entry, including while the resident is still in the hospital. An additional copy of the residents rights, and potential out of pocket expenses, will be supplied to the resident at the time of admission. If the admission agreement is not signed on or before the day of admission, the coordinator/designee will document in the record all attempts to get the agreement signed in a timely manner.</p> <p>III. The admission coordinator will receive training on this requirement, and the training will be documented and a copy put in their personnel file.</p> <p>IV. The medical records clerk/front desk/designee will audit all admissions for compliance, and report to the administrator the findings.</p> <p>Noncompliance will be handled by the administrator/designee, including the development of alternative plans to achieve compliance. The administrator will report the findings to the monthly QA meeting for 3 months, or until there is 100% compliance, & PRN.</p> <p>V. Completion date: May 21, 2016</p>		

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F 156	<p>Continued From page 5</p> <p>flu and pneumonia vaccinations, and black box warnings and anti-psychotic medications, if needed. The LN said she did not have anything to do with the Admission Agreement.</p> <p>On 4/28/16 at 10:50 am, LN #3 said would occasionally admit a new resident and have them sign "lots of consents" including for treatment, side rails and bed bolsters, flu and pneumonia vaccinations, black box warnings, anti-psychotic medications, and a POST, if needed, and that the Community Liaison would have them sign the Admission Agreement.</p> <p>1. Resident #6 was admitted to the facility on 4/19/16 with multiple diagnoses, including recent multi-organ failure and diabetes mellitus.</p> <p>A 4/19/16 nursing progress note documented the resident was alert and oriented and signed consent forms when admitted at 3:45 pm that day.</p> <p>The forms signed by the resident on 4/19/16 included a Consent For Treatment, a flu vaccination consent, side rail and bed bolster consents, and consents for medications with black box warnings. An Admission Agreement was not included in the forms signed on 4/19/16.</p> <p>Resident #6's POA signed the Admission Agreement on 4/25/16, six days after the resident was admitted to the facility.</p> <p>On 4/25/16 at 12:10 pm, Resident #6 did not recall signing an Admission Agreement when admitted and referred the surveyor to talk to the POA.</p>	F 156			

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

PRINTED: 06/28/2016
FORM APPROVED
OMB NO. 0938-0391

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F 156	<p>Continued From page 6</p> <p>On 4/25/16 at 2:20 pm, the POA said he was present when the resident was admitted to the facility and he had visited Resident #6 every day for several hours at a time during the day since 4/19/16. The POA said no one approached him to sign an Admission Agreement until 4/23/16 at which time he refused to sign it because of unanswered questions about the resident's daily out-of-pocket costs. The POA said he signed the Admission Agreement on 4/25/16 after the questions about costs were resolved.</p> <p>An "Admission Note," dated 4/25/16 at 3:09 pm, documented, "I attempted to do patient's admission agreement upon admission, [the resident] did not want to do it until the [POA] was present. I again tried when the [POA] was available on Saturday the 23 rd..."</p> <p>On 4/27/16 at 3:00 pm, the Community Liaison said that on 4/25/16, Resident #6 refused to sign the Admission Agreement until the POA was present and on 4/23/16, the POA refused to sign the Admission Agreement until questions about out-of-pocket costs were resolved. The Liaison said the cost questions were resolved on 4/25/16 and the POA signed the Admission Agreement that day.</p> <p>On 4/27/16 at 4:30 pm, the Community Liaison said she verified Resident #6's insurance information on 4/18/16, one day before the resident was admitted. The Liaison said she questioned the resident's cost of \$200 per day and called the facility's corporate billing department for direction on 4/19/16 and 4/20/16. The Liaison said she "kept trying" and succeeded in contacting someone in the corporate billing department on 4/25/16.</p>	F 156			

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F 156	<p>Continued From page 7</p> <p>2. Resident #2 was admitted to the facility on 4/15/16 with multiple diagnoses, including congestive heart failure.</p> <p>An admission nursing note, dated 4/15/16 at 5:00 pm, documented Resident #2 was admitted at "approx[imately]" 4:00 pm in stable condition and was alert and oriented to person, place, time, and situation.</p> <p>The clinical record contained a Consent For Treatment, side rail consent, flu and pneumonia consents, and five consents for medications with black box warnings, signed by Resident #2 on 4/15/16. An Admission Agreement was not included in the forms signed on 4/15/16.</p> <p>The resident signed the Admission Agreement on 4/23/16, eight days after admission. The reason for the delay was not documented in Resident #2's clinical record.</p> <p>On 4/27/16 at 3:00 pm, the Community Liaison said Resident #2 did not sign the Admission Agreement on 4/15/16 because he/she may have been in therapy or may have refused to sign it. The Liaison said she did not document that because there was no place for her to document in the clinical record.</p> <p>3. Resident #4 was admitted on 4/20/16. Review of her Admission Agreement documented the resident had signed the agreement on 4/25/16, five days after admission. On 4/27/16 at 8:10 am, Resident #4 stated she did not remember exactly when she had signed the admission agreement, but it was definitely after she had been in the facility for awhile.</p>	F 156			

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F 156	Continued From page 8	F 156			
F 167 SS=C	<p>4. Resident #5 was admitted on 4/18/16. Review of her Admission Agreement documented the resident had signed the agreement on 4/23/16, five days after admission. On 4/27/16 at 8:00 am, Resident #5 stated a representative from the facility had talked with her and a family member at the hospital. The resident stated she had not signed the admission agreement until after she had been at the facility for a few days.</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's survey binder, and staff interview it was determined the facility failed to ensure 9 of 9 sample residents (#1-#9) residing in the facility and all other residents residing in the facility, had access to the facility's most recent standard survey. The information was also not available to family members and other visitors, seeking information related to the facility's compliance history. Findings include: On 4/25/16 at 9:00 am, the survey binder located</p>	F 167	<p>I. The most recent standard survey was put in the survey binder located in the library when its absence was pointed out on 4/28/2016.</p> <p>II. All residents and potential residents have the potential to be affected. The most recent standard survey will remain in the survey binder until it is replaced with a more current survey, as noted in the regulation.</p> <p>III. The administrator/designee will check</p>	5/21/16	

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F 167	Continued From page 9 in the library contained the 1/23/15 Follow up survey and the 10/19/15 Life Safety code survey. It did not contain the most recent standard survey conducted on 11/05/2014. On 4/28/16 at 7:15 am, the Administrator confirmed the survey binder did not contain the most recent standard survey.	F 167	the binder monthly to ensure compliance, and replace as needed any missing required information. IV. The administrator/designee will report the findings to the monthly QA meeting for 3 months, or until there is 100% compliance, & PRN. V. Completion date: May 21, 2016		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		5/21/16	

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706		
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F 225	<p>Continued From page 10</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews, review of the facility's abuse policy/procedures, grievance file, and review of the employee files, it was determined the facility failed to ensure all potential allegations of abuse and/or neglect were thoroughly investigated. This was true for 4 of 4 (#s 13, 14, 15, & 16) random residents. The lack of investigation placed four residents at risk for potential abuse and/or neglect. Findings included:</p> <p>The Abuse Prevention policy, dated 8/2006, documented the facility would identify and thoroughly investigate all reports and allegations of abuse.</p> <p>The Abuse Investigation policy, dated 12/2009, documented:</p> <ul style="list-style-type: none"> * Interviews would be completed with any witnesses to the incident; * Interviews would be completed with staff members, on all shifts, who had contact with the resident during the period of the alleged incident; * Interviews would be completed with other residents with whom the accused employee provided care or services too. 	F 225	<p>I a. Resident #16 discharged on 9/15/2015. The facility had determined abuse did not occur for Resident #16 because during the investigation the Resident stated she had NOT been physically harmed, NOR caused pain, NOR did she feel unsafe, NOR had anything harmful been said to her.</p> <p>b. Resident #15 discharged on 12/2/2015. Resident #13 discharged on 2/5/2016 . Resident #14 discharged on 1/22/2016.</p> <p>II. All residents have the potential to be affected. The administrator/designee will review with the IDT, and at an all staff meeting, the abuse prevention and investigation policies and procedures for this facility, including stipulation for discipline, up to and including termination if warranted, for failing to follow the facility's policy. The corporate office provided education to the administrator, DNS, and LSW on investigating and documenting grievances and allegations of abuse.</p> <p>III. All grievances and allegations of abuse will be investigated by the abuse</p>		

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F 225	<p>Continued From page 11</p> <p>This policy was not followed. Examples include:</p> <p>a. A Resident Grievance/Complaint form, dated 7/23/15, documented,</p> <p>* Resident #16 reported to CNA #1 she felt uncomfortable with the night shift staff on 7/22/15. CNA #1 documented Resident #16 told her, "The gentlemen and lady last night were not nice to me and I felt like a burden. The gentleman told me that I could do things for myself and was ordering me around." CNA #1 documented the resident, "seemed very upset and informed family as they arrived."</p> <p>* LSW #8 interviewed Resident #16 and documented:</p> <p>-When asked if CNA #2 had physically harmed her or did anything to cause her pain, Resident #16 stated, "No."</p> <p>-When asked if she felt unsafe, Resident #16 stated, "No, but I would like him not to work with me again!"</p> <p>-When asked if CNA #2 had said anything harmful to her, Resident #16 stated, "No, it was his attitude and his impatience."</p> <p>* Resident #16 expressed the following expectations related to her concern, "CNA #2 would no longer work with her and staff would not make her feel like she was a burden to anyone..."</p> <p>* Actions taken towards CNA #2 included, disciplinary action taken by the DON and that CNA #2 would not be working with Resident #16.</p>	F 225	<p>coordinator/designee on an ongoing basis, and the documentation will be reviewed and signed by the administrator/designee. The results of the investigation will be discussed by the IDT at the morning meeting, to ensure all steps have been taken to comply with our facility policies and procedures.</p> <p>IV. The administrator/designee will interview 2 random staff and/or residents to determine if they have any concerns, and if they feel issues brought to facility staff were investigated and followed up on appropriately. These interviews will continue for 3 months, then PRN thereafter, and results of the interviews will be reported to the monthly CQI meeting. The corporate clinical compliance officer/designee will review all grievance and/or abuse investigation reports to ensure ongoing compliance, and results of audits and reviews will be presented to the QA committee monthly for 3 months or until the facility is at 100% compliance & PRN.</p> <p>V. Completion: 5/21/2016</p>		

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F 225	<p>Continued From page 12</p> <p>The complaint investigation did not include interviews of other witnesses; interviews with staff members, on all shifts who had contact with the resident during the period of the alleged incident; and did not include interviews of other residents with whom the employee provided care or services to. The report did not indicate the facility had identified the female staff reported to CNA #1 by Resident #16. It could not be determined from the nature of Resident #16's grievance how the facility determined abuse had not occurred</p> <p>b. CNA #2's employee file included the following additional resident concerns:</p> <p>* A handwritten statement, dated 11/25/15, written by LN #1 documented, "[Resident #15] stated that [CNA #2] was rude to her during the night shift." There was no documentation this allegation was investigated, therefore it could not be determined if abuse had or had not occurred.</p> <p>* A Discipline Documentation Form, dated 1/6/16, documented, CNA #2 reported to day shift that Resident #14 had a bowel movement and he cleaned it up. However, Resident #14 was observed to have dried stool on his legs, groin area and on the bed.</p> <p>* A Discipline Documentation Form, dated 1/7/16, documented, the day shift CNA found Resident #13 wet with urine from the, "waist all the way up the back." CNA #2 told the day shift CNA Resident #13 refused cares all shift. Resident #13 told the DON that, "No one had come in to [his room] all night and he had not refused any cares."</p> <p>* A Personnel Change form, dated 1/8/16, documented, CNA #2 was, "terminated related to</p>	F 225			

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F 225	<p>Continued From page 13</p> <p>the incidents on 1/6/16 and 1/7/16 and four additional write-ups."</p> <p>On 4/27/16 at 8:50 am, the Administrator, who was not employed by the facility until December 2015, was asked to review the grievance/complaint dated 7/23/15. When asked if the complaint should have been investigated as potential abuse, the Administrator stated, that if the resident had verbalized concerns related to physical abuse and/or emotional abuse, it may have been investigated as abuse. The Administrator stated he felt, "It was just an uncomfortable interaction between CNA #2 and the resident." He stated other resident's should have been interviewed related to the care they received from CNA #2 to determine if a pattern existed. Additionally, he stated the female staff member identified in the witness statement should have been interviewed.</p> <p>On 4/29/16 at 4:00 pm, the Clinical Compliance Auditor, who was the facility's DON in November 2015, reviewed the handwritten statement, dated 11/25/15, written by LN #1. When asked if an investigation was completed related to CNA #2's rude behavior towards Resident #15, the Clinical Compliance Auditor stated, "I am not aware of that situation."</p> <p>On 4/29/16, at 4:15 pm, the DON was asked to review the Discipline Documentation Form dated 1/6/16 and 1/7/16. When asked if an investigation related to possible neglect was initiated on 1/6/16, the DON stated, "No, because CNA #2 attempted to clean the resident he just didn't do a very good job." When asked if other residents that CNA #2 provided care and services to were interviewed, the DON stated, "No, because most residents are</p>	F 225			

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F 225	Continued From page 14 alert and oriented and would usually tell me if there was a problem." When asked if an investigation related to possible neglect was initiated on 1/7/16, the DON stated, "No, why? I didn't need to conduct an investigation because I fired him on 1/8/16." When asked why CNA #2 was terminated, the DON stated, "He was terminated related to the incidents on 1/6/16, 1/7/16, and after reviewing other disciplinary actions in his employee file. She stated he was not terminated related to concerns of neglect, he just was not a good fit for the facility." On 4/29/16, at 4:30 pm, when LN #1 was asked about the incident on 11/25/15, she stated she remembered the resident reported CNA #2 had been rude to her on the night shift. LN #1 stated she did not ask follow-up questions and the resident did not provide specific information related to CNA #2's "rude" behavior. LN #1 stated she reported her concerns to management and was told they would look into it. On 4/29/16, at 4:55 pm, the Administrator was asked if an investigation should have been completed on 11/25/15 related to a potential allegation of abuse, the Administrator stated, "No, not necessarily but a grievance form should have been completed by the nurse, given to me for review, and then I would determine the next step." When asked if other residents CNA #2 provided care and services for should have been interviewed, the Administrator stated, "Yes, it helps to identify potential patterns of poor customer service."	F 225			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		5/21/16	

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F 226	<p>Continued From page 15</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility failed to identify, investigate, and protect residents from mistreatment, abuse and/or neglect. This was true for 4 of 4 (#s 13, 14, 15, & 16) random residents. Failure to operationalize the facility's abuse policies and procedures placed these four residents at risk for physical and/or psychological harm. Findings include:</p> <p>The Abuse Prevention Program, dated 8/2006, documented the facility would:</p> <ul style="list-style-type: none"> * Identify occurrences and patterns of potential mistreatment/abuse; * Thoroughly investigate all allegations of mistreatment, abuse, and neglect in a timely manner; and * Monitor staff on all shifts to identify inappropriate behaviors towards residents, for example: using derogatory language, rough handling of residents, ignoring residents while providing cares, and directing residents who need toileting assistance to urinate or defecate in their clothing/beds. <p>The Abuse Investigation policy, dated 12/2009, documented:</p> <ul style="list-style-type: none"> * Interview any witnesses to the incident; 	F 226	<p>I a. Resident #16 discharged on 9/15/2015. The facility had determined abuse did not occur for Resident #16 because during the investigation the Resident stated she had NOT been physically harmed, NOR caused pain, NOR did she feel unsafe, NOR had anything harmful been said to her.</p> <p>b. Resident #15 discharged on 12/2/2015. Resident #13 discharged on 2/5/2016. Resident #14 discharged on 1/22/2016.</p> <p>II. All residents have the potential to be affected. The administrator/designee will review with the IDT, and at an all staff meeting, the abuse prevention and investigation policies and procedures for this facility, including stipulation for discipline, up to and including termination if warranted, for failing to follow the facility's policy. The corporate office provided education to the administrator, DNS, and LSW on investigating and documenting grievances and allegations of abuse.</p> <p>III. All grievances and allegations of abuse will be investigated by the abuse coordinator/designee on an ongoing basis, and the documentation will be reviewed and signed by the</p>		

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F 226	<p>Continued From page 16</p> <ul style="list-style-type: none"> * Interview staff members, on all shifts, who have had contact with the resident during the period of the alleged incident; * Interview other residents to whom the accused employee provides care or services; and * Review all events leading up to the alleged incident. <p>These policies were not followed. Examples include:</p> <p>a. A Resident Grievance/Complaint form, dated 7/23/15, documented:</p> <ul style="list-style-type: none"> * Resident #16 reported to CNA #1 she felt uncomfortable with the night shift staff on 7/22/15. CNA #1 documented Resident #16 told her, "The gentlemen and lady last night were not nice to me and I felt like a burden. The gentleman told me that I could do things for myself and was ordering me around." CNA #1 documented the resident, "seemed very upset and informed family as they arrived." * LSW #8 interviewed Resident #16 and documented, <ul style="list-style-type: none"> - When asked if CNA #2 had physically harmed her or did anything to cause her pain, Resident #16 stated, "No." - When asked if she felt unsafe, Resident #16 stated, "No, but I would like him not to work with me again!" - When asked if CNA #2 had said anything harmful to her, Resident #16 stated, "No, it was his attitude and his impatience." * Resident #16 expressed the following 	F 226	<p>administrator/designee. The results of the investigation will be discussed by the IDT at the morning meeting, to ensure all steps have been taken to comply with our facility policies and procedures.</p> <p>IV. The administrator/designee will interview 2 random staff and/or residents to determine if they have any concerns, and if they feel issues brought to facility staff were investigated and followed up on appropriately. These interviews will continue for 3 months, then PRN thereafter, and results of the interviews will be reported to the monthly CQI meeting. The corporate clinical compliance officer/designee will review all grievance and/or abuse investigation reports to ensure ongoing compliance, and results of audits and reviews will be presented to the QA committee monthly for 3 months or until the facility is at 100% compliance & PRN.</p> <p>V. Completion: 5/21/2016</p>		

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F 226	<p>Continued From page 17</p> <p>expectations related to her concern, "CNA #2 would no longer work with her and staff would not make her feel like she was a burden to anyone..."</p> <p>* Disciplinary actions were taken towards CNA #2 and included he would not work with Resident #16.</p> <p>The complaint investigation did not document interviews had been conducted with witnesses; staff members on all shifts who had contact with the resident during the period of the alleged incident; and did not include interviews of other residents with whom the employee provided care and/or services to. Additionally, the report did not indicate the facility had identified the "rude" female staff reported to CNA #1 by Resident #16. It could not be determined from the nature of Resident #16's grievance how the facility determined abuse had not occurred</p> <p>b. CNA #2's employee file included the following additional resident concerns:</p> <p>* A handwritten statement, dated 11/25/15, written by LN #1 documented, "[Resident #15] stated that [CNA #2] was rude to her during the night shift." There was no documentation this allegation was investigated, therefore it could not be determined if abuse had or had not occurred.</p> <p>* A Discipline Documentation Form, dated 1/6/16, documented, CNA #2 reported to day shift that Resident #14 had a bowel movement and he cleaned it up. However, Resident #14 was observed to have dried stool on his legs, groin area and on the bed.</p> <p>* Discipline Documentation Form, dated 1/7/16,</p>	F 226			

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

PRINTED: 06/28/2016
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 18</p> <p>documented, the day shift CNA found Resident #13 wet with urine from the, "waist all the way up the back." CNA #2 told the day shift CNA Resident #13 refused cares all shift. Resident #13 told the DON that, "No one had come in to [his room] all night and he had not refused any cares."</p> <p>* A Personnel Change form, dated 1/8/16, documented, CNA #2 was, "terminated related to the incidents on 1/6/16 and 1/7/16 and four additional write-ups."</p> <p>On 4/27/16 at 8:50 am, the Administrator, who was not employed by the facility until December 2015, was asked to review the grievance/complaint dated 7/23/15. When asked if the complaint should have been investigated as potential abuse, the Administrator stated, that if the resident had verbalized concerns related to physical abuse and/or emotional abuse, it may have been investigated as abuse. The Administrator stated he felt, "It was just an uncomfortable interaction between CNA #2 and the resident." He stated other resident's should have been interviewed related to the care they received from CNA #2 to determine if a pattern existed. Additionally, he stated the female staff member identified in the witness statement should have been interviewed.</p> <p>On 4/29/16 at 4:00 pm, the Clinical Compliance Auditor, who was the facility's DON in November 2015, reviewed the handwritten statement, dated 11/25/15, written by LN #1. When asked if an investigation was completed related to CNA #2's rude behavior towards Resident #15, the Clinical Compliance Auditor stated, "I am not aware of that situation."</p>	F 226			

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F 226	<p>Continued From page 19</p> <p>On 4/29/16, at 4:15 pm, the DON was asked to review the Discipline Documentation Form dated 1/6/16 and 1/7/16. When asked if an investigation related to possible neglect was initiated on 1/6/16, the DON stated, "No, because CNA #2 attempted to clean the resident he just didn't do a very good job." When asked if other residents that CNA #2 provided care and services to were interviewed, the DON stated, "No, because most residents are alert and oriented and would usually tell me if there was a problem." When asked if an investigation related to possible neglect was initiated on 1/7/16, the DON stated, "No, why? I didn't need to conduct an investigation because I fired him on 1/8/16." When asked why CNA #2 was terminated, the DON stated, "He was terminated related to the incidents on 1/6/16, 1/7/16, and after reviewing other disciplinary actions in his employee file. She stated he was not terminated related to concerns of neglect, he just was not a good fit for the facility."</p> <p>On 4/29/16, at 4:30 pm, when LN #1 was asked about the incident on 11/25/15, she stated she remembered the resident reported CNA #2 had been rude to her on the night shift. LN #1 stated she did not ask follow-up questions and the resident did not provide specific information related to CNA #2's "rude" behavior. LN #1 stated she reported her concerns to management and was told they would look into it.</p> <p>On 4/29/16, at 4:55 pm, the Administrator was asked if an investigation should have been completed on 11/25/15 related to a potential allegation of abuse, the Administrator stated, "No, not necessarily but a grievance form should have been completed by the nurse, given to me for review, and then I would determine the next</p>	F 226			

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F 226	Continued From page 20 step." When asked if other residents CNA #2 provided care and services for should have been interviewed, the Administrator stated, "Yes, it helps to identify potential patterns of poor customer service." The facility failed to ensure policies and procedures that prohibited mistreatment, abuse and/or neglect of residents were operationalize.	F 226			
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews it was determined the facility failed to ensure that 3 of 12 sampled residents, (#4, #5, and #8) discharge planning needs were identified, discharge plans individualized to address each resident's specific needs, and that each resident's clinical record documented progress toward meeting those needs. This created the potential for more than minimal harm if residents experienced medical or/or psychosocial adverse outcomes due to unmet post-discharge needs. Findings include: Review of Admission and Discharge records documented the following: *February, 13 admissions and 17 discharges; *March, 27 admissions and 29 discharges; and	F 250	I. 1. Resident #4 has been discharged to another SNF on 4/27/2016. On 4/26/2016 Social Services noted in the record discharge planning to another SNF. The note includes post discharge care needs, and was done within a reasonable time frame since the discharge was unplanned. 2. Resident #8's discharge goal and discussion was noted on 4/27/2016. Residents #8 had not discharged at the time of survey exit, nor had a discharge date been set. 3. Resident #5's discharge goal and discussion was noted in the record on 4/27/2016. Residents #5 had not discharged at the time of survey exit, nor	5/21/16	

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F 250	<p>Continued From page 21</p> <p>*April 1-22, 22 admissions and 19 discharges.</p> <p>1. Resident #4 was admitted on 4/20/16 with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, anxiety, asthma, and major depressive disorder.</p> <p>On 4/25/16 at 7:30 am, Resident #4 stated she had not had her sleeping medication since admission, and her oxygen therapy had been delayed. Resident #4 stated she had told staff multiple times. She stated she was waiting to have surgery on her left shoulder, but surgery had been delayed until she became stronger.</p> <p>Nursing Progress Notes did not contain documentation regarding Resident #4's admission, potential discharge needs, plans for discharge, or discharge discussions 4/26/16 at 2:27 pm, LSW documented Resident #4 was angry about not getting her sleep medication since admission. Resident #4 had stated she wanted to transfer to a different facility, and had called another facility. At 5:55 pm, the LSW documented she had received a call from another facility that could accept the resident on 4/28/16. The LSW explained to Resident #4 that the facility could not admit her until later. Nursing Progress Notes did not contain documentation regarding Resident #4's discharge needs such as; ongoing physical and occupational therapy, oxygen therapy, or sleeping medication or discussions with the other facility as to Resident #4's care needs.</p> <p>On 4/27/16 at 8 am, Resident #4 stated she was transferring to another facility. On 4/28/16 at 11:00 am, Resident #4 was discharged.</p>	F 250	<p>had a discharge date been set</p> <p>II. All residents have the potential to be affected. Discharge goals will be included in the scheduled welcome conference with the resident and/or family, and an initial Discharge Care Plan will be initiated. An audit was completed on May 20, 2016 of 10 discharged residents was done to determine if Medically related discharge planning was done to provide for the physical, mental and psychosocial well being of the resident post discharge, and evidence was documented in the record. The audit showed 100% compliance in the discharged resident's records.</p> <p>III. The LSW/designee will note in the resident's record the initial Discharge Care Plan based on the information gathered at the welcome conference (usually held within 1 week of admission), and/or from the comprehensive assessment. This care plan will be updated 7 to 14 days, or as needed, prior to planned discharge, and will include post discharge care needs.</p> <p>IV. The corporate compliance team/designee will weekly audit a random sample of 3 charts for compliance, and report to the administrator who will report the findings to the monthly QA meeting for 3 months or until the facility has reached 100% compliance & PRN.</p> <p>V. Completion: 5/21/2016</p>		

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F 250	<p>Continued From page 22</p> <p>2. Resident #8 was admitted on 4/11/16 following a cervical laminectomy and spinal fusion surgery. Resident #8's admitting diagnoses included severe cervical stenosis, kyphosis, progressive myelopathy, and diabetes mellitus. Nursing Progress Notes did not contain documentation regarding Resident #8's potential discharge needs, plans for discharge, or discharge discussions.</p> <p>On 4/27/16 at 1:30 pm, in an interview with Resident #8 and family members, they stated Resident #8's future plans were unknown. Resident #8 lived in her motor home and traveled. Resident #8 stated she was not sure what level of help she would need or what was available. Resident #8 stated discharge or discharge plans had not been discussed.</p> <p>3. Resident #5 was admitted on 4/18/16 with diagnoses which included right leg laceration, gastric reflux disease and congestive heart failure. Nursing Progress Notes on 4/23/16, the LSW documented Resident #5's family member had declined the welcome conference. The LSW had spoke with Resident #5 and the resident's family at that time did not have any questions or concerns. The Nursing Progress Notes did not contain documentation regarding Resident #5's potential discharge needs, plans for discharge, or discharge discussions. On 4/25/16 at 9:50 am, Resident #5 stated she had not discussed discharge plans with anyone from the facility. Resident #5 stated she had previously lived with her daughter and would like to return, but was not sure she could. She stated there were facilities where she lived, but was not sure if the they [facilities] could accommodate her.</p>	F 250			

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

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F 250	<p>Continued From page 23</p> <p>On 4/26/16 at 1:05 pm, the LSW stated that all social service notes were in the Progress Notes. She stated she only did discharges and did not do anything with admissions. The LSW stated she was involved in the 72 hour "welcome conference" which went over any concerns, questions about therapy, or pain medication with the resident. The LSW stated she did not start discharge planning until about a week before actual discharge. She stated she met with IDT to discuss possible discharges and started the discharge care plan. The LSW stated after a resident's 5 day assessment, the discharge information was not transferred, updated, or revised on the initial care plan. The LSW stated her role on discharge was limited to C,D,E, an Q portions of the MDS. The LSW stated the average stay for a resident was usually 20 days and many residents did not have a completed MDS assessments.</p> <p>On 4/26/16 at 4:00 pm, the LSW stated she did not write discharge notes in the Progress Notes until after the resident was discharged. At this time, the Administrator stated, discharge planning started on admission. The Administrator stated discharges were discussed in the interdisciplinary team meetings. The LSW and the administrator stated there was no written documentation of the team's discharge discussions.</p> <p>On 4/27/16 at 8:30 am, PT #1 indicated rehab staff met every Wednesday where discharge information was received, usually from nursing. The PT Director attended morning IDT meetings and then the rehab unit got the notes from the meetings. OT #2 stated discharges were discussed during morning meetings and nursing usually directed the discharges. At 2:50 pm, OT</p>	F 250			

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F 250	Continued From page 24 #1 stated discharges depended upon the situation and therapy usually heard about discharges in the Welcome Conferences where therapy gave feedback, goals, planing and timeframe's. OT #1 stated the management team notified rehab and social services as to discharges. She stated rehab never saw orders for discharges, that social services and nursing determined discharges. At 8:55 am, the Administrator stated discharges were discussed in stand up and the rehabilitation meeting every Wednesday. He stated he was not sure there were any formal notes and could not explain how residents' discharge planning was monitored, revised, audited or followed up on without documentation. On 4/28/16 at 7:30 am, the Administrator stated the average stay for a resident was approximately 20 days and the average admission and discharge rate was around 20-30 residents a month. At 3:30 pm, the Administrator and DON confirmed there was no further information or documentation regarding discharges.	F 250			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		5/21/16	

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F 279	<p>Continued From page 25</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure care plans were individualized, updated and revised to meet the needs of 7 of 12 sampled residents (#2, #3, #4, #5, #6, #8, and #9). This failed practice resulted in generic care plans that were not revised to reflect residents' ADL and transfer needs and the amount of staff assistance necessary to meet them. It also resulted in care plans that did not include or clearly describe residents' discharge planning needs and interventions to meet them. These negative practices created the potential for more than minimal harm by placing residents at risk of adverse outcomes due to accidents and falls, and unmet post-discharge needs. Findings include:</p> <p>1. Resident #5 was admitted on 4/18/16 with diagnoses which included right leg laceration, gastric reflux disease and congestive heart failure.</p> <p>a. Resident #5's care plan, dated 4/18/16, documented the following interventions under ADL self care performance:</p>	F 279	<p>1. Residents #2, #3, #4, #5, #6, #8, & #9, have had their comprehensive 14 day assessments done timely, and individualized care plans were created based on the assessment.</p> <p>1. Resident #5</p> <p>a. Resident #5 was admitted on 4-18-2016, and according to the regulations, the comprehensive assessment/care plans were completed and updated as necessary.</p> <p>b. Discharge plans will be done and documented as needed per the regulation.</p> <p>2. Resident #6's discharge plans will be done and documented as needed per the regulation.</p> <p>3. Resident #3's discharge plans will be done and documented as needed per the regulation. Her Discharge goal was updated on 4/23/2016. And the resident discharged on 4/27/2016 before the comprehensive plan of care was due.</p> <p>4. Resident #2's discharge plans will be done and documented as needed per the regulation. An initial/interim plan of care</p>		

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F 279	<p>Continued From page 26</p> <p>*Toilet use: she may need 1-2 staff assistance with toilet transfers and under bathing: may need 1-2 staff assistance to bath.</p> <p>*Transfer: May need 1-2 staff assistance with transfers, setup adaptive equipment as recommended by therapy. Resident is a 2-3 maximum assist with Hoyer transfers.</p> <p>*Bathing: May need 1-2 staff assistance to bath. Assist with gathering supplies and setting up bathing area. Provide hands on assistance during bathing.</p> <p>*Personal hygiene/oral care: Assist resident to gather hygiene supplies and setup sink area. Provide assistance with oral care and grooming as recommended by therapy.</p> <p>*Dressing: May need 1-2 staff assistance to dress upper and lower extremities.</p> <p>On 4/18/16 at 7:00 pm, Nursing Progress Notes documented Resident #5 required 2 staff for hoyer lifts for all transfers on admission. On 4/26/16 at 3:44 pm, Nursing Progress Notes documented Resident #5 complained of difficulty breathing during hoyer lift transfers.</p> <p>Daily Skilled Nursing Assessments documented the following:</p> <p>*On 4/24/16, therapy staff transferred Resident #5 with 2 person assist and she required total assistance with dressing, hygiene and peri-care.</p> <p>*On 4/25/16, Resident #5 required total assist with dressing and peri care and attend changes.</p> <p>*On 4/26/16, Resident #5 required 1-2 person extensive assist with transfers to wheelchair, total assist with dressing and all her ADL's and used her wheel chair for mobility.</p> <p>On 4/25/16 at 12:00 pm, Resident #5 was</p>	F 279	<p>was in place as noted by the surveyors on the 2567.</p> <p>5. Resident #2, Resident #3, Resident #4, Resident #6, Resident #9, Resident #12 discharge plans will be done and documented as needed per the regulation.</p> <p>6. Resident #9; discharge plans will be done and documented as needed per the regulation.</p> <p>7. Resident #4 discharge plans will be done and documented as needed per the regulation.</p> <p>II. All residents have the potential to be affected. A review of all current resident records was done on or before 5/21/2016 to determine if the comprehensive assessment was due, and if so, was it done accurately, and are individualized care plans being developed based on the assessment. For residents past 7 days from the completion of their comprehensive assessment, a review was done to determine if the individualized care plans were completed timely. Resident care plans will be individualized based on the comprehensive assessment, and as needed. Care plans will be individualized based on the nursing assessment upon admission, the 14 day comprehensive assessment, and as needed anytime during the resident's stay. DON/designee will train nurses to update care plans as needed.</p> <p>III. The MDS nurse/designee will review the medical records of residents, and report to the IDT the status of the completion of the comprehensive</p>		

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F 279	<p>Continued From page 27</p> <p>observed getting a bed bath. CNA #3 stated the resident always got a bed bath per Resident #5's request. CNA #3 stated Resident #5 had bed baths at home. At 4:00 pm, Resident #5 was observed transferring from her bed to the wheel chair with PT, an LN and a CNA.</p> <p>On 4/26/16 at 9:00 am, Resident #5 was observed with CNAs helping her use a bedpan. CNA #3 stated Resident #5 always used a bedpan per her request. CNA #3 stated Resident #5 was able to voice her needs and staff responded based on her requests. CNA #3 stated PT was transferring Resident #5 and they [CNAs] were not transferring her.</p> <p>Resident #5's care plan was not individualized to reflect Resident #5's initial assessment, daily assessments, changes in the level of assistance or devices, or when she started requesting a bed bath and bedpan. Direct care staff could not explain how Resident #5's needs were communicated.</p> <p>b. Resident #5's care plan did not address discharge.</p> <p>2. Resident #6 was admitted to the facility on 4/19/16 with multiple diagnoses, including diabetes mellitus.</p> <p>Resident #6's April 2016 Order Summary Report included, "No restrictions (patient currently non ambulatory)" and PT and OT to evaluate and treat for safety, balance, strength, ADL performance, and restorative function. Both orders were dated 4/19/16.</p> <p>A Progress Note, dated 4/19/16 at 5:31 pm,</p>	F 279	<p>assessment. Each discipline of the IDT required to create individualized care plans will report to the IDT when they are completed.</p> <p>IV. The corporate compliance team/designee will audit a random sample of 3 charts per week for compliance, and report to the administrator who will report the findings to the monthly QA meeting for 3 months or until the facility has reached 100% compliance & PRN.</p> <p>V. Completion: 5/21/2016</p>		

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F 279	<p>Continued From page 28</p> <p>documented Resident #6 needed maximum assistance of 2 staff for transfers due to severe weakness in both lower extremities.</p> <p>A PT Evaluation and Plan of Treatment, dated 4/20/16, documented Resident #6 had functional limitations in strength, ROM, endurance, posture, balance, coordination, muscle contraction/recruitment, cardiopulmonary function and functional performance in be mobility, transfers, and gait. It further documented Resident #6 needed minimal assistance with bed mobility and maximum assistance with transfers.</p> <p>An OT Evaluation and Plan of Treatment, dated 4/20/16, documented Resident #6 had decreased strength, functional activity tolerance, pain, and cognition and safety deficits during ADLs. It further documented Resident #6 needed set-up assistance for self feeding, minimal assistance for hygiene and grooming, maximum assistance for bathing, total dependence for toileting, clothing management, and personal hygiene, moderate assistance for upper body dressing, and maximum assistance for lower body dressing.</p> <p>Resident #6's care plan for ADL self care performance deficit related to weakness and recent septic shock, initiated 4/20/16, included the interventions of:</p> <ul style="list-style-type: none"> * may need 1-2 staff assistance with toilet transfers, clothing management, and pericare; * may need 1-2 staff assistance with transfers, setup adaptive equipment as recommended by therapy; * may need assistance with bed mobility; requires assistance for bathing; * may need assistance to dress upper and lower 	F 279			

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F 279	<p>Continued From page 29</p> <p>extremities; and * may need staff participation with setup to eat.</p> <p>The level of assistance was not individualized to Resident #6's specific needs and the type of adaptive equipment recommended by therapy was not identified.</p> <p>3. Resident #3 was admitted to the facility on 4/8/16 for after care right knee replacement.</p> <p>Resident #3's Admission MDS assessment, dated 4/15/16, indicated: Resident #3 required set-up help and supervision for bed mobility, transfers, toileting, and personal hygiene; required limited assistance of one staff for walking on and off the unit; and had functional limitation in range of motion of the lower extremity on one side.</p> <p>Resident #3's current ADL care plan documented:</p> <p>* may need 1-2 staff assistance with toileting, transfers, clothing management, and personal hygiene. Provide adaptive equipment recommended by therapy, however the adaptive equipment was not identified. * may need assistance with bed mobility, however the care plan did not include what level of assistance Resident #3 required.</p> <p>Resident #3's care plan was not individualized to address Resident #3's assessed needs.</p> <p>4. Resident #2 was admitted to the facility on 4/15/16 with multiple diagnoses, including coronary artery disease.</p> <p>Resident #2's April 2016 Order Summary Report included a 4/15/16 order for PT and OT to</p>	F 279			

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F 279	<p>Continued From page 30</p> <p>evaluate and treat for safety, balance, strength, ADL performance, and restorative function.</p> <p>A PT Evaluation and Plan of Treatment, dated 4/16/16, documented decreased general strength, decreased endurance, decreased balance, slightly abnormal gait and decreased ROM limited Resident #2's functional mobility in gait, transfers, and bed mobility which placed the resident at risk for falls.</p> <p>An OT Evaluation and Plan of Treatment, dated 4/17/16, documented decreased current level of function with decreased use of the left upper extremity, Resident #2's dominant side, with limited coordination and safety with transfers.</p> <p>a. Resident #2's care plan for ADL self care performance deficit related to weakness, limited physical mobility, and massive obesity, initiated 4/16/16, included the interventions of:</p> <ul style="list-style-type: none"> * may need 1-2 staff assistance with toilet transfers, clothing management, and pericare; * may need 1-2 staff assistance with transfers, setup adaptive equipment as recommended by therapy; * may need 1-2 assistance with bed mobility; * may require 1-2 staff assistance for bathing; * may need 1-2 staff assistance to dress upper and lower extremities; and * may require staff participation with setup to eat. <p>The level of assistance was not individualized to Resident #2's specific needs and the type of adaptive equipment recommended by therapy was not identified.</p> <p>b. As of survey entrance date of 4/25/16,</p>	F 279			

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F 279	<p>Continued From page 31</p> <p>Resident #2 had been in the facility for 10 days. However, Resident #2's care plan did not include a discharge plan.</p> <p>5. The care plans of Residents' #2, #3, #4, #6, #8, #9, and #12 identified the focus of ADL Self Care Performance and included the same interventions for each of the residents' ADLS:</p> <ul style="list-style-type: none"> * Praise all efforts at self care; * PT/OT evaluation and treatment per MD orders; * Toilet use: May require 1-2 assist with toilet transfers, clothing management, and pericare. * Provide adaptive equipment recommended by therapy. * Transfer: May need 1-2 staff assistance with transfers," setup adaptive equipment as recommended by therapy. * Bed Mobility: May need assist with bed mobility. Help to setup 1/4 siderails. Provide instruction on use of 1/4 siderails and bed controls. * Encourage to participate to the fullest extent possible with each interaction. * Encourage to use bell to call for assistance. * Bathing: May require the assistance of staff to bath. Assist with gathering supplies and setting up bathing area. Provide hands on assistance during bathing. * Personal hygiene/oral care: Assist in gathering hygiene supplies and setup sink area. Provide assistance with oral care and grooming as recommended by therapy. * Dressing: May need assistance to dress upper and lower extremities. * Eating: May need staff participation with setup to eat. <p>The residents' care plan interventions were not individualized to address the unique needs of</p>	F 279			

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F 279	<p>Continued From page 32</p> <p>each resident and the specific number of staff required for safe transfers and cares. Residents' care plans did not provide clear and comprehensive guidance to staff.</p> <p>6. Resident #9 was admitted 3/29/16 with diagnoses which included chronic obstructive pulmonary disease, kidney disease, osteoporosis and major depression.</p> <p>Resident #9's 14 day MDS assessment, dated 4/13/16, documented active discharge planning was already occurring for her to return to the community. Resident #9's care plan, dated 4/07/16, identified a discharge goal of her returning home with her husband with the target date of 7/18/16. One intervention of, "provide referrals and orders for community resources as indicated, i.e. home health, SS, outpt [outpatient] therapy, home care, DME alternative living options" was noted. Resident #9's care plan did not include the specific type of home health services, social services, therapy, DME, home care, and living arrangements Resident #9 would need upon discharge.</p> <p>7. Resident #4 was admitted on 4/20/16. Resident #4's care plan did not address discharge. Resident #4 was discharged on 4/28/16.</p> <p>On 4/26/16 at 1:05 pm, The LSW stated a resident's 5 day assessment, Daily Skilled nursing Assessment, and the discharge information was not transferred, updated, or revised on the initial care plan. The LSW stated her role on discharge was limited to C,D,E, an Q portions of the MDS. The LSW stated the average stay for a resident was usually 20 days</p>	F 279			

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F 279	Continued From page 33 and many residents would not have a completed MDS assessments or CAAs to make it to care planning. On 4/28/16 at 8:40 am, LN #6, who identified herself as the MDS nurse and assisted in developing care plans, stated the "May" on the care plan interventions meant the resident may or may not need assistance. At 8:45 am, the Regional Compliance Officer joined the interview and stated, a temporary care plan is created on admission and since the facility did not know the resident, the resident may or may not need assistance. On 4/28/19 at 9:10 am, the DON stated that on admission the residents all received the same care plan. Care plans were then modified based upon the results of the 5 day assessments. No explanation was given as to how staff would know what to do for each individual resident.	F 279			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, it was determined the facility failed ensure residents received	F 309	I. a. Resident #8 1. LPN and RN staff were in-serviced on 5/20/2016 regarding ordering medications	5/21/16	

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F 309	<p>Continued From page 34</p> <p>necessary cares as ordered by the physician for 5 of 12 sampled residents (#2, #4, #5, #6, and #8). This deficient practice resulted in harm to Residents #8 and #4. Resident #8 experienced psychosocial harm when the resident endured escalating aching pain though the night and into the next day due to delayed procurement of pain medication. Resident #4 was harmed when she did not get her sleep medication for six nights and as a result, felt "miserable" due to lack of sleep. The deficient practices also created the potential for more than minimal harm to: a) Residents #2, #3, and #8 when medications were not administered as ordered by the physician; b) Resident #8 when the resident's oxygen orders were not clarified; and Resident #5 when the staff did not identify and assess a small necrotic wound and potential allergic reactions. Findings include:</p> <p>1. Resident #8 was admitted on 4/11/16 following a cervical laminectomy and spinal fusion surgery. The resident's admitting diagnoses included severe cervical stenosis, kyphosis, progressive myelopathy, and diabetes mellitus.</p> <p>a. Physician Orders documented the following pain medication orders: * 4/12/16 Acetaminophen 650 mg every 6 hours as needed for pain. * 4/15/16, Oxycodone HCL [opioid analgesic] was discontinued and Tramadol HCL [opioid analgesic] 1-2 tablets every 4 hours as needed for pain was ordered. * 4/19/16 Norco [opioid analgesic and acetaminophen], 1-2 tablets every 6 hours as needed for pain.</p> <p>Review of Resident #8's care plan dated 4/19/16,</p>	F 309	<p>from the pharmacy when needed and not available.</p> <p>2. LPN and RN staff were in-serviced on the policy to contact the DON, NHA or their designee when an ordered medication is not available.</p> <p>3. LPN and RN staff were in-serviced on 5/20/2016 regarding when to clarify a physician's (NP's) order.</p> <p>b. Resident #4</p> <p>1. LPN and RN staff were in-serviced on 5/20/2016 that the attending physician, medical director or nurse practitioner must be promptly notified when there is a question about a resident's medication or clarification of an order is necessary.</p> <p>c. Resident #5</p> <p>1. The Facility's Skin Assessment Policy and Procedures were reviewed and revised, as appropriate.</p> <p>2. All involved staff were in-serviced regarding completing and documenting skin assessments (initial and weekly skin assessments).</p> <p>3. Whenever a resident states that he/she has an allergy to a medication, the physician or NP will be promptly notified and there will be supporting documentation of a resident's claims and whether any side effects were observed.</p> <p>d. Resident #6</p> <p>1. As noted above, LPN and RN staff were in-serviced about administering medications in accord with a physician's order and/or seeking clarification where necessary.</p>		

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F 309	<p>Continued From page 35</p> <p>identified the resident had "acute neck/upper back pain r/t recent neck surgery and chronic pain r/t recent lumbar back surgery in 2015." The interventions included: "administer analgesia as per orders; anticipate [Resident #8's] need for pain relief and respond immediately to any complaint of pain;" and "notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain."</p> <p>Review of the Medication Administration Record documented Norco administered: *4/19/16 one Norco tablet at 9:39 pm; *4/20/16 two Norco tablets at 8:37 pm; *4/21/16 two Norco tablets at 7:26 pm; *4/26/16 two Norco tablets at 12:10 pm, and 9:18 pm; *4/24/16 two Norco tablets at 6:03 am, 2:14 pm, and 11:34 pm; *4/25/16 two Norco tablets at 8:42 am, 5:52 pm, and 11:17 pm; *4/26/16 two Norco tablets at 7:39 am, 3:56 pm, and 10:19 pm; *4/27/16 two Norco tablets at 8:09 am, and 3:44 pm.</p> <p>Nursing Progress Notes documented, on 4/27/16 at 8:09 am, "pt. reports aching pain to cervical surgical site;" at 3:44 pm, "aching pain to cervical incision." Norco 2 tablets given; at 4:44 pm the resident was seen by the NP and the resident stated, "...pain is tolerable with pain medication. "</p> <p>On 4/27/16 at 1:30 pm, during an interview with Resident #8 and family members, they stated the biggest issue with the resident was getting her pain under control. Resident #8 had stopped eating and drinking due to her pain, resulting in</p>	F 309	<p>e. Resident #2</p> <p>1. LPN and RN staff were in-serviced on 5/20/2016 about the need for the administration of medications to exactly match the physician's (NP's) order with accurate documentation on the MAR.</p> <p>II. We have educated the nursing staff and updated the facility's policies and procedures, as needed for the following;</p> <p>a. All care plans will be reviewed and audited weekly for two months by the NHA/DON or their designee to determine if assistance and or adaptive equipment is required. Reports of the audit will be forwarded to the QAPI Committee at least monthly.</p> <p>b. Stat medication requests</p> <p>c. BIPAP use and order reconciliation</p> <p>d. Medication errors</p> <p>e. Resident claims of allergies</p> <p>1. The Facility's policy of noting any known allergies to drugs (or other substances) will continue to be conspicuously noted on the resident's medical record, MAR, with notification to the pharmacy, etc.</p> <p>III. a. The NHA/DON or their designee will audit all resident records for four weeks to determine whether all physician (NP) orders have been administered as ordered and accurately noted on the MAR.</p> <p>b. Results of the audit will be given to the QAPI committee for review and insurance with compliance.</p> <p>c. In-service education was completed</p>		

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F 309	<p>Continued From page 36</p> <p>dehydration that required IV fluids. They stated the resident was doing better now with the Norco.</p> <p>On 4/28/16 at 6:45 am, LN #1 stated Resident #8 had two separate pain medications ordered, Tramadol and Norco, which were staggered at different times to cover the resident's pain. She stated the resident had been out of Norco since "yesterday," and she would request a refill from pharmacy when they [pharmacy] opened at 9:00/9:30 am. She stated she was giving Resident #8 Tramadol and Tylenol until the facility got the Norco. She stated she had informed the DON.</p> <p>On 4/28/16 at 3:51 am, Nursing Progress Notes documented, Tramadol 2 tablets was given for, "aching head and back pain;" at 6:44 am, "pt. reports aching to cervical site/head/neck and bilateral legs:" at 8:12 am, "aching pain to cervical site and legs per patient;" at 9:34 am, "spoke with [name] from Pharmerica regarding Norco refill, requested stat [immediate] delivery on refill at this time, pharmacy tech [technician] stated she would try to get a rush on delivery."</p> <p>4/28/16 at 10:35 am, Resident #8 was observed lying in bed twitching with spastic movements. Resident #8 stated she, "had not had Norco all night," and "was waiting for it to get here," the nurse was "supposed to call the pharmacy at 9:30 am." The resident stated the other medications did not work completely and she needed the Norco. Resident #8 stated she would rate her pain at "7 or 8" if up and moving and "5-6" now lying down.</p> <p>On 4/28/16 at 10:55 am, LN #1 stated the Norco should be at the facility by 11:45 am. She stated</p>	F 309	<p>on 5/20/2016 with LPN and RN staff regarding compliance with physician orders</p> <p>d. In-service education was completed on 5/20/2016 with LPN and RN staff regarding proper use of equipment such as BIPAP units.</p> <p>e. In-service education was completed with all Licensed Nurses on policy and procedure regarding skin assessments.</p> <p>f. Policies and Procedures for Medication Errors and Skin Assessments were reviewed and revised as appropriate.</p> <p>IV. a. The NHA/DON or Facility designee will monitor compliance of the medication reconciliation and administration process every week for 4 weeks then monthly thereafter.</p> <p>b. The Facility will complete an audit to validate compliance with ordered medications on admission (medication reconciliation), quarterly, annually or if there is a significant change in condition. The audit will be completed every week for 4 weeks then monthly thereafter.</p> <p>c. The Facility will audit compliance with notification to the physician and/or responsible party for residents who request a medication not ordered or contraindicated. When a resident requests a medication that is not ordered, the physician and/or NP will be notified and the nurse will timely document the request and physician/NP response in the resident's progress notes.</p> <p>d. Result of the compliance audit will be</p>		

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F 309	<p>Continued From page 37</p> <p>the pharmacy opened at 9:00 am. When asked about needing a medication after hours, she stated the after-hours phone number just sent a message to the pharmacy to deliver the medication when the pharmacy opened the next day. The pharmacy technician at the pharmacy could not give a code for the Pyxis system [locked medication dispensing system at the facility] for a refill. The pharmacy delivered twice a day at 2:00 pm and 8:30 pm and for stat [immediate] requests, the pharmacy would have a courier deliver the medication. The Pyxis system could not be used for refills and the facility did not use another service. She stated she reported medication issues to the DON, who reported to the Administrator, who would then contact the pharmacist.</p> <p>On 4/28/16 at 11:10 am, the DON stated she could not override the Pyxis system for refills. When the DON was told that Resident #8 rated her pain at "5-6," she stated the resident had other pain medications, she did not want the resident in pain and they [facility] were trying to get the medication.</p> <p>The Controlled Substance Log documented the Resident #8's refill for Norco was received on 4/28/16 at 11:30 am and the resident was given Norco 2 tablets. At 2:55 pm, Resident #8 was observed resting quietly with her eyes closed.</p> <p>On 4/28/16 at 2:55 pm, LN #1 stated the nurses were responsible for getting refills and faxing over the refill requests. She stated the reorder was faxed over last night for the resident, but the request was not documented anywhere.</p> <p>On 4/28/16 at 3:00 pm, the Administrator stated</p>	F 309	<p>reported to the QAPI committee quarterly, and as appropriate.</p> <p>e. The plan of corrections is integrated into the Facility's QAPI program.</p> <p>f. The MDS Coordinator will complete an audit of assessments and care plans to determine and identify if any residents have unique needs regarding specific equipment, such as BIPAP units. The audit will be completed weekly for four weeks, then monthly thereafter to ensure on-going compliance.</p> <p>g. The Facility has established a QAPI committee which consists of the Medical Director, Administrator, Director of Nursing, representative from Social Service, MDS, Nutritional/Dietary, and Activity/Recreational Department.</p> <p>h. The QAPI Committee meets quarterly, and as necessary, to identify and address issues that can affect the safety and well-being of the residents in which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct and identify deficiencies.</p> <p>VI. Completion: 5/21/2016</p>		

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F 309	<p>Continued From page 38</p> <p>the after-hours phone numbers for the pharmacy were effective in getting medication. He stated that sometimes medications were obtained through a local drug store after hours. He further stated there were exceptions to the rule that the Pyxis system could be used for refills. He stated this exception required the DON to call the pharmacy.</p> <p>On 4/28/16 at 3:30 pm, the DON stated the Norco was PRN [as needed] and she was not aware the resident had asked for the Norco. She stated the request for the refill had been faxed the night before, but she had not retained documentation or tracking of the request. She stated the facility did not have a policy regarding refill requests or who was responsible.</p> <p>Resident #8 remained in pain through the night and into the next day. The Pyxis system was not overridden or other measures taken to get the resident the Norco pain medication.</p> <p>b. On 4/11/16, Resident #8 was ordered Lantus Insulin [long acting insulin] 10 units in the morning for diabetes mellitus. Administration of the medication was ordered based upon Resident #8's morning BG. The order documented, "hold [insulin] for BG < 125."</p> <p>The MAR documented the following: *4/12/16, blood glucose was 112. The medication was checked and initialed as administered. *4/18/16, blood glucose was 102. The medication was checked and initialed as administered. *4/20/16, blood glucose was 99. The medication was checked and initialed as administered. *4/24/16, blood glucose was 112. The medication was checked and initialed as administered.</p>	F 309			

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F 309	<p>Continued From page 39</p> <p>On 4/28/16 at 6:45 am, LN #1 stated a check mark on the MAR under the blood glucose documentation indicated the medication was given and the initials documented that the nurse administered the medication. She stated that anything outside the parameters of the order should be documented in the Nursing Progress Notes and the physician notified.</p> <p>Medication error investigation documentation for the facility contained two incidents related to antibiotic therapy in December and January. Neither investigation contained a medication error reporting form.</p> <p>On 4/28/16 at 9:10 am, the DON stated she was responsible for auditing medication and medication errors. Her audits were based on reports by the nurses and random audits. The DON stated she only had two medication errors, for which she had produced copies for the survey. She stated the facility did not have a policy on medication errors. The DON stated the PCC computerized documentation system did not have built in alarms when blood glucose readings were outside the ordered parameters for medication administration. She stated she would look for a medication error form.</p> <p>On 4/28/16 at 4:15 pm, after reviewing Resident #8's MAR, LN #1 stated the 4 days in which the resident was given insulin (4/12, 4/18, 4/20, and 4/24), the medication should have been held since Resident #8's blood glucose was less than 125. LN #1 confirmed her initials on 2 of the 4 days. She stated Resident #8 had requested the insulin because she was worried about her mighty shakes [supplement], increasing her blood</p>	F 309			

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F 309	<p>Continued From page 40</p> <p>glucose. She stated she did not notify the physician or document in Nursing Progress Notes, but should have. The LN #1 confirmed each incident would be a medication error and the physician should have been notified and the incident documented. She stated she had never identified a medication error and did not know of a paper or computer form to fill out and would have to ask the DON help her.</p> <p>On 4/28/16 at 4:35 pm, the Clinical Compliance Auditor stated there was a form in the system, but the DON had been changing things. At 5:00 pm, the Clinical Compliance Auditor produced a Medication Error Reporting Form.</p> <p>On 4/28/16 at 5:05 pm, LN #3 and LN #4 were asked what they would do if they had identified a medication error. LN #3 stated there "was a form." LN #4 stated they [LN #3 and LN #4] needed to go get a supervisor before they talked to the surveyor. When asked if the form was kept at the nurses station, LN #3 stated she would go get a supervisor and LN #4 stated they needed to have a supervisor to answer. A response to the question of whether the form was kept at the nurses' station was not provided by LN #3 or LN #4. The interview ended at that time.</p> <p>2. Resident #4 was admitted on 4/20/16 with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, anxiety, asthma, and major depressive disorder.</p> <p>a. Review of Resident #4's acute hospitalization medication record, dated 4/20/16, documented the resident received Trazodone [antidepressant used for insomnia] 100 mg 1 tablet at bedtime. Medications ordered/recommended to be</p>	F 309			

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F 309	<p>Continued From page 41</p> <p>continued for Resident #4 did not include an order for Trazodone.</p> <p>On 4/25/16 at 7:30 am, during the survey's initial tour, Resident #4 was observed sitting in her chair eating cereal. When the surveyor introduced herself and stated the purpose of the visit, Resident #4 stated she thought the state was here because she had not been getting her sleeping medication, Trazodone. Resident #4 stated she had been at the facility since last Wednesday and had not been able to sleep because she did have the Trazodone, and was miserable.</p> <p>Nursing Progress Notes documented that on 4/25/16 at 4:50 pm, the NP saw Resident #4. Resident #4 had requested an order for Trazodone. The NP had declined to order the medication until labs could be obtained due to the sedating side effects. The NP had written orders for Melatonin 3 mg at bedtime for sleep. The documentation noted Resident #4 was not happy.</p> <p>On 4/26/16 at 2:27 pm, Social Service Progress Notes documented Resident #4 told the LSW she had not had her Trazodone for sleep since she was admitted and told the nurse yesterday and had seen the NP, but had to wait for laboratory results. Resident #4 had stated she wanted to transfer to another facility.</p> <p>On 4/27/16 at 8:10 am, Resident #4 stated she had taken the medication at home for years and had told the nurses over and over she needed her sleeping pill. She stated she had taken it in the hospital, but was told it had not made it on the medication sheet for the facility. Resident #4 stated she had finally gotten the Trazodone last</p>	F 309			

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F 309	<p>Continued From page 42</p> <p>night. Resident #4 stated she did not understand why someone could not have contacted the hospital or her primary physician.</p> <p>On 4/27/16 at 9:10 am, LN #2 stated that on Monday morning (4/25/16), there was a note from the night nurse to contact the NP about an order for Trazodone, a medication the resident had been taking at home for years. The NP had seen the resident and wanted to wait for laboratory results before ordering the medication. LN #2 stated that although Resident #4's History and Physical and hospital records documented the use of Trazodone, no one had contacted the hospital or the resident's primary physician to clarify. The procedure was to wait for the NP or physician to see Resident #4 and reorder the medication. LN #2 stated information between shifts was passed on through reports, daily nursing assessments, and progress notes.</p> <p>On 4/28/16 at 9:10 am, the DON stated the facility or nurse does not make any changes to admitting orders and would not call the hospital or the resident's physician to clarify the orders. She stated they [facility] would request at some point to talk to the NP or call the NP. The NP visited the facility on Monday, Wednesday and Friday. She stated there were progress notes that the NP had saw Resident #4 on 4/25/16 and was waiting for lab reports. No further explanation or documentation was provided. Admitting orders were not thoroughly checked against orders for medications taken in the hospital. Resident #4 did not receive a medication she had taken for years and depended upon for sleep.</p> <p>The Black box warning for Trazodone included: Taper when stopping; do not stop abruptly (Karch,</p>	F 309			

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F 309	<p>Continued From page 43</p> <p>A. M., Lippincott ' s Pocket Drug Guide for Nursing, (2016) Wolters Kluwer: Philadelphia, 354).</p> <p>b. An Order Summary for Resident #4 dated 4/21/16, documented the resident used a BIPAP machine with 2 Liters of oxygen at night for sleep apnea.</p> <p>On 4/21/16, Resident #4's Care Plan identified her as requiring oxygen therapy related to congestive heart failure and asthma related to chronic obstructive pulmonary disease and congestive heart failure and the use of oxygen as needed to keep her oxygen saturation levels above 90%.</p> <p>The Nursing Progress Notes did not contain documentation regarding oxygen, use of a BIPAP, oxygen or discussions regarding the issue.</p> <p>On 4/25/16 at 7:30 am, during the survey's initial tour, Resident #4 was observed to have a BIPAP machine at her bedside connected to an oxygen concentrator. Resident #4 stated the BIPAP machine was hers that she used at home.</p> <p>On 4/27/16 at 8:10 am Resident #4 stated she had used the BIPAP machine in the hospital, but the facility had not connected it to the oxygen right away because they did not know how to hook it up and did not have respiratory in the facility. She stated she had not been sleeping. She stated she had tried to get them to call [oxygen supplier] to have them come out and fix it. She stated she did not understand the reason they [facility] could not have called someone or ask her what to do.</p>	F 309			

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F 309	<p>Continued From page 44</p> <p>On 4/27/16 at 9:10 am, LN#1 stated Resident #4 did not have an order for the BIPAP when she was admitted on 4/20/16 and she had to call [oxygen supplier] the next day to get the settings. LN #2 confirmed the BIPAP machine was the resident's and the resident had brought it in with her from the hospital. LN #2 stated everything should be documented in the Nursing Progress Notes. LN #1 and LN #2 confirmed no one was contacted on 4/20/16 and Resident #4 was without oxygen for her BIPAP the night of 4/20/16.</p> <p>On 4/27/16 at 9:10 am, the Regional Compliance Officer stated Resident #4 did not have oxygen for her BIPAP the night of 4/20/16.</p> <p>3. Resident #5 was admitted on 4/18/16 with diagnoses which included right leg laceration, gastric reflux disease and congestive heart failure.</p> <p>a. On 4/18/16 Nursing Progress Notes documented Resident #5 was admitted from the hospital with a right leg shin laceration related to a fall at home.</p> <p>On 4/21/16, a Braden scale for predicting pressure sore risk identified Resident #5 as "high risk."</p> <p>Daily Skilled Nursing Assessments, dated 4/21/16-4/23/16, did not identify skin issues other than the right leg laceration. On 4/24/16, an assessment identified skin irritation under Resident #5's left breast, pannus and abdominal folds. Assessments for 4/24/16, 4/25/16, and 4/26/16 did not identify new or additional skin issues.</p>	F 309			

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F 309	<p>Continued From page 45</p> <p>On 4/25/16 at 12:00 pm, during a dressing change to Resident #5's right leg laceration, LN #5 was asked to remove the resident's socks. Directly on top of the tip of the resident's right second toe, there was an approximately 1 cm x 1 cm circular callous area with approximately 0.5 cm x 0.5 cm black area in the center. LN #5 stated she was unaware of this area. At this time, Resident #5 stated she had a callous on the toe where her sock and shoe rubbed. She stated she would periodically peeled off the callous and that it had been there for a long time.</p> <p>A Late Entry Nursing Progress Note for 4/25/16 at 9:53 am, documented the right second toe had been identified as a skin issue. Nursing Progress Notes from 4/18/16- 4/24/16 did not contain documentation of skin issues related to the right second toe.</p> <p>On 4/27/16 at 10:30 am, during an observation of the toe with the DON, the DON stated the toe issue had been discovered on 4/25/16. The DON measured the area noting a "1 cm x 1.04 cm callus area with 0.5 cm x 0.4 cm blacken eschar" to right second toe. She stated daily skin assessments and weekly skin checks were completed by the nurse. She stated the physician had saw Resident #5 and had referred her to the wound clinic, but the resident had refused to go.</p> <p>On 4/28/16 at 9:10 am, the DON stated the admitting nurse performed the initial skin assessment and floor staff did weekly assessment. She stated any skin issue should be documented and noted. She stated she would have expected to see documentation about Resident #5's toe in the initial and weekly</p>	F 309			

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F 309	<p>Continued From page 46</p> <p>assessments. She stated there was no additional documentation and could not provide additional information.</p> <p>b. Nursing Progress Notes documented Resident #5 refused her gastric reflux medication, Pantoprazole on 4/24/16 and 4/25/16. On 4/25/16, the resident refused her diuretic medication furosemide, stating she did not want the generic form of Lasix [diuretic].</p> <p>On 4/25/16 at 4:00 pm, Resident #5 was up in her wheelchair in the therapy room with PT. The resident complained of nausea. She stated it was the diuretic making her sick, because she could not take the generic form of Lasix.</p> <p>On 4/27/16 at 8:00 am, the resident stated she was allergic to generic medications. Resident #5 stated they [medications] made her nauseous and have trouble breathing. She stated she had previously had reaction experiences from medications and knew what they felt like. She stated at first she thought it was her medication for heartburn, but then thought it was the furosemide. She stated she paid more for insurance just so she could get brand name medications. The resident stated she had told the nurses she was reacting to a medication, but they did not do anything, so she started refusing the medications.</p> <p>On 4/27/16 at 10:30 am, the DON stated she heard something about the resident reacting to furosemide. She stated the physician should have been notified and whatever the resident had voiced should have been documented in the Progress Notes. The DON stated the facility did not have a policy that addressed allergic</p>	F 309			

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F 309	<p>Continued From page 47 reactions or medication reactions.</p> <p>On 4/27/16 at 10:40 am, LN #5 stated Resident #5 had complained of allergic reactions to medications. Resident #5 had stated she had reacted to medications previously, and had to take the brand names because the others made her nauseous and short of breath. LN #5 stated Resident #5 had the right to refuse medications, and Resident #5 had refused medications. The refusals were documented in the progress notes. LN #5 stated that although Resident #5 had voiced she was reacting to the medication, she had not noticed any signs or symptoms of reactions, such as shortness of breath or nausea.</p> <p>The Nursing Progress Notes did not contain documentation of Resident #5's complaints of medication reactions or discussions with her regarding her actual or potential reaction to medications.</p> <p>4. Resident #6 was admitted to the facility on 4/19/16 with multiple diagnoses, including diabetes mellitus.</p> <p>The Order Summary Report for April 2016 contained four insulin orders, including Lantus pen-injector, 12 units sub-q in the morning with instructions to hold the Lantus if Resident #6's BG was less than 160. It was ordered 4/19/16 and started 4/20/16.</p> <p>The April 2016 MAR documented that Lantus was administered 3 times when Resident #6's BG was less than 160. The Lantus was administered</p>	F 309			

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F 309	<p>Continued From page 48</p> <p>when Resident #6's BG was 149 on 4/21/16, 140 on 4/22/16, and 124 on 4/25/16.</p> <p>On 4/27/16 at 2:00 pm, the DON and Regional Compliance Officer said the Lantus insulin was not held three times, as ordered, when Resident #6's BG was less than 160.</p> <p>5. Resident #2 was admitted to the facility on 4/15/16 with multiple diagnoses including coronary artery disease.</p> <p>Resident #2's hospital discharge orders, dated 4/15/16, documented Amiodarone 400 mg by mouth two times a day for 1 week, then 400 mg every day for 1 week, then 200 mg every day.</p> <p>Resident#2's facility Order Summary Report for April 2016 documented 3 orders for Amiodarone with the order, start, and end dates as follows:</p> <p>* Amiodarone 400 mg by mouth 2 times a day for 1 week, order and start date 4/15/16, and end date 4/22/16.</p> <p>* Amiodarone 400 mg by mouth in the morning for 1 "day," order date 4/15/16, start date 4/23/16, and end date 4/24/16. The typewritten word "day" had a single line drawn through it with the handwritten word "week" next to it. The date of the change from "day" to "week" was not documented and there were no initials to identify who made the change.</p> <p>* Amiodarone 200 mg by mouth in the morning, order date 4/15/16, start date 4/24/16.</p> <p>No other Amiodarone orders were found in Resident #2's clinical record.</p>	F 309			

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F 309	Continued From page 49 A nurse signed the April 2016 Order Summary Report on 4/15/16. The physician and a different nurse signed the same Order Summary Report two days later on 4/17/16. Resident #2's April 2016 MAR documented Amiodarone 400 mg two times a day was administered for 8 days, rather than 1 week, or 7 days, as ordered. It was administered at bedtime on 4/15/16, twice a day on 4/16/16 through 4/23/16, and once on 4/24/16 and 4/25/16. Resident #2 received an extra dose of the antiarrhythmic medication on 4/23/16. On 4/26/16 at 1:25 pm, LN #2 and the Clinical Compliance Auditor reviewed Resident #2's orders and MAR. LN #2 said that Amiodarone 400 mg two times a day was administered more than 7 days. The Clinical Compliance Auditor said she would research the issue and get back with the surveyor. On 4/27/16 at 2:15 pm, the DON said she did not have more information about the Amiodarone issue.	F 309			
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.	F 323		5/21/16	

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F 323	<p>Continued From page 50</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff and resident interviews, and record review, it was determined the facility failed to ensure bed rails were assessed to determine if they were safe for resident use and that residents who were at risk for falls received the necessary supervision and assistance to prevent falls. This was true for 2 of 12 sample residents (#2 and #10). Resident #2's risk for entrapment increased when a bed/side rail assessment was completed before the side rails were on the bed. Resident #10 fell and sustained a hematoma, a skin tear, and a bruise when left alone in the bathroom when the care plan was not individualized and lacked direction regarding the amount of assistance and the number of staff needed, to keep her safe.</p> <p>Findings included:</p> <p>1. Resident #2 was admitted to the facility on 4/15/16 with multiple diagnoses, including coronary artery disease.</p> <p>Resident #2's April 2016 Order Summary Report included bilateral quarter side rails to assist with bed mobility. The side rails were ordered on 4/15/16.</p> <p>Resident #2's care plan for ADL deficits included the use of bed rails as an intervention on 4/16/16. The potential for pressure ulcers care plan also included bed rails as an intervention on 4/16/16 and a pressure relieving bariatric air mattress on the bed on 4/18/16.</p> <p>Bilateral quarter bed rails were observed in the raised position on Resident #2's bed on 4/25/16 at 8:00 am while the resident was in a recliner by</p>	F 323	<p>I. 1. Resident #2 discharged from the facility on 4/25/2016. Resident #2 was readmitted on 5/6//2016, and His side rail assessment were done and signed on that day.</p> <p>2.. Resident #10 discharged from the facility on 2/16/2016.</p> <p>II. All residents have the potential to be affected. An audit of bedrail assessments was done on 5/20/2016 for completion and accuracy. Upon admission, all resident will be checked every hour the first 24 hours for safety concerns.</p> <p>III. Initial/interim care plans will address safety concerns as they are identified or per regulation. Care plans will be individualized based on the nursing assessment upon admission, the 14 day comprehensive assessment, and as needed anytime during the resident's stay. DON/desginee will train nurses to update care plans as needed.</p> <p>IV. The medical records designee/designee will audit the record of all newly admitted residents for evidence of bedrail safely assessments, and hourly safety checks during the first 24 hours of admission. Audits will continue for all new admissions for 3 months, and a summary of the audits will be presented to the QA&A committee. Audits will continue until the facility is 100% compliant & PRN.</p> <p>V. Completed; 5/21/2016.</p>		

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F 323	<p>Continued From page 51</p> <p>the bed. The resident said he used the bed rails to assist with positioning. The bed rails were also observed in the raised position on 4/25/16 at 9:55 am, 10:55 am, 12:00 pm, and 12:35 pm.</p> <p>A Side Rail Assessment, dated 4/15/16, documented Resident #2 was not able to demonstrate proper use of the side rails and, "Bed is a Bariatric [sic] bed and there are no side rails on the bed at this time. Side rails to be applied." The assessment also documented, "The resident has been evaluated using the side rails and has been determined to be safe with side rails." The assessment completion date was 4/15/16, 3 days before the bariatric mattress was added on 4/18/16.</p> <p>A Progress Note, dated 4/18/16 at 11:25 am, documented the bariatric air mattress was implemented and Resident #2 requested bilateral side rails be placed on the bed to help with bed mobility.</p> <p>On 4/27/16 at 2:15 pm, the DON said the side rails were not on Resident #2's bed initially when the Side Rail Assessment started but the side rails were applied to the bed before the assessment was completed. The DON reviewed the resident care plan and could not explain the bariatric air mattress intervention added on 4/18/16, three days after the Side Rail Assessment was completed.</p> <p>2. Resident #10 was admitted to the facility on 2/14/15 with diagnoses of CVA, left side hemiplegia, and muscular wasting and disuse atrophy. On 2/16/15, the resident was transferred to a hospital ER.</p>	F 323			

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

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F 323	<p>Continued From page 52</p> <p>The 2/14/15 Nursing Admit/Readmission Assessment documented Resident #10 was oriented to person, place, time, and situation, needed extensive assistance with transfers, total dependence for ambulation, non-weight bearing on the left arm and leg, used a walker or w/c for mobility, and had a fall on 2/4/15 during the month prior to admission.</p> <p>Resident #10's 2/14/15 care plan for moderate risk for falls related to deconditioning and gait/balance problems included interventions to anticipate and meet the resident's needs and ensure the call light and personal items were within reach.</p> <p>Resident #10's 2/14/15 care plan for ADL performance deficit related to stroke, fatigue, limited mobility, pain, and impaired balance included the interventions "may" require staff participation to use the toilet, "may" require staff participation with transfers, and "may" require staff participation with personal hygiene and oral care, and for PT and OT to evaluate and treat per physician orders.</p> <p>The care plan was not individualized to Resident #10's specific needs and lacked direction regarding when and how much assistance was needed and the number of staff needed to provide assistance.</p> <p>Resident #10's clinical record included a 2/16/15 OT note signed at 8:32 pm, which documented, "Collaborated with PT re[grading] standing tasks to problem solve footwear needs. Patient needs significant work on trunk control and this will facilitate improved motor control for ADL and transfers. She takes postural cues relatively well</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 WEST AMERICANA TERRACE BOISE, ID 83706		
(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 323	<p>Continued From page 53</p> <p>given density of CVA in addition to subdural hematoma.</p> <p>An I & A report, dated 2/16/15, documented Resident #2 had a fall and was found in the bathroom on the floor underneath the sink with her left arm behind her. The report documented Resident #10 said she leaned over on her weak side and slid out of the chair. The resident's mental status was noted as oriented to person only and injuries were a hematoma on the scalp, left hand skin tear, and right knee bruise. An attached Progress Note documented, "At 22:00 [10:00 pm] patient fell in her bathroom while brushing her teeth. Hit her forehead and right knee and got a skin tear to the back of her left hand...Neuro checks started. Dr...and husband notified...Husband...requested...a CT scan...Due to prior history...sent her to...ER...at 2300 [11:00 pm]."</p> <p>On 4/28/16 at 8:40 am, LN #6 said she helped develop care plans and the word "may" in care plans meant a resident "may or may not" need assistance. At 8:45 am, the Regional Compliance Officer joined the interview and said that temporary care plans were developed at admission and "may" was used because the staff did not know the resident.</p> <p>The care plan did not provide direction to staff regarding Resident #10's individualized needs and the resident sustained injuries from a fall when she was left alone in the bathroom.</p>	F 323			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 24, 2016

Chuck Williams, Administrator
Riverview Rehabilitation
3550 West Americana Terrace
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Williams:

On **April 28, 2016**, an unannounced on-site complaint survey was conducted at Riverview Rehabilitation.

The following observations were conducted:

- Response to call light; and,
- Staff working capacity, demeanor, and appropriateness.

The following documents were reviewed:

- Random employee records for current, and previous employed CNAs, LNs, and administrative staff;
- Impaired employee policy;
- Grievance files from November 2015 to current; and,
- Abuse investigations from November 2015 to current

The following interviews were conducted:

- Individual resident interviews regarding quality of care issues and staff interactions with residents;

- Family interviews regarding quality of care issues and staff interactions with residents;
- Staff interviews regarding quality of care issue, staff interactions with residents and staff issues; and,
- Administration interviews regarding quality of care issues, staff interactions with residents, and staff issues.

The Complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted from April 25 to April 28, 2016. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006921

ALLEGATION #1:

The reporting party alleged a Certified Nursing Assistant was working under the influence of medication and alcohol and the administration was aware.

FINDINGS:

Review of randomized employee files did not contain documentation of an employee working under the influence of medication or alcohol, or demonstrating behavior that warranted further investigation. Review of the grievance and abuse investigation files did not contain documentation related to impaired staff. Interviews with residents and family members did not reveal issues with impaired staff. Interviews with staff and the administrative staff did not reveal current or previous issues with impaired staff.

Based on record review and interviews, it was determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The reporting party alleged a Certified Nursing Assistant was slow in answering call lights.

FINDINGS:

During the survey, staff were observed to timely respond to residents' call lights. Review of grievance and abuse investigations did not contain issues with call lights. Interviews with

Chuck Williams, Administrator
August 24, 2016
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residents and family members did not reveal issues with call light response. Interviews with staff and administration did not reveal previous or current issues with staff responding to call lights.

Based on observation, record review and interviews, it was determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson LSW".

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj