IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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May 20, 2016

Michael Blauer, Administrator
St Luke's Elmore Long Term Care
895 North 6th East
Mountain Home, ID 83647-1270

Provider #: 135006

Dear Mr. Blauer:

On **April 29, 2016**, a survey was conducted at St Luke's Elmore Long Term Care 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

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 30, 2016**. Failure to submit an acceptable PoC by **May 30, 2016**., may result in the imposition of additional civil monetary penalties by June 6**, 2016**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.

- Include dates when corrective action will be completed in column (X5).

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

A civil money penalty. 42 CFR §488.430
Denial of Payment for New Admissions made on or after July 28, 2016

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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

F-226 42 CFR §483.13(c)
has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

> The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:
>
> Residents # **1, 2. 3, 4, 5, 6, 7,** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the 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, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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:

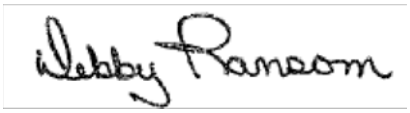
- BFS Letters (06/30/11)

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

This request must be received by **May 30, 2016**. If your request for informal dispute resolution is received after **May 30, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Debby Ransom, RN, RHIT, Supervisor
Long Term Care

dr/lj
Enclosures
cc: Chairman, Board of Examiners - Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135006		04/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKE'S ELMORE LONG TERM CARE	895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey from April 25 to April 29, 2016. The surveyors conducting the survey were: Presie C. Billington, RN, Team Coordinator Nina Sanderson, LSW David Scott, RN Jenny Walker, RN Teresa Kobza, RDN, LD Definitions include: ADL- Activities of daily living BID - twice a day BP - Blood Pressure BR - Bed room CAP - Clinical Assistant Personnel CDM- Certified Dietary Manager CP - Care Plan DNS- Director of Nursing Services FTS- Facility Training Specialist H&P- History and Physical IDT- Interdisciplinary Team LSW - License Social Worker MARS - Medication Administration Record MASD - Moisture Associated Skin Damage MD- Physician MDS- Minimum Data Set OMRA- Other Medicare Required Assessment OOB - Out of Bed OT- Occupational Therapy mg - milli grams PR- Pulse Rate RSA- Resident Services Advocate SBP- Systolic Blood Pressure UTI - Urinary Tract Infections	F 000		
F 154	483.10(b)(3), 483.10(d)(2) INFORMED OF	F 154		6/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/27/2016

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 154 SS=D	Continued From page 1 HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were informed of the FDA Black Box Warning regarding antipsychotic use and their right to decline usage based on that information. This was true for 1 of 1 resident (#6) sampled for antipsychotic medication use. The deficient practice placed the resident at increased risk of unknowingly experiencing adverse reactions to the medication. Findings include: The FDA documented a Black Box warning for the usage of the medication Seroquel in elderly persons with dementia to include, "Drug isn't approved for use in elderly patients with dementia-related psychosis because of increased risk of death from [cardiovascular] disease or infection." Resident #6 was admitted to the facility on 7/25/14 with diagnoses which included Parkinson's dementia. Resident #6's record documented he was admitted to the facility with	F 154	The Director of Nursing (DNS) and the Pharmacist In Charge (PIC) are ultimately responsible for ensuring the residents are informed of the FDA Black Box Warning regarding antipsychotic use and their right to decline usage based on that information. Plan of Correction The family of resident #6 has been informed of the FDA Black Box Warning regarding antipsychotic use and the right to decline usage based on the information. Current residents who have orders and are receiving medications with Black Box Warnings have the potential to be affected by the indicated citation. Residents who have orders for antipsychotic medications with Black Box Warnings have had the medications reviewed and updated consent forms	

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F 154	Continued From page 2 orders for Seroquel 50 mg every morning and 100 mg at bedtime for a diagnosis of Parkinson's behaviors. Resident #6 continued to take this medication until 4/26/16, when the dosage was changed. A Skilled Nursing Charting form in Resident #6's record, dated 7/25/14, documented, "[Guaridan] advised that antipsychotic medication can be deadly/harmful to elderly meaning Seroquel usage. Family states understanding ..." The note did not document whether the guardian had been informed of the specific contents of the FDA black box warning, or that the guardian had the right to refuse its usage. Resident #6's record did not include documentation that the guardian consented to the continued use of the medication after being informed the medication could be harmful or deadly. On 4/29/16 at 8:45 am, the DNS stated the FDA Black Box warning was implied in the documentation the medication was deadly or harmful, and when the family stated understanding of that consequence it was permission to continue with usage.	F 154	have been signed for psychoactive medications as indicated. The residents/family were informed of the black box warnings and their understanding and consent to use was documented. Residents/family were provided a patient education handout about the specified medication. Receipt of the handout by the resident/family is documented in the resident record. A pharmacist will review new prescribed psychoactive medications for interactions and appropriateness. The medication will not be initiated until the process is completed. Verbal and written education on FDA black box warning regarding antipsychotic medication use and the right to decline usage based on the information was provided to nursing staff. QAPI integration Audits will be completed by DNS or designee to ensure that residents/families with psychotropic medications have received the proper education related to applicable black box warnings and consented to treatment. Audits will be conducted daily x 30 days, then weekly x 3 months. The audit results will be shared at the psychotropic drug review meetings, and quarterly to the Continual Readiness/Quality committee. In addition, data will be shared with the	

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F 154	Continued From page 3	F 154	Quality and Safety Council of St. Luke□s Elmore and the Quality, Safety and Service Excellence Committee of the Board.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:	F 164		6/30/16

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F 164	Continued From page 4 Based on observation, and staff interview, it was determined the facility failed to ensure privacy was provided while checking residents' blood sugar levels. This was true for 2 of 7 (#3 and #4) sampled residents residing in the facility and 1 random resident (#10). This failed practice had the potential to negatively impact residents' psychosocial well being. Findings include: On 4/26/16 at 5:30 pm, CNA #12 was observed to check the blood sugar levels of Resident's #3, #4, and #10 in the day room, in full view of multiple other residents and visitors. On 4/28/16 at 4:30 pm, the FTS stated the practice of checking blood sugar in the day room was inappropriate.	F 164	The Director of Nursing (DNS) is ultimately responsible to ensure personal privacy for residents, including while checking residents□ blood glucose levels. Plan of Correction Residents #3, #4, and #10 are receiving care and services, including checking blood sugar levels, in a manner to protect individual resident privacy. Residents who reside in this facility and require blood glucose levels to be checked have the potential to be affected by the indicated citation. 1:1 re-education was provided to the staff member CNA #12 observed during survey. The examples of Residents #3 and #4 were reviewed on 5/12/2016 with clinical staff as an example of inadequate dignity and privacy for resident□s rights. Training on dignity and privacy while addressing blood glucose was added to the new employee orientation. Long term care staff were provided education with competency validation on resident rights, to include privacy and dignity. Annually competency will be assessed at the point of care skills validation training. QAPI Integration	

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F 164	Continued From page 5	F 164	Education will audit compliance with required training monthly. Audit data will be shared with unit leadership. Staff will be removed from the work schedule until required education is completed. Results will also be shared with the Continual Readiness/Quality Committee. Audits of blood glucose testing by the unit to ensure resident□s privacy and dignity will be conducted. Audits will be conducted daily x 30 days, then weekly x 3 months. Audit data to be reviewed at Continual Readiness/Quality Committee monthly. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and the Quality, Safety, and Service Excellence Committee of the Board.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and review of the facility's grievance log, it was determined the facility failed to ensure residents were provided a means to voice grievances. This was true for 4 of 4 residents attending the resident group, and could impact other residents wishing to file a grievance. The deficient practice had the potential for harm when residents became	F 166	The Administrator is ultimately responsible for ensuring that residents are provided with a means to report a grievance. Plan of Correction Of the residents who voiced concerns at the Resident Council meeting with the	6/30/16

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F 166	Continued From page 6 frustrated with the lack of response to their concerns, and stopped informing the facility of their concerns. Findings include: On 4/26/16 at 9:00 am, the facility provided their grievance file for October 2015 through April 2016. The grievance file contained one complaint from a nurse about the way a physician had responded to her when informed of a change in a resident's status, and one grievance which had been filed by a resident with the facility's parent company regarding missing laundry. The resolution of the missing laundry grievance was a) the laundry could not be located, b) the facility's handbook did not require the replacement of missing items, and c) that after the facility explained this to the resident and his family, and both "acknowledge the facility is not responsible for lost belongings." The disposition of the grievance was documented as, "review complete." On 4/26/16 at 10:00 am, the residents in the resident group stated they did not know how to file a grievance with the facility. The four residents attending the group each stated they had concerns they would like the facility to address, which they had told staff about "over and over," but had seen no resolution. Three of the residents had concerns with missing laundry, two with the treatment they received from the staff, and one with the temperature in the facility. The residents who were missing laundry stated they had informed direct care staff of their concerns repeatedly, but when no resolution was forthcoming, they did not know of further steps they could take to get their concerns addressed. The residents with concerns regarding the way	F 166	surveyors, two were identified by the facility for follow-up. Resident #10 verbalized concern that her dress was not returned from laundry services. Leadership met with Resident #10 and offered to replace her dress and the resident declined. Resident #10 verbalized concern with a night shift Clinical Assistive Personnel (CAP). A formal investigation was completed in conjunction with St. Luke□s Health System Human Resources department. A formal report including the investigation was completed in accordance with State and Federal guidelines and submitted as appropriate. Residents residing in the facility were interviewed to identify concerns in order to initiate resolution. Current residents and their families have been provided with contact information for the Director of Nursing (DNS) and facility Administrator in order to ensure that they are aware of and are able to contact leadership to initiate a concern or indicate if there is a concern that has not been resolved to their satisfaction. Education on the grievance process was provided to residents residing in the facility. Education was provided in written format and hand delivered to each resident, that also included contact information for unit and facility leadership.	

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F 166	Continued From page 7 their treatment was provided stated they could not say anything when the people were working, because it was night shift, and they were not sure who they could contact during the day. On 4/28/16 at 10:25 am, the DNS stated the residents knew who she was, and that they could let her know about anything. However. the DNS did not track when residents brought concerns to her attention, how they were resolved, and whether the residents were satisfied with the outcome.	F 166	Photos of the DNS and facility Administrator with contact information were posted at wheelchair height in the common area. Resident handbooks were updated and distributed to current residents. Changes included contact information for DNS and facility Administrator as well as the organization compliance hotline. The grievance process will be reviewed as part of orientation to residents to the unit. The Activities director was educated on the grievance process and the required follow up, timeline and documentation for Resident Council meetings. The DNS was educated on the electronic Midas grievance reporting system and documenting concerns received. DNS to attend Resident Council quarterly, with approval from Resident Council, to review how to report a concern related to care. DNS to review Resident Council minutes and ensure concerns are properly reported and investigated. Grievances to be reviewed monthly at the Continual Readiness/Quality Committee. Complaints not resolved at Resident Council will be considered a grievance	

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F 166	Continued From page 8	F 166	and entered into Midas event report system. Response will be provided in writing to the Resident Council Members. An electronic report will be provided to the facility Administrator weekly that will reflect the status of Midas grievances. LTC staff to receive education on the grievance process including competency check off. Patient rights education provided to staff on an annual basis moving forward. QAPI Integration Facility leadership will round on residents each month. Rounding will include a review of potential concerns and how to report a concern should one occur. Results of rounding will be reviewed at monthly Continual Readiness/Quality Committee.	
F 168 SS=C	483.10(g)(2) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure complete contact information for resident advocacy groups was posted. This was true for all residents in the	F 168	The Administrator is ultimately responsible for ensuring complete contact information for resident advocacy groups is posted.	6/30/16

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F 168	Continued From page 9 facility wishing to contact the State Agency. The failed practice created the potential to have concerns unaddressed by entities outside the facility. Findings include: On 4/26/16, the required postings for resident advocacy groups were located in the alcove next to the nurses' station. The posting with the contact information for the State Agency listed the physical address of the agency. The telephone number for the State Agency was not listed. On 4/29/16 at 2:30 PM, the Administrator acknowledged the posting lacked a contact telephone number.	F 168	Plan of Correction Enhanced signs for the Bureau of Facility Standards and Adult Protective services with current contact information are posted in the resident common areas. Contact information includes telephone number, mailing and physical addresses. Current residents and their families have been provided with contact information for Bureau of Facility Standards, advocacy groups, DNS and facility Administrator. Ombudsman and Adult Protection Services contact information was checked for accuracy. Each month the Resident Services Advocate or designee will verify the posted advocacy contact is current. Information identified as not being posted or current will immediately be resolved and updated. Additionally, an audit question was added to the Environment of Care Audit checklist. Information identified as not being posted or current will be immediately resolved and updated. Complete rounds will occur twice a year with results reported to the Environment of Care Committee.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of	F 221		6/30/16

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F 221	Continued From page 10 discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined that the facility failed to ensure the use of recliners was assessed as a potential physical restraint. This was true for 3 of 8 (#1, # 3, # 6) sampled residents. This deficient practice created the potential for residents to develop skin related issues, decreased mobility, and increased incontinence. Findings include: 1. Resident #1 was admitted to the facility with multiple diagnoses including advanced dementia, UTI, generalized weakness and frequent falls. Resident #1's most recent quarterly MDS assessment, dated 2/17/16, indicated she was severely cognitively impaired. The assessment noted Resident #1 required extensive assistance from one for transfers, toilet use, and bed mobility. It also stated she required a wheelchair or walker for ambulation. The MDS assessment indicated Resident #1 was frequently incontinent and that she had a fall with injury. The Physical Therapy Discharge Summary, dated 9/7/15, documented Resident #1 continued to require supervision for all transfers and with walking using a quad cane, due to her advanced dementia and poor insight. The 8/20/15 the Care Plan for Restraints did not include a recliner as a possible restraint. There were no corresponding care plan updates	F 221	The Director of Nursing (DNS) is ultimately responsible to ensure that residents are free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident□s medical symptoms. The DNS is responsible to ensure that the resident□s use of recliners are assessed as a potential physical restraint for each individual resident. Plan of Correction Residents #1, #3 and #6 were assessed to determine if they can appropriately use the remote to get out of the reclined position. A restraint assessment was completed for each resident. Care plans have been updated to reflect the current status of each resident. There will be staff available in the day room while residents who are at risk for falls are present. Non-electric recliners were removed from the facility on 5/23/2016. Residents are assessed to determine if they can appropriately use the remote to get out of the reclined position and care plans will be updated to reflect the current	

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F 221	Continued From page 11 documented. Resident #1's record did not contain documentation of an assessment for the use of the recliner. On 4/25/16 at 1:15 pm, Resident #1 was observed sitting in the day room in a recliner chair. The chair was located against the wall closest to the nurses' station. Resident #1 had a tab alarm attached to her shirt and it was set on the chair behind her. She could not sit completely up right or get up from the recliner. The control for the recliner was in a pocket on the side of the recliner and was out of Resident #1's reach. An activity was close to starting and Resident #1 was unable to get up or move by herself to be able to participate in the activity. On 4/26/16 at 9:03 am, Resident #1 was sitting in the recliner in the day room in the same location. The control for the recliner was in the pocket on the side of the recliner and out of Resident #1's reach. The current activity was watching The Price is Right and she was unable to view the program. She tried to view the program by moving but was unable to and stopped trying after a few minutes. On 4/27/16 at 11:00 am, the DNS stated the residents should be able to get out of the chairs and the controls should be within their reach. 2. Resident #3 was admitted to the facility on 5/21/15 with multiple diagnoses, including dementia, diabetes mellitus and urinary tract infection.	F 221	status of residents who utilize the recliners. Staff were re-educated on 5/12/2016 regarding the potential for restraint when a resident is in the reclined position and they do not have remote in their possession or if the resident is unable to get out of the reclined position without assistance. A clinical documentation form was developed for intentional rounding which will include a review of residents who are utilizing the recliners and verifying that they are not being utilized as a restraint. Long term care staff were provided education for intentional rounding workflow. A review of intentional rounding form will be conducted by the Resident Care Plan Team including: assessment of repositioning, toileting, hydration, restraints. Restraint education and competencies will be audited for compliance to include annual training and orientation. QAPI Integration An audit of the intentional rounding form will be conducted by nursing staff daily x 30 days, weekly x 3 months. A summary of the Resident Care Plan Team will be reported monthly to the Continual Readiness/Quality Committee.	

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F 221	Continued From page 12 Resident #3's most recent Quarterly MDS assessment, dated 2/26/16, documented short and long term memory impairment, required set-up only on eating and one person physical assist for all activities of daily living. On 4/26/16 at 6:00 pm, Resident #3 was observed alone in the Day Room sitting in the recliner with the foot rest in the elevated position. The dinner meal was being served in the Dining Room. Resident #3 was sitting forward in recliner and pushing herself up as if attempting to scoot herself forward on recliner seat. At 6:04 pm, Resident #3 dropped her right leg off the footrest and attempted to twist her body to the right but was unsuccessful and sat back in the chair. Resident #3 remained unattended while in the Day Room. Staff were not observed to help her. At 6:08 pm, Resident #3 was observed sitting in the recliner, periodically fidgeting with her hands. She reached for the end of recliner arm and pulled herself forward and dropped her right leg off the footrest and said "Help me" and pushed herself forward again. A CAP approached Resident #3 and said "Can you wait for one of the girls to come help you?" At 6:12 pm, two CAPs were observed assisting Resident #3 to her wheelchair and pushed her to the Dining Room. On 4/27/16 at 11:00 am, the DNS said residents should be able to get out of recliner chairs and the controls should be within their reach. 3. Resident #6 was admitted to the facility on 7/25/14 with diagnoses including Parkinson's Disease and dementia. Resident #6's 2/1/16 Quarterly MDS assessment	F 221	Significant events and event report trends will continue to be reported monthly to the Continual Readiness/Quality Committee. In addition, data will be shared with the Quality and Safety Council of St. Luke□s Elmore and the Quality, Safety and Service Excellence Committee of the Board. The Education department or designee will conduct audits of compliance related to required abuse and neglect training monthly. Audit data to be shared with unit leadership. Staff not in compliance will be removed from work schedule until required education is completed.	

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F 221	Continued From page 13 stated he required physical assistance to move from a seated to a standing position and to ambulate, and required extensive assistance from 2 people for transfers. Resident #6's care plan documented he required a sit-to-stand machine during transfers, and liked to sit in a recliner in the early morning. On 4/25/26 at 1:15 pm, Resident #6 was observed sitting in a lift recliner in the Day Room. The control to the recliner was in a pocket at the base of the recliner, out of Resident #6's reach. At 2:41 pm, he became fidgety in the chair, using his right arm to lift the right side of his torso and buttocks off of the chair surface. At 2:44 pm, Resident #6 was still trying to lift himself from the chair when the LSW, an LPN, and a CAP walked by. Resident #6 lifted his hand to get their attention, but the staff did respond or acknowledge him. Resident #6 briefly settled back in the chair, then at 2:48 pm again attempted to lift himself out. On 4/27/16 at 11:00 am, the DNS stated that when residents are sitting in lift recliners, the control should be within reach. The DNS stated the facility had not considered the possibility that Resident #6's use of a recliner could serve as a restraint. The DNS stated the facility did not have an assessment of Resident #6's ability to use the recliner, or how to increase his ability to use the recliner as independently as possible.	F 221		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226		6/30/16

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F 226	Continued From page 14 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and review of facility policies and clinical records, it was determined the facility failed to ensure policies and procedures were developed and implemented to a) identify potential instances of abuse and neglect, 2) protect residents once allegations had been made, report allegations as required to the appropriate state authorities, and 3) ensure allegations of abuse were thoroughly investigated. This failure was true for 7 of 7 (#1, #2, #3, #4, #5, #6, and #7) sampled residents residing in the facility, 4 of 4 residents attending resident group, and impacted all other residents in the facility. The failure created the potential for all residents in the facility to experience abuse and neglect. Findings include: 1. Policy a. The facility's policy for abuse prevention documented the prevention plan was to ensure adequate staffing levels, which would be reviewed by department leadership, with appropriate supervision to identify inappropriate staff behaviors. The prevention section of the policy did not identify how or to whom residents or staff could report concerns, incidents, or grievances, or how feedback would be provided once a concern had been made. b. The facility's policy for abuse identification	F 226	The Administrator is ultimately responsible for ensuring policies and procedures are developed and implemented to identify potential instances of abuse and neglect, protect residents once allegations have been made, report allegations as required to the appropriate state authorities, and ensure allegations of abuse are thoroughly investigated. Plan of Correction Of the residents who voiced concerns at the Resident Council meeting with the surveyors, two were able to be identified by the facility and appropriate follow-up was able to be completed. Resident #10 verbalized concern that her dress was not returned from laundry services. Leadership met with Resident #10 and offered to replace her dress and the resident declined. Resident #10 verbalized concern with a night shift clinical assistive personnel (CAP). A formal investigation was completed in conjunction with St. Luke□s Health System Human Resources department. A formal report including the investigation was completed in	

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F 226	Continued From page 15 documented the facility would have "proactive identification of environmental events" through "Environmental Tours and Security Risk Assessments," and designate all employees as responsible for reporting abuse to their immediate supervisor. The policy did not identify events such as suspicious bruising of residents, or other trends or patterns in the facility which should be investigated as potential instances of abuse. c. The facility's policy did not stipulate that residents needed to be protected from further abuse or neglect once an allegation was made, or how the facility would ensure the residents were to be protected. d. The facility's policy for abuse investigation did not clearly identify which staff members within the Long Term Care employee structure were responsible for initiating and coordinating the investigation of abuse and neglect allegations. The policy identified the "Rehabilitation Hospital Administrator or designee" was responsible. On 4/25/16, the facility identified the RSA as the person in the facility responsible for the abuse policy, training, and investigation. The policy stated injuries of unknown origin, accidental death, injury caused by staff mistake, and misappropriation of property would all be investigated in the same manner, but did not identify what those investigations would entail. 2. Training On 4/27/16 at 4:00 pm, the Administrator and VP stated the facility used contract services to provide physical therapy in the facility. At 4:30	F 226	accordance with State and Federal guidelines and submitted as appropriate. Resident #1□s care plan was updated to reflect preference for female shower aides. The updated plan of care was reviewed with the patient and her daughter and agreed upon. Resident #2□s chart was reviewed and updated to current status with new Fall Risk Assessment, BRADEN scale and care plan. The Abuse and Neglect policy has been reviewed and updated to ensure regulatory requirements are clearly addressed. The Licensed Social Worker (LSW) conducted interviews on 04/27/2016 with alert and oriented residents to identify potential concerns regarding abuse and neglect. Non-alert and oriented residents received a full head-to-toe skin assessment on 04/27/2016 by an Emergency Room Registered Nurse to evaluate for signs of abuse and neglect. Current residents in the facility were asked for their preferences for shower aide and care plans were updated appropriately. The Director of Nursing (DNS) and LSW	

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F 226	Continued From page 16 pm, the agency PTA stated she had not received specific training on how to report abuse and neglect within the facility. The PTA stated that she used the "common sense method" and reported concerns to either the MDS nurse or the DNS. On 4/27/16 at 4:07 pm, the RSA confirmed she was the person designated by the facility as the person responsible for the facility's abuse prevention program. The RSA stated her background was in criminal justice, with her previous occupation as the Health Unit Clerk for the facility. The RSA stated her own training on abuse when she assumed her current position consisted of going over the abuse policy with the DNS and being instructed to read it and ask any questions she may have. The RSA stated she then signed a form to confirm that she had received training on abuse and neglect. 3. Prevention On 4/26/16 at 10:00 am, 4 of 4 residents at the group interview said they did not know how to file a grievance with the facility. Three of four residents had concerns with missing laundry and said they had informed the direct care staff of their concerns repeatedly but had not received an answer or follow up. They stated they did not know what to do next or to whom they should make an inquiry about their missing laundry. One concern raised by 2 of 4 residents in the group interview was about treatment they received from a CAP during the night shift. One of four residents said, "She makes me nervous." Residents said they were not sure who they could contact about this concern during the day.	F 226	rounded on current residents on 04/27/2016 and provided written and verbal education regarding abuse and neglect, including what constitutes abuse and neglect, and who to contact with concerns. The DNS attended the Resident Council meeting on 05/26/2016 to verify that Resident Council concerns were addressed to the residents satisfaction. Information regarding how to report concerns with care, including photos of the facility Administrator and DNS, were posted at wheelchair height in the common area. Written and verbal education on the Abuse and Neglect policy and reporting requirements have been provided to staff, contractors, volunteers, and students with access to long term care residents. The Resident Services Advocate (RSA) was provided individualized education on abuse and neglect including a competency assessment. The Quality and Patient Safety Manager reinforced education to staff regarding reporting of events, including how to submit events through the electronic reporting system. An interim Minimum Data Set (MDS) coordinator has been identified for the facility.	

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F 226	Continued From page 17 4. Identification On 4/27/16 at 4:07 pm, the RSA stated that if a resident approached her to let her know they were afraid of a specific staff person, the facility would make sure the staff person was never alone with the resident again. The RSA stated such a report would not necessarily be reported or investigated as an allegation of potential abuse or neglect. 5. Investigation *On 8/5/15, Resident #1 reported to staff that she was fearful of being raped if she had male attendants in the shower. She had been showered by a male attendant that day. The facility did not investigate further, and made no adjustments to Resident #1's care plan. *A Fall Risk Evaluation form showed Resident #2 was assessed as at high risk for falls. The MDS staff documented on the back of the form, that Resident #2 had a fall on 2/12/16 and 3/14/16. There was no further investigation found in Resident #2's clinical record about the falls. The DNS said she was not made aware of the falls. 6. Reporting On 4/27/16, the RSA stated if the facility received a specific allegation of abuse or neglect, the facility would suspend the staff member accused, and report the incident to the Ombudsman. The RSA stated she would also inform the DNS. The RSA was not certain whose responsibility it was to suspend the employee, but thought it was the	F 226	The interim MDS coordinator provides immediate updates to the DNS regarding concerns she has identified related to potential or alleged abuse and neglect of residents. Identified concerns are immediately reported to the facility Administrator. The RSA provides immediate updates to the LSW, DNS, and CNO regarding concerns she has identified related to potential or alleged abuse and neglect of residents. Identified concerns are immediately reported to the facility Administrator. The DNS reviews and approves Resident Council minutes. The DNS attends Resident Council meetings quarterly, with approval from Resident Council, to review reporting concerns related to care and to verify that concerns are addressed to the residents□ satisfaction. Upon admission, residents will be assessed for preference in shower aides and preference will be reflected on the care plan. The Administrator, DNS, and LSW report and investigate allegations of abuse and neglect in accordance with facility policy and State and Federal regulations. The abuse and neglect training, including	

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F 226	Continued From page 18 DNS. On 4/29/16 a copy of the organizational chart for the facility was reviewed. The chart documented all facility personnel were directly supervised by the DNS. The DNS was directly supervised by the facility Administrator. There was no indication incidents of abuse or neglect were reported to the Administrator or that the Administrator provided oversight of the abuse and neglect investigative processes. The above negative systemic practices placed residents #1, #2, #3, #4, #5, #6, #7, and all other residents residing in the facility, at risk of abuse and neglect. On 4/29/16 at 11:50 am, the Administrator, VP, and DNS stated they would immediately begin to work on correcting the above issues.	F 226	reporting of concerns, will continue to be provided during new hire orientation for staff and contractors. Annually, the abuse and neglect training, including reporting of concerns, will be provided for staff and contractors. Based on unit leadership assessment, re-education on abuse and neglect for staff including assessment of competency will be provided as needed. The Administrator will continue to review and sign LTC Midas incident and accident reports. The Organizational chart has been updated to reflect the RSA□s reporting relationship to the LSW; the LSW□s reporting relationship to the hospital CNO; and the LSW matrix reporting to the facility Administrator. The updated chart also shows the Quality and Patient Safety Manager reporting to the System VP of Quality Operations and the Quality and Regulatory Programs Coordinator reporting to the West Region Director of Accreditation/Patient Relations. The refined organizational chart demonstrates enhanced lines of communication. LTC staff to receive education on revised abuse and neglect policy and procedure. QAPI Integration The Education department or designee will conduct audits of compliance related to required abuse and neglect training	

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F 226	Continued From page 19	F 226	monthly. Audit data to be shared with unit leadership. Staff not in compliance will be removed from work schedule until required education is completed. Results will also be shared with the Continual Readiness/Quality Committee. Unit Leadership to round on residents and staff each month. Rounding to include review of potential concerns and how to report a concern should one arise. Results of rounding to be reviewed at monthly Continual Readiness/Quality Committee.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure residents were treated with dignity. This was true for 7 of 7 sampled residents (#1, #2, #3, #4, #5, #6, and #7) residing in the facility and all residents in the facility who ate in the facility's dining room. The deficient practice created the potential for harm if residents became embarrassed when using incontinence wipes to clean their faces and hands after meals, by eating a meal in wet clothing, or when served foods in a way they could not be gracefully consumed. Findings include:	F 241	The Director of Nursing (DNS) and Resident Services Advocate (RSA) are ultimately responsible for ensuring residents are treated with dignity. Plan of Correction Resident #6□s nutritional care plan has been reviewed to verify current status. Resident #6 is being provided appropriate assistance related to food intake when needed. Residents #1, #2, #3, #4, #5, #6, and #7,	6/30/16

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F 241	Continued From page 20 1. Resident #6 was admitted to the facility on 7/25/14 with a diagnosis of Parkinson's dementia. Resident #6's 2/1/16 Quarterly MDS assessment noted he required limited assistance of 1 person for eating, was dependent on 1 person for dressing, and dependent on 2 persons for transfers. Resident #6's nutritional care plan, initiated 8/7/15, documented he was to be provided assistance as needed to consume meals. a. On 4/25/16 at 2:53 pm, Resident #6 was sitting in a recliner in the day room. The Activities Director placed a bag of popcorn in his right hand, then left. Resident #1 spent several minutes trying to move his left hand into the bag to reach the popcorn, but was unsuccessful. He then moved the bag of popcorn towards his head, lowered his face into the bag, and began to eat. Resident #1's face sunk lower and lower into the bag. When he could no longer reach the popcorn in the bag he pulled his head out of the bag and tried again to put his left hand in the bag. Again, he was unsuccessful. After a few minutes, Resident #1 laid his left hand in his lap, used his right hand to set the bag of popcorn in his left hand, and began to reach into the bag with his right hand to feed himself handfuls of popcorn. b. On 4/26/16 at 5:49 pm, Resident #6 was sitting at a table in the dining room. Resident #6 reached for a glass of soda sitting on the table, and in the process of bringing it towards him to drink, spilled both the coffee and his soda in his	F 241	will be provided individual pre-moistened towelettes. Staff education and competencies on change of practice to use individual pre-moistened towelettes has been provided. 1:1 education has been provided to the Activities Director regarding following patient plan of care when providing snacks. Staff educated 5/12/2016 on need to observe and provide residents with an opportunity to change clothes if a spill or soiling of clothing occurs. Decorative containers that provide a more homelike environment will be utilized for washcloths and appropriate towelettes for resident usage in the dining area. QAPI Integration A Dining Room audit will be conducted by the unit staff to ensure appropriate towelettes are utilized during meal times and residents are provided an opportunity to change if a spill occurs. Audits will be conducted at 3 meals per day x 30 days and then one meal per week x 3 months. Audit data will be reported to the Continual Readiness/Quality Committee on a monthly basis. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and Quality, Safety, and Service Excellence Committee of the Board. Issues identified	

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F 241	Continued From page 21 lap. CAP #5 approached, wiped up the liquid from the table and dried the tabletop. CAP #5 then wiped the excess liquid from Resident #6's lap. No further assistance was offered or provided. Resident #6's pants were visibly wet as he consumed his meal. On 4/27/16, the DNS stated Resident #6 should have been presented his popcorn in a manner he could consume, and he should not have had to dine in wet clothing. 2. On 4/26/16 and 4/27/16 during all meals, 4/25/16 and 4/28/16 during lunch and dinner meals, and 4/29/16 during breakfast, Residents #1, #2, #3, #4, #5, #6, and #7 were observed in the dining room. Residents and staff were observed to clean residents' faces and hands using the same type of sanitizing wipes used to provide peri care.	F 241	during the audits will be addressed at the time they are identified and will be reported to the DNS or RSA to ensure appropriate resolution.	
F 250 SS=G	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, staff interview, and record review, it was determined the facility failed to ensure a) residents were assessed, and care plans developed, for residents with potential suicidal behavior; b) care was provided in a way to minimize resident distress; and c) advanced	F 250	The Director of Nursing (DNS) is ultimately responsible for ensuring residents with potential suicidal behaviors are assessed and appropriate care plans are developed, that care is provided in a way to minimize resident distress, and	6/30/16

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F 250	Continued From page 22 directives were enacted per resident wishes. This was true for 2 of 6 (#2 and #5) residents sampled for the provision of social services. Resident #5 was harmed when she had expressed ongoing feelings that she would be better off dead, or of hurting herself in some way, without response from the facility. Resident #5 was at further risk for harm when the facility did not secure copies of her advanced directives. Resident #2 was at risk of harm when she verbalized intent and a plan to take her own life. Findings included: 1. Resident #5 was admitted 7/8/15 with diagnoses of non-Alzheimer's dementia, macular degeneration, and stroke. Resident #5's admission MDS assessment, dated 7/8/15, noted she rarely/never understood and had severely impaired decision making abilities. Staff assessed her as having no signs of depression. a. The 9/9/15 OMRA MDS assessment stated Resident #5 had delusions. On 9/10/15, a social services progress note documented the possibly of depression. The progress note stated behaviors were noted and her care plan was updated. On 9/11/15, Resident #5's care plan was updated to include mood disturbances and delusions. Resident #5's documented behaviors included depression, negative thoughts, disrobing, delusions of delivering twin babies, and paranoia that her daughter is out to get her. She was noted to be uncooperative and made verbal threats. The MD was notified and declined orders for an antidepressant at that time.	F 250	that advanced directives are enacted per resident wishes. Plan of Correction Resident #5 was reassessed for depression on 04/28/2016 by the Licensed Social Worker (LSW) using the depression scale for dementia and the care plan was updated to reflect current status. Resident #2 was reassessed for depression on 04/28/2016 by the LSW using the depression scale for dementia and the care plan was updated to reflect current status. The Resident Services Advocate (RSA) was provided enhanced education on the importance of timely reporting to the LSW, DNS or designee of concerns brought forward by nursing, clinical assistive personnel (CAP), or MDS assessments regarding signs and symptoms of depression. Behavior monitors were revised to require charting on each shift. The LSW will attend the Resident at Risk Committee to assist in identification of potential concerns. The LSW will attend Psychotropic Drug Committee to assist in identification of potential concerns. The RSA will review behavior monitors for	

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F 250	Continued From page 23 No further social services documentation was noted from 9/11/15 to 10/21/15. On 10/15/15 a quarterly MDS assessment indicated Resident #5 had moderately impaired cognition and she could participate in a mood assessment. During the mood interview, Resident #5 reported feeling down, depressed, or hopeless. The overall mood score was 21 out of 27 indicating possible severe depression. Resident #5 also reported that she had thoughts she would be better off dead or hurting herself in some way more than half of the days in the previous two weeks. The MDS assessment indicates that for residents with those thoughts, the facility is make a safety notification to the responsible staff or provider that Resident #5 was at risk of harming herself. The response on the MDS assessment documented this had been done. Resident #5's record did not contain documentation of physician notification or further evaluation of her psychosocial needs. Her care plan was not updated to include further interventions related to her psycho-social and mood status. In a social services progress note, dated 10/15/15, the RSA (unlicensed personal) documented Resident #5 was afraid the bed alarms and toilet alarms she was hearing were fire alarms. No further evaluation was conducted of this fear. New care plan interventions were not documented.	F 250	trends. The LSW will also review behavior monitors to ensure potential concerns are identified. The Organizational chart has been updated to reflect the RSA□s reporting relationship to the LSW; the LSW□s reporting relationship to the hospital CNO; and the LSW matrix reporting to the facility Administrator. The updated chart also shows the Quality and Patient Safety Manager reporting to the System VP of Quality Operations and the Quality and Regulatory Programs Coordinator reporting to the West Region Director of Accreditation/Patient Relations. The refined organizational chart demonstrates enhanced lines of communication. Residents who trigger for depression on MDS will be referred to the LSW for an MDS review and resident assessment to determine if mental health consult is indicated. The LSW will refer as appropriate. Resident #5□s family was requested to bring in documentation of Power of Attorney and Advanced Directive or seek guardianship of resident. Facility to contact ombudsman by 06/30/16 if family unable to provide requested documentation. Current residents will be reviewed for proper documentation for Advanced Directives/POST and Power of Attorney for healthcare and updated as	

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F 250	Continued From page 24 There was no further social services documentation between 10/21/15 and 1/18/16. On 1/15/16 a quarterly MDS assessment indicated Resident #5 continued to have thoughts of being better off dead, or hurting herself in some way, several days out of the previous two weeks. The assessment documented the responsible staff or provider was informed of the potential for Resident #5 to harm herself. Resident #5's record did not contain documentation of physician notification or further evaluation of her psychosocial needs. New interventions were not identified on her mood care plan. On 1/18/16, the RSA documented a care conference was held with Resident #5's daughter and the facility had no identified concerns at that time. On 4/26/16 at 4:55 pm, Resident #5 was observed talking with Resident #1. She asked if Resident #1 had seen "the baby". Resident #1 directed Resident #5 to go talk to the nurse. Resident #5 approached RN #10, asked about the baby, was told, "not now," and taken back to the day room. Resident #5 reaproached the nurses' station and asked RN #10 about the baby. RN #10 returned Resident #5 to the day room. Resident #5 was observed to be crying. She was escorted to a quiet area in the day room with CNA #8. At 4/26/16 at 5:20 pm, Resident #5 was observed propelling her wheelchair towards the nurses' station. Resident #5 stated, "I'm looking for my babies," and began to cry.	F 250	appropriate. On admission, residents will continue to be screened for Advanced Directives and Power of Attorney for healthcare and proper documentation will be obtained. QAPI Integration The LSW□s audits of behavior monitors will be completed daily x 30 days, then weekly x 3 months. This data will be reviewed at the monthly Nursing Staff meetings and Continual Readiness/Quality Committee Meetings on a monthly basis. In addition, audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and Quality, Safety and Service Excellence Committee of the Board.	

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F 250	Continued From page 25 On 4/27/16 at 4:55 pm, the MDS nurse stated, Resident #5 used to live alone, was fearful of being alone, and wanted to die. The MDS nurse stated, there was no further documentation regarding these issues. She said she simply knew Resident #5 well enough to know that. b. On 8/5/15, the MDS nurse documented in the social services progress notes, "PT staff came to this nurse and said, '[Resident #5] is anxious today because she's fearful of being raped in the shower potential. Resident did receive shower by male CAP on 8/5/15...will care plan her for female showers only to decrease anxiety." Resident #5's care plan did not contain documentation of her preference for female shower aides. One note was documented on Resident #5's behavior monitor for the month of August, on 8/7/15, for "attention seeking-see nurse's notes." No documentation related to this behavior was found in the nurses' notes. There was no further documentation found regarding the use of female shower aides only. On 4/27/16 at 4:55 pm, the MDS nurse stated Resident #5's concern was not an allegation of rape, but more a fear that something might happen. The MDS nurse stated she believed the information was added to Resident #5's care plan. She had no additional documentation to offer. The MDS nurse stated if the item was no longer on the care plan, that meant that the facility had determined that the item may be removed. The MDS nurse stated, per her	F 250		

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F 250	Continued From page 26 recollection, Resident #5 had only mentioned the fear of rape once and Resident #5's daughter had no concerns with male aides showering her mother. On 4/27/16 the LSW stated she had no memory of the incident on 8/5/15. The LSW stated the facility did not have a permanent social worker from March 2015 to end of August 2015. c. Resident #5's record contained a photocopy of a wallet sized Notice to Health Care Providers that she executed advanced directives designating a primary and secondary agents for health care decisions. The notice documented where the directive could be located. The photocopy contained a hand written addition stating the primary agent had passed away and the secondary agent is the surrogate health care decision maker. The photocopy documented the secondary health care agent was to provide a copy of the advance directives. The photocopy was dated 7/8/15. On 4/27/16 at 1:30 pm, the LSW and RSA stated Resident #5 expressed paranoia that the secondary agent was going to, "take all her stuff" and that the secondary agent had not provided a copy of the advance directive. The facility had not followed up to obtain the document. 2. Resident #2 was admitted to the facility on 8/8/13 with multiple diagnoses, including depressive disorder, diabetes mellitus, and hypertension. An MDS assessment, dated 8/14/15, documented Resident #2 felt bad about herself	F 250		

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F 250	Continued From page 27 2-6 days out of the week and had thoughts that she would be off better dead or thoughts of hurting herself "7 of 11 days". A Suicide Screening Form, dated 8/17/15, documented Resident #2 as high risk with a score of 13. In the question, "In your lifetime: Did you ever make a suicide attempt?" Resident #2 answered, "No, but wanted to". The interventions included: *Charge Nurse will notify DNS, MD, and family of Suicidal Screening Form results within 24 hours after completion. *Safety monitor to be placed in MARS for 72 hours. *Nursing staff will place patient in protective environment with continuous observation. Continuous observation will be provided by hospital staff... The Suicide Screening Form documented staff were to provide continuous observation of the resident if the score was greater than or equal to 10 (high potential). Resident #2 scored 13. Social Services Progress Notes, dated 8/17/15, documented Resident #2 had feelings of hurting herself every day and had planned to use a gun. The progress notes also documented the LN and MD were notified and suicide prevention was initiated. A CP regarding Resident #2's daily feelings of hurting herself was not found in her clinical record.	F 250		

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F 250	Continued From page 28 On 4/28/16 at 10:30 am, the RSA said she notified the LN on duty about Resident #2's feelings of hurting herself and told the LN to notify the MD. When asked if she had notified the LSW, the RSA said "Yes, her advice was to continue observing the resident and to continue the safety monitor for 72 hours." On 4/28/16 at 10:40 am, the LSW said she provided guidance to the RSA on how to deal with Resident #2's situation and to follow up with her, if needed. When asked if she had visited and assessed Resident #2, the LSW said she did not. She said she was told Resident #2 did not show signs and symptoms of depression and her family said she would make comments about hurting herself when she was in pain or would be mean to people when she was upset. The LSW said there was no urgency to see Resident #2 at that time. The LSW indicated Resident #2 had dementia with short term memory loss and it would be difficult for her to retain therapy information and participate in therapy sessions. The LSW was requested to provide the documentation of the referral made by the RSA to her. She said she would check her email and would give it to the surveyor. When asked about the continuous observation as documented on Resident #5's Suicide Screening Form for a high risk score, the LSW said, "That is confusing, it didn't say one to one. She was monitored every 30 minutes." At 12:20 pm on 4/28/16, the LSW indicated she was unable to provide documentation of the consultation she provided to the RSA. She said it was a verbal consultation and if there was an email sent during that time their computer system cleared everything after	F 250		

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F 250	Continued From page 29 three months unless they saved it. On 4/28/16, LN #1 said she had notified the MD at 2:30 pm on 8/17/15, and was told to continue the safety monitor in place, but said "Probably I did not write it." She said Resident #2 was monitored every 30 minutes and was kept in line of sight of staff during the daytime by putting her in the day room; and then in the evening, staff made rounds every 30 minutes, and also in between the 30 minute checks, to make sure Resident #2 was safe.	F 250		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a homelike environment was provided for resident living and common spaces. This was true for 1 of 7 sampled residents (#5) residing in the facility, residents using the facility's dining room, day room, or hallways, and 2 of 18 (21 and 23) resident rooms. The deficient practice created the potential for harm if residents experienced embarrassment over disrepair in their home. Findings included: 1. Dining Room	F 252	The Building Services Manager is ultimately responsible for ensuring the residents are provided with a home-like environment. Plan of Correction Dining room will be repaired to include wallpaper, nail holes, and discoloration on walls. Exit door and door to kitchen will be repaired to include door scuffs and stains. Support posts will be repaired to include scuffed marks and chipped paint. The linoleum will receive new seams to address curling and separation.	6/30/16

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F 252	Continued From page 30 On 4/26/16 at 2:00 pm, the wallpaper along the west side of the dining room, and on the north side of the dining room past the exit door was noted with separation at the seams and nail holes and discolorations where wall hangings had been removed. The exit door and the door into the kitchen were scuffed and stained. The support posts had scuff marks and chipped paint extending from the floor up approximately 2 feet. The linoleum flooring was separating and the seams were curling at the base of the post. 2. Day Room On 4/26/16 at 2:00 pm, the wallpaper on the east side of the day room was noted with several areas of discoloration. The baseboards were pulling away from the walls on that side of the room. The wall panels under the windows had gouges and chips in the paint. The outside window frames, visible from inside the day room, also had gouges and chips in the paint. The support posts near the east wall had stained and torn wallpaper. The seam in the linoleum had separated and was curling up near the base of the southernmost pole, extending across the day room. There were recliners lined up along the south wall of the day room. The one furthest to the east was worn, faded, and though the chair was blue, the seat and back of the recliner had a brown-tinged film covering them. There were gouges in the drywall behind the row of recliners. The south wall, above a row of windows, had chips in the drywall. The seams of the drywall were visible with screw holes or sections of cloth tape scattered in various places. Similar observations were made of the west wall of the room. There was a row of windows along the	F 252	Day room will be repaired to include wallpaper, discoloration on walls, and baseboards separation. The wall panels and outside window panes will be repaired for gouges and chipping paint. Support posts will be repaired to include stains and torn wallpaper. Linoleum will receive new seams to address curling and separation. The blue recliner will be shampooed. Dry wall gouges, seams and screw holes will be repaired. Window sills will be cleaned. Baseboards will be repaired and cleaned. Door frame will be repaired to include holes and chipped paint. Hallways outside rooms #9, #17, #19, #20, #21, and #24 will be repaired to include stains and holes in wall. The linoleum will receive new seams to address curling and separation. Door frames will be repaired to include chipped paint. The Nurses station carpet will be removed and new floor planking installed. Resident #9 room bedside table will be replaced. Resident #1□s room will be repainted, and beside dresser will be replaced. Resident□s #21 and #23 rooms will be repainted and walls repaired. An audit of additional patient rooms to be	

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F 252	Continued From page 31 west wall above the patio doors. Two of the windows had a black fuzzy substance along the bottom window sills. The baseboards along the patio walls had scuffed paint and dirt visible. The doorframe to the patio doors had screw holes and chipped paint. 3. Hallways On 4/26/16 at 2:00 pm, the hallway outside resident rooms 19 and 20 was observed with stains and screw holes in the wallpaper, and the linoleum curled and separating. The paint at the bottom of the doorframes when entering those rooms, was chipped. The same features were noticed outside resident rooms 9, 17, 21, and 24. 4. Nurses' Station On 4/26/16 at 2:00 pm, the flooring of the nurse's station, visible to all residents as they approached from the day room or dining room, and to ambulatory residents as they passed the station or stopped and talked to the nurses. The carpet covering the floor was visibly stained and worn in several places. 5. Resident Rooms On 4/25/15 at 10:30 am, resident rooms 21 and 23 were observed to have mismatched colors of paint on the walls where wall hangings had been removed, as well as screw holes, discolorations, and chipped paint. On 4/25/16 at 10:00 am and on 4/29/16 at 9:30 am, the bedside table in Resident #5's room was observed with tape around the ledges.	F 252	completed including evaluation of walls, floor, ceiling, and lighting for necessary repairs. The Environment of Care Committee tours will be updated to include checklist to audit for necessary repairs. Vacated rooms will be evaluated following discharge to ensure necessary repairs are completed prior to admitting additional patients. Windows outside of the Environmental Services department□s reach will be put on a cleaning schedule for the Building Services department. Environmental Services staff to conduct monthly audits of facility to identify need for necessary repairs. Any opportunities identified will be reported to the Building Services department for completion. QAPI integration A facility environment assessment has been conducted to ensure the facility is safe, clean, comfortable and homelike in the environment. Areas identified in need of enhancements have been documented and a scheduled work plan has been developed. Staff in the unit have been educated on the process of submitting a work order for new issues that are identified. Environment of care audits will be completed every six months by the Environment of Care committee. Results of audits will be reported to the St.	

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F 252	Continued From page 32 In Resident #1's room there was miss matched paint on the walls and tape on the top corner of the bedside dresser. Tape was also on each corner of the bedside drawers. The tape was located facing Resident #5's bed. On 4/27/16 at 11:00 am, the DNS stated the facility had recognized that there was some upkeep that had to be done, but had not had a chance yet to complete the work. On 4/29/16 at 9:30 am, the Maintenance Director agreed with the DNS statement.	F 252	Luke□s Elmore Environment of Care Committee following completion. In addition an annual report of Environment of Care tours will be provided to the Continual Readiness/Quality committee of the Long Term Care unit. New areas identified in need of repair or enhancements will be addressed timely and will be logged and tracked through time of resolution of the work order.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staf interview and record review, it was determined the facility failed to ensure a significant change of condition MDS assessment	F 274	The Director of Nursing (DNS) is ultimately responsible for ensuring that the MDS assessments are completed	6/30/16

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F 274	Continued From page 33 was completed when a resident experienced a decline in ADL's and continence. This was true for 1 of 8 (#1) sampled residents. This created the potential for harm when the facility failed to incorporate this decline into the resident's care plan. Findings included: 1. Resident #1 was admitted to the facility 8/10/15 with multiple diagnoses which included dementia, generalized weakness with frequent falls and a history of UTI's. The quarterly MDS assessments, dated 11/17/15 and 8/17/15, indicated Resident #1 required limited assistance of one for transfers and bed mobility and required a cane for ambulation. Resident #1 had no falls since the prior MDS assessment. The MDS assessments noted Resident #1 was occasionally incontinent of urine. An incident report documented Resident #1 fell on 11/26/15 and sustained a pelvic fracture. The CAP Flow Sheet prior to the fall, from 10/25/15 to 11/26/15, documented Resident #1 was continent 97 of 111 times and incontinent 14 of 111 times. The flow sheet also indicated Resident #1 required no more than limited assistance with bed mobility and transfers. The CAP Flow Sheet after the fall, from 11/27/15 to 12/29/15, documented Resident #1 was continent 58 of 110 times and incontinent 52 of 110 times. The flow sheets also indicated Resident #1 required extensive assist with bed mobility and transfers.	F 274	accurately after a significant change of condition and/or a decline in ADL□s. Corresponding care plans will be reflective of the residents□ current functional state and care needs. Plan of Correction Resident #1□s MDS and care plan was updated to show the significant changes and updated to CMS. The Quality and Patient Safety manager will forward resident safety events to MDS Coordinator to ensure that the information and occurrence is reflected in the MDS and the care plan. The MDS Coordinator will review MDS for significant change and update care plans as needed. Weekly Resident at Risk meetings will include review of residents who are identified to have a significant change. A Resident Care Plan Team will meet monthly for review and comparison of MDS, Care Plans, and CAP Charting. The DNS or designee to review 3 random resident MDS□s each week for 30 days, then 5 random MDS□s each monthly for 3 months. QAPI Integration A summary of the Resident Care Plan Team will be reported monthly to the Continual Readiness/Quality Committee. Significant events and event report trends will continue to be reported monthly to the	

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F 274	Continued From page 34 On 2/17/16, the most recent quarterly MDS assessment, stated Resident #1 required extensive assistance of one for transfer and bed mobility and required a wheelchair or walker for ambulation. The assessment also noted Resident #1 had a fall with injury. The MDS assessment stated Resident #1 was frequently incontinent of urine. On 4/29/16 at 11:50 am, the VP and the PI Accreditation personnel indicated a change of condition MDS assessment should have been performed.	F 274	Continual Readiness/Quality Committee. In addition, data will be shared with the Quality and Safety Council of St. Luke□s Elmore and the Quality, Safety and Service Excellence Committee of the Board.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278		6/30/16

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F 278	Continued From page 35 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure accurate MDS assessments were completed for 1 of 8 (#1) sampled residents. This resulted in the potential for the resident's care plan to not reflect her current functional status and care needs. Findings include: 1. Resident #1 was admitted to the facility with multiple diagnoses which included advancing dementia, generalized weakness, frequent falls, and recent L1 and L5 compression fractures from falls. On 11/27/15 at 5:00 pm, the MD Progress notes/Order's noted a diagnosis of pelvic fracture. Major injury on the MDS assessment was defined as including bone fractures. On 2/17/16 the Resident #1's quarterly MDS assessment indicated Resident #1 had fallen and sustained a minor injury. Minor injury on the MDS was defined as skin tears, abrasions, lacerations, superficial bruising, hematoma, sprains or any fall-related injury that causes the resident to complain of pain. The MDS nurse was unavailable to discuss this occurrence.	F 278	The Director of Nursing (DNS) is ultimately responsible for ensuring that the residents Minimum Data Set (MDS) assessments are completed accurately and corresponding care plans are reflective of the residents current functional state and care needs. Plan of Correction Resident #1s MDS and care plan was updated to show the significant changes and updated to CMS. The MDS Coordinator and DNS will have scheduled weekly meetings for resident status review. In addition, the MDS Coordinator will report significant change in status to the DNS in a timely manner. The Quality and Patient Safety manager will forward resident safety events to MDS Coordinator. The MDS Coordinator will review MDS for significant change and care plans updated as needed. Weekly Resident at Risk meetings will include review of residents who are identified to have a significant change.	

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F 278	Continued From page 36 On 4/29/16 at 11:50 am, the VP and the PI Accreditation personnel indicated the MDS assessment should have identified that Resident #1 had a fall with injury.	F 278	A Resident Care Plan Team to meet monthly for review and comparison of MDS, Care Plans, and CAP Charting. The DNS or designee to review 3 random resident MDS□s each week for 30 days, then 5 random MDS□s each monthly for 3 months. QAPI Integration A summary of the Resident Care Plan Team will be reported monthly to the Continual Readiness/Quality Committee. Significant events and event report trends will continue to be reported monthly to the Continual Readiness/Quality Committee. In addition, data will be shared with the Quality and Safety Council of St. Luke□s Elmore and the Quality, Safety and Service Excellence Committee of the Board.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the	F 280		6/30/16

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F 280	Continued From page 37 participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observation, it was determined the facility failed to ensure care plans were updated and revised to reflect residents' current status and needs. This was true for 3 of 8 (#1, #2 and #5) sampled residents. This created the potential for harm if these residents did not receive appropriate care due to lack of direction in their care plan. Findings included: 1. Resident #2 was admitted to the facility on 8/8/13 with multiple diagnoses, including depressive disorder, diabetes mellitus and hypertension. Resident #2's most recent Quarterly MDS assessment, dated 2/12/16, documented short and long term memory impairment, set-up only for eating, one person physical assist for bed mobility, toilet use, personal hygiene, transfers, and bathing. Resident #2 was assessed as at high risk for falls on Fall Risk Evaluations form, dated 2/12/16 and 3/14/16. At the back of the Fall Risk Evaluation form the MDS staff documented the following: *2/12/16- "Non-injury fall, Safety	F 280	The Director of Nursing (DNS) is ultimately responsible for ensuring care plans are updated and revised to reflect residents□ current status and needs. Plan of Correction Residents #1, #2 & #5 Minimum Data Set (MDS) and care plans were reviewed and updated to reflect current status. Residents who reside in this facility have the potential to be impacted by the indicated deficiency. A review of MDS and care plans for residents who reside in this facility is being conducted to validate that the documentation reflects current resident needs and status. Variations that are identified will be corrected. The Resident Care Plan Team will meet monthly for review and revision of care plans as needed. The DNS or designee to review 3 random resident MDS□s each week for 30 days, then 5 random MDS□s each monthly for 3 months.	

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F 280	Continued From page 38 monitor/interventions in place. Confusion with decreased safety awareness." *3/14/16- "Unwitnessed slide out of bed, small skin tear/bruise on L arm- no other injury. Continuing with the same safety strategies." Resident #2's Fall Risk/Safety/Restraint Protective Devices care plan documented the following: bed alarm, tag alarm, landing pads, bed in low position. Fall Review CP dated 10/4/15, documented, "Stand up get balance 1-2 minutes then ambulate with FWW, staff have direct visual on her while in BR. Have all equipment available before going/coming from BR, don't leave her unattended in BR." Dates of falls were also documented on the CP. The last documented falls on Resident #2's CP was 10/4/15. On 4/27/16 at 11:45 am, the DNS said Resident #2's CP should have been updated after the falls. 2. Resident #5 was admitted on 7/8/15 with multiple diagnoses, including non-Alzheimer's dementia, macular degeneration, and stroke. Resident #5's social services progress note, dated 8/5/15, documented, "PT staff came to this nurse and said, '[Resident #5] is anxious today because she's fearful of being raped in the shower potential. Resident did receive shower by male CAP on 8/5/15...will care plan her for female showers only to decrease anxiety." Resident #5's care plan did not contain documentation of her preference for female shower aides.	F 280	LTC clinical staff to receive training on care plan documentation. QAPI Integration A summary of the Resident Care Plan Team will be reported monthly to the Continual Readiness/Quality Committee. In addition data will be shared with the Quality and Safety Council of St. Luke□s Elmore and the Quality, Safety and Service Excellence Committee of the Board.	

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F 280	Continued From page 39 On 4/27/16 at 4:30 pm, the MDS nurse said she thought the care plan had been updated. 3. Resident #1 was admitted to the facility on 8/10/15 with multiple diagnoses which included advancing dementia, generalized weakness with frequent falls and UTI 's. On 11/26/15 Resident #1's Care Plan documented she was incontinent of bladder and nursing was to take her to the bathroom every two to three hours while she is awake; to use Attends due to increased incontinence; and that Resident #1 had a fall on 11/26/15, in which she was injured. On 2/13/16 at 3:00 pm, a nursing progress note documented Resident #1 had been asking for increased help when needing to use the restroom. On 2/17/16, Resident #1's most recent quarterly MDS indicated she required extensive assistance of one for transfer, bed mobility and toilet use. The MDS noted a fall since the past assessment, and that Resident #1 was frequently incontinent. On 2/17/16, Resident #1's Quarterly Review Progress Note of her bladder function documented she now required more extensive assist with toileting and the facility would continue to assist her to the toilet every two hours and after every meal. On 2/28/16 at 5:55 am, Resident #1's nursing notes documented she fell when the bed alarm went off and she was found sitting on the floor in	F 280		

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F 280	Continued From page 40 wet Attends. There were no corresponding care plan updates documented for either change in status. On 4/27/16 at 11:00 am, the DNS stated Resident #1's Care Plan should have been updated.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure a nasal spray medication was not pre-signed as given prior to administration by a nurse for 1 of 1 random resident (#10). Failure to document medication before administration could lead to medication errors and the potential to harm residents. Findings include: On 4/27/16 at 7:50 am, during medication pass LN #1 administered oral medications in the dining room to Resident #10. LN #1 told Resident #10 she would give the nasal spray after breakfast. LN #1 signed the MAR for Flonase nasal spray as administered. On 4/27/16 at 9:15 am, LN #1 administered Flonase nasal spray to each of Resident #10's nostrils.	F 281	The Director of Nursing (DNS) is ultimately responsible for ensuring that services provided meet professional standards. This expectation includes ensuring that medication is not pre-signed as given prior to administration. Plan of Correction There was no negative impact on resident #10 due to the deficient practice. Resident #10 is receiving medication as ordered and appropriate documentation of medication administration is occurring. Residents who reside in this facility and receive medications have the potential to be affected by the indicated citation. Residents who receive medications receive those medications as ordered and documentation of the administration occurs according to professional	6/30/16

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F 281	Continued From page 41	F 281	standards. 1:1 coaching was provided to the licensed nurse observed during survey on correct procedure of medication administration. Competency validation related to medication administration has occurred with this licensed nurse. Long term care nursing staff were provided additional education on the medication administration policies and practices. Nursing staff were educated on dignity and respect in regards to medication administration. QAPI Integration Audits of Medication Passes to be conducted by DNS or designee to ensure proper medication administration and documentation. Audits to be conducted daily x 30 days, then weekly x 3 months. Audit data will be reviewed at Continual Readiness/Quality Committee monthly. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and the Quality, Safety, and Services Excellence Committee of the Board.	
F 286 SS=F	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.	F 286		6/30/16

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F 286	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure the MDS assessments were available to all staff for 7 of 7 (#1, #2, #3, #4, #5, and #6) sampled residents residing in the facility, and all other residents in the facility. This resulted in potential harm for when staff could not access historical data. Findings include: The most recent MDS assessments, including those for residents #1, #2, #3, #4, #5, #6, #7 were located in each resident's active chart at the nurses' station. Other MDS assessments were available on weekdays when the MDS nurse was working and when the MDS nurse left for the day they were locked in the MDS nurse's office. On 4/27/16 at 2:00 pm the MDS nurse stated the past 15 months' worth of MDS assessment were not put in the charts because the MD's did not like them in there. On 4/29/16 at 11:50 am the VP and the PI Accreditation personnel stated the MDS reports should be available for the staff 24 hours a day.	F 286	The Health Information Management (HIM) Manager is ultimately responsible for ensuring the Minimum Data Set (MDS) assessments are available to staff. The facility will maintain 15 months in the resident□s active record. Plan of Correction Residents #1, #2, #3, #4, #5, and #6 current charts were updated to include 15 months of MDS assessments. Active charts were audited to ensure they contained required MDS assessments. The MDS Coordinator who was responsible for these functions is no longer employed with the facility. An interim MDS Coordinator has been identified and has received the appropriate education related to the requirements and timeframes for the documentation. The HIM department will conduct weekly open chart audits for one month and then quarterly thereafter to verify that MDS assessments are in the chart as required.	
F 309 SS=D	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	F 309		6/30/16

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F 309	Continued From page 43 and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure care and services were provided to promote the optimal physical health of 1 of 8 (Resident #5) sampled residents. This had the potential to result in harm due to inadequate monitoring and assessment for further signs or symptoms of stroke. Findings include: Resident #5 was admitted to facility on 7/8/15 with muliple diagnoses including, non-Alzheimer's dementia and stroke. Resident #5's nurses' notes, dated 1/29/16 at 9:40 am, documented Resident #5 was experiencing seizure like activity, left-sided facial droop, and was unresponsive. She was sent to a local ER for further evaluation. Resident #5's ER discharge summary, dated 1/29/16 at 12:28 pm, documented she experienced a stroke and was to follow up with her private physician. There were no new orders noted. Resident #5's nurses' notes, documented on 1/29/16 at 1:05 pm, that Resident #5 returned from the ER with no new orders and she responded to verbal commands and movement in all extremeties. No further documentation was noted for monitoring or assessing for signs and symptoms of a stroke.	F 309	The Director of Nursing (DNS) is ultimately responsible for ensuring care and services are provided to promote the optimal physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for residents who reside in this facility. Plan of Correction Resident #5 is receiving care and services to promote the optimal physical health. A new assessment of Resident #5 has been completed to confirm that appropriate monitoring and assessments are in place in accordance with needs and orders. Appropriate monitoring and assessments are occurring. Resident is receiving care and services in accordance with physician orders. Resident #5 was reviewed with Licensed Nursing staff as an educational opportunity to ensure adequate monitoring and assessment for further signs or symptoms of stroke for this resident and other residents who reside in this facility. Residents that experience a change of condition, behavior, change in medication or who are prescribed antibiotics have the	

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F 309	Continued From page 44 Resident #5's medical record did not contain additional documentation regarding her health status after the stroke. On 4/28/16 at 1:30 pm, the DNS said she did not know the reason for the lack of follow up regarding Resident #5's health status.	F 309	potential to be affected by the indicated citation. Residents that experience a change of condition, behavior, change in medication or who are prescribed antibiotics will be placed on alert charting. The alert charting will be reviewed by DNS or designee daily to assure alert charting and proper assessments are complete. QAPI Integration Audits of alert charting will be maintained daily x 30 days, then weekly x 3 months. This data will be reviewed at the monthly Nursing Staff meetings and Continual Readiness/Quality Committee Meetings on a monthly basis. In addition, audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and Quality, Safety and Service Excellence Committee of the Board.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314		6/30/16

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F 314	Continued From page 45 Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents were repositioned as needed. This was true for 3 of 7 (#3, #4, and #6) sampled residents residing in the facility. The deficient practice created the potential for harm if residents developed skin breakdown when left in the same position for extended periods of time without pressure relief. Findings include: 1. Resident #6 was admitted to the facility on 7/25/14 with diagnoses including Parkinson's dementia. Resident #6's 2/1/16 Quarterly MDS assessment noted he had severely impaired cognition, no behavioral concerns interfering with his care, and was dependent on 2 persons for bed mobility and transfers. Resident #6's current care plan documented he required repositioning and off loading every 2 hours. On 4/26/16 between 9:05 am and 12:00 noon, Resident #6 was observed to be sitting in his wheelchair in the day room. Resident #6 was not observed to receive assistance to off load or reposition during that time. On 4/26/16 between 2:08 pm and 4:35 pm, Resident #6 was observed sitting in his wheelchair in the day room. Resident #6 was not observed to receive assistance to reposition or off load during that time. On 4/28/15, Resident #6 was observed in his wheel chair in the day room between 8:45 am	F 314	The Director of Nursing (DNS) is ultimately responsible for ensuring residents are repositioned as needed. Plan of Correction Residents #6, #3, and #4 plan of care has been reviewed to ensure that the plan reflects the residents current needs. Resident #6, #3, and #4 are receiving care and services in accordance with the physician orders for the individual resident needs. These residents are receiving assistance and repositioning to minimize potential for skin breakdown. Residents who reside in this facility who are at risk for pressure sores and require assistance with repositioning have the potential to be affected by the indicated citation. A review of MDSs and care plans has been completed to confirm that residents at risk for pressure sores have care plans in place to minimize the potential for occurrence and services being provided in accordance with the physician order and resident need. CAP charting for residents #6, #3 and #4 has been reviewed to confirm that proper repositioning occurs. CAP charting for current residents has been reviewed to reflect assistance and repositioning. An hourly rounding form has been developed for documentation of intentional rounding.	

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F 314	Continued From page 46 and 11:30 am. Resident #6 was not observed to receive assistance to reposition or off load during that time. On 4/28/15 at 11:30 am, the DNS stated Resident #6 should be repositioned and offered assistance to the bathroom at least once every 2 hours. 2. Resident #3 was admitted to the facility on 5/21/15 with multiple diagnoses, including dementia, diabetes mellitus and pneumonia. Resident #3's most recent Quarterly MDS assessment, dated 2/26/16, documented that she required set-up only for eating and the assistance of one person for all activities of daily living. Resident #3's Skin Care/Preventative Devices care plan documented, "Assessment by LN with showers and PRN, moisturizing lotion with cares, anti-pressure devices to w/c, reposition and off load every two hours PRN ..." On 4/26/16 between 3:10 pm to 6:00 pm, Resident #3 was observed sleeping in the recliner in the Day Room. Staff were not observed to move or reposition her during the 2 hour and 50 minute time frame. On 4/28/16 at 11:00 am, the DNS said the staff should have offered to turn or reposition Resident #3 while she sleeping. 3. Resident #4 was admitted on 11/16/09 with multiple diagnoses including, Alzheimer's disease, diabetes mellitus, decrease functional activity, and morbid obesity.	F 314	LTC Staff were provided education for intentional rounding workflow. A review of the intentional rounding form will be conducted by the Resident Care Plan Team. QAPI Integration Charge nurse rounding for repositioning of residents every 2 hours x1 week, then 3x a shift x3 weeks, then one day a week x3 months. Results of audits as well as a summary of the Resident Care Plan Team will be reported monthly to the Continual Readiness/Quality Committee. In addition data will be shared with the Quality and Safety Council of St. Luke□s Elmore and the Quality, Safety and Service Excellence Committee of the Board.	

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F 314	Continued From page 47 Resident #4's care plan documented interventions on 11/24/14 and 11/30/15 included: *[Resident #4] has cares present to her MASD to her buttocks-Maceration. *Elimination: Dependent on staff, incontinent of bladder & bowel, check & change every 2 hours, protective skin barrier cream with each incontinence. *Transfers: Non weight bearing, hoyer lift with 2 assist, dependent. On 4/26/16 from 9:00 am to 12:00 pm, Resident #4 was observed in the day room in her Broda chair during activities. Her eyes were closed and she was facing the television. At 10:30 am, a staff member moved the Broda chair to face the activity and moved Resident #4's hands out from under the blanket to participate in a ball toss activity. On 4/27/16 at 8:50 am, CNA #8 said Resident #4 laid down between meals because she had an open area to her buttocks about a month prior.	F 314		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent	F 315		6/30/16

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F 315	Continued From page 48 urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review if was determined the facility failed to ensure residents were assessed to determine if a bladder retraining program may be beneficial, and failed to ensure that toileting plans were carried out. This was true for 4 of 6 sampled residents (#1, #3, #4, and #6) reviewed for assistance with toileting. This failure created the potential for harm if residents developed skin issues or infections. Findings include: 1. Resident #1 was admitted to the facility with multiple diagnoses to include advancing dementia, generalized weakness, frequent falls and recent UTI. On 8/10/15 Resident #1's Urinary Incontinence/ Pattern Sheet was partially filled out. The area of the form documenting "Treatment being used" was blank. The form was not signed by the nurse. On 2/17/16 Resident #1's most recent quarterly MDS assessment documented Resident #1 required extensive assistance from one person for transfer and toilet use. The MDS assessment also documented that Resident #1 was frequently incontinent of urine. On 11/26/15 Resident #1's Care Plan documented she was incontinent of bladder and nursing was to take her to the bathroom every	F 315	The Director of Nursing (DNS) is ultimately responsible for ensuring residents are assessed to determine if a bladder retraining program may be beneficial, and ensuring toileting plans are carried out. Plan of Correction Documentation for residents #1, #3, #4, and #6 were reviewed. Bladder reassessments and care plans were updated to reflect current status of each individual resident. Residents who reside in this facility who may benefit from a bladder retraining program have the potential to be affected by the indicated citation. Current residents have had bladder reassessments and care plans have been updated to reflect current status. A clinical documentation form has been developed for intentional rounding to address hydration, repositioning, toileting, and restraints. LTC Staff were provided education for intentional rounding workflow. A review of intentional rounding form will be conducted by the Resident Care Plan Team.	

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F 315	Continued From page 49 two to three hours when awake. The care plan also documented the use Attends due to increased incontinence. On 2/13/16 at 3:00 pm, a nursing progress note documented Resident #1 had been asking for increased help when needing to use the restroom. On 2/17/16 Resident #1's Quarterly Review Progress Note of her bladder function, documented she now required more extensive assistance with toileting and the facility would continue to assist her to the toilet every two hours and after every meal. Resident #1's care plan was reviewed. It did not include corresponding updates based on her need for more extensive assistance with toileting. On 4/25/16 from 11:30 am to 3:00 pm, Resident #1 was observed during the meal time in the dining room and after the meal time in the day room. She participated in various activities throughout the observation from eating to playing bingo. Resident #1 drank coffee throughout the various activities. Resident #1 was not observed to be offered assistance to the bathroom during the 4.5 hour time frame. On 4/26/16 from 2:30 pm to 4:12 pm, Resident #1 participated in various activities in the day room from listening to stories, watching TV, and eating and drinking snacks. Resident #1 was observed to be fidgety, moving her chair back and trying to get up from her chair twice before she managed to completely stand up and take two steps towards her walker. CAP #6 came into the room as she was walking and directed her to	F 315	QAPI Integration Charge nurse rounding for toileting of residents every 2 hours x1 week, then 3x a shift x3 weeks, then one day a week x3 months. Results of audits as well as a summary of the Resident Care Plan Team will be reported monthly to the Continual Readiness/Quality Committee. In addition data will be shared with the Quality and Safety Council of St. Luke□s Elmore and the Quality, Safety and Service Excellence Committee of the Board.	

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F 315	Continued From page 50 sit down in her chair. Resident #1 asked to go to the restroom at 3:42 pm as CAP #6 was directing her to sit down. As of 4:12 pm, Resident #1 had not been assisted to the bathroom. On 4/27/16 at 10:45 am, CAP #3 stated Resident #1 let nursing know when she had to go to the bathroom. CAP #3 also stated that if Resident #1 did not ask to go, staff were to offer to assist her to the bathroom every half hour. On 4/27/16 at 11:00 am, the DNS stated that Resident #1 had increasing incontinence issues and that up until about 3 months ago she could tell the staff when she had to go. She stated Resident #1 was offered assistance to the restroom every two hours per the care plan. The DNS also stated that they had not done a bladder retraining program or assessed her toileting plan since her admission. 2. Resident #3 was admitted to the facility on 5/21/15 with multiple diagnoses, including dementia, diabetes mellitus and pneumonia. Resident #3's most recent Quarterly MDS assessment, dated 2/26/16, documented she required the physical assistance of one person for all activities of daily living, set-up only for eating, and was frequently incontinent of bladder. Resident #3's Elimination care plan documented, "Incontinence of bladder and bowel, check and change every 2 hours and on rounds at night, use of protective skin barrier with each incontinence ..." On 4/26/16 between 3:10 pm to 6:00 pm, Resident #3 was observed sleeping in the recliner in the Day Room. At 6:12 pm, two CAPs	F 315		

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F 315	Continued From page 51 were observed assisting her to her wheel chair and she was pushed to the dining room. The CAPs were not observed or heard to offer Resident #3 assistance to the bathroom. On 4/28/16 at 11:00 am, the DNS said the staff should have offered Resident #3 assistance to the bathroom prior bringing her to the dining room for dinner. 3. Resident #4 was admitted on 11/16/09 with multiple diagnoses including, Alzheimer's disease, Diabetes mellitus, decrease functional activity, and morbid obesity. Resident #4's care plan documented interventions on 11/24/14 and 11/30/15 included: *[Resident #4] has cares present to her MASD to her buttocks-Maceration. *Elimination: Dependent on staff, incontinent of bladder & bowel, check & change every 2 hours, protective skin barrier cream with each incontinence. *Transfers: Non weight bearing, hoyer lift with 2 assist, dependent. On 4/26/16 from 9:00 am to 12:00 pm, Resident #4 was observed in the day room in her Broda chair during activities. Her eyes were closed and she was facing the television. At 10:30 am, a staff member moved the Broda chair to face the activity and moved Resident #4's hands out from under the blanket to participate in a ball toss activity. Resident #4 was not observed to be assisted to the bathroom during the 3 hour time	F 315		

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F 315	Continued From page 52 frame. On 4/27/16 at 11:00 am, the DNS stated Resident #4 was to be assisted to the bathroom every 2 hours. 4. Resident #6 was admitted to the facility on 7/25/14 with diagnoses including Parkinson's dementia. Resident #6's 2/1/16 Quarterly MDS assessment documented he had severely impaired cognition, no behavioral concerns interfering with his care, was dependent on 2 persons for transfers, and was dependent on one person for toileting. Resident #6's current care plan documented he required assistance with toileting every 2 hours during the day. On 4/26/16 between 9:05 am and 12:00 noon, Resident #6 was observed sitting in his wheelchair in the day room. He was not observed to offered assistance to use the restroom during this time. On 4/26/16 between 2:08 pm and 4:55 pm, Resident #6 was observed sitting in his wheelchair in the day room. He was offered, and accepted, assistance to the toilet at 4:55 pm. He was not observed to be offered assistance to the bathroom prior to 4:55 pm. On 4/28/15, Resident #6 was observed in his wheel chair in the day room between 8:45 am and 11:30 am. He was offered, and accepted, assistance to the bathroom, after a surveyor prompted staff to do so.	F 315		

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F 315	Continued From page 53 On 4/28/15 at 11:30 am, the DNS stated Resident #6 was to be repositioned and offered assistance to the toilet, at least once every 2 hours.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents at risk for falls were provided the supevision and interventions necessary to prevent falls. This was true for 1 of 5 (#1) residents sampled for falls. Resident #1 was harmed when she fell in the day room and sustained a pelvic fracture. Findings include: 1. Resident #1 admitted to the facility 8/10/15 with multiple diagnoses included which included advancing dementia, generalized weakness with frequent falls, and recent L1 and L5 compression fractures from falls. Resident #1's 8/10/15 long term care H&P documented she had a history of frequent falls prior to her admission to the facility.	F 323	The Director of Nursing (DNS) is ultimately responsible for ensuring that residents who are at risk for falls are provided the supervision and interventions necessary to prevent falls. Plan of Correction Resident #1 was re-evaluated by Physical Therapy staff on transfers and ambulation, with the care plan updated to reflect current status. Care plans for current residents have been reviewed to verify current status for transfers and ambulation. Physical Therapy consults with recommendations for safe transfer are obtained as needed. There will be staffing in the Day Room	6/30/16

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F 323	Continued From page 54 On 8/10/15, Resident #1's fall risk assessment documented she had an overall score of 21. The assessment form instructed an overall score of 10 or higher meant the resident was at risk for falls. On 8/17/15, Resident #1's admission MDS assessment documented she had at least one fall in the month prior to her admission. On 8/20/15, Resident #1's Care Plan documented he was at risk for injuries related to a history of falls. Interventions included to remind her to call for assistance with mobility/transfer as needed, proper use of assistive devices, and to observe for safety. On 9/7/15, the Physical therapy Discharge Summary documented Resident #1 continued to require supervision for all transfers and with walking using a quad cane due to her advanced dementia and poor insight. Resident #1's 11/17/15 quarterly MDS assessment, documented she had severe cognitive impairment. Resident #1 also required limited assistance of one person for transfer, bed mobility and ambulation; was not steady with moving from a seated to a standing position and walking with an assistive device; needed staff assistance to stabilize if turning while walking; and required a cane for ambulation. On 11/17/15, Resident #1's fall risk assessment score was documented at 15. A nursing note dated 11/26/15 at 9:30 am, documented Resident #1 fell in the day room and	F 323	while residents who are at risk for falls are present. Weekly Resident at Risk meetings will include review of residents who are identified to be a high fall risk. Referrals to Therapy Services will be provided as needed for safety concerns, or a change in condition. Review of Safe Patient Handling (including fall prevention) training scheduled for 06/24/16. QAPI Integration Audits to be conducted by unit to ensure residents are not left unattended in the day room. Audits will be conducted hourly while residents are present, daily x 30 days, then weekly x 3 months. Audit data to be received at Continual Readiness/Quality Committee monthly. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and the Quality, Safety, and Services Excellence Committee of the Board.	

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F 323	Continued From page 55 was transferred to the ER for an x-Ray. The x-ray report indicated possible pelvic fracture. An MD progress note, dated 11/27/15 at 5:00 pm, documented Resident #1 was diagnosed with an acute pelvic fracture. The fall incident report, dated 11/30/15, documented Resident #1 was sitting in the day room and nursing staff was behind the desk. Staff heard a noise and Resident #1 was on the floor on her bottom. Resident #1 complained of her back and butt hurting. The nurse got her up and her legs gave out. The nurses moved her to her bed where they assessed for injury. The doctor was called and he ordered an x-ray. Resident #1's updated Care Plan, undated, documented Resident #1 fell on 11/26/15 and she hurt her left hip, and x-rays were ordered. Interventions included a bed alarm and landing pads at night, a wheelchair for locomotion, and for PT to evaluate and treat. On 4/26/15 at 2:30 pm, Resident #1 was sitting in the day room participating in an activity. CAP #6 was conducting the activity and was supervising all residents in attendance, including Resident #1. At 3:15 pm, CAP #6 left the room briefly and returned several times. At 3:21 pm, CAP #6 left the room and returned at 3:38 pm. At 3:26 pm, Resident #1 moved her chair back from the table where she had been sitting and tried to stand from the chair. At 3:31 pm, CAP #6 briefly entered the room and left again. At 3:38 pm, Resident #1 was unattended in the day room. She stood completely on her own. Resident #1's walker was approximately 6 feet behind her at	F 323		

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F 323	Continued From page 56 another table. Resident #1 had taken two steps away from the table without her walker, when CAP #6 returned to the day room to assist her. On 4/26/16 at 4:55 pm, Resident #1 was sitting in a stationary chair along the wall of the day room. No staff were present in the area. At 5:07 pm, she attempted to stand. At 5:08 pm, she asked CAP #6 for assistance as he passed her chair. CAP #6 did not assist Resident #1 and left the area. Resident #1 was unsupervised. At 5:12 pm, Resident #1 again attempted to rise from her chair. Over the next 3 minutes multiple staff passed by Resident #1. Each staff told her to sit back down or stated "not now". At 5:24 pm, Resident #1 stood on her own, grabbed the walker next to her chair, and took 5 steps towards the dining room. CAP #4 took Resident #1 by the arm and told her to sit back down. At the same time CAP #5, who was approaching the nursing station, called out from the nusing station for Resident #1 to sit down. CAP #5 was around the corner and behind a glass wall from where Resident stood. CAP #4 escorted Resident #1 to the dining room. On 4/27/16 at 11:00 am, the DNS stated Resident #1 was admitted with a history of falls. The DNS stated she talked to Resident #1's family to get a fall history at the time she was admitted. The DNS stated the family had Resident #1 sit in a chair at home and tell her to stay in the chair. However, as soon as they left the room she would stand and fall. The DNS stated Resident #1 had multiple falls at home in this manner.	F 323		

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F 323	Continued From page 57 The DNS further stated nurses seated at the nurses' station can see the residents in the day room because the day room is bordered by a glass wall. The DNS stated there was typically an activity being conducted in the day room after breakfast for additional supervision. On the day Resident #1 fell, the DNS stated it was Thanksgiving Day so no activites were in progress. Resident #1 was admitted to the facility with a history of falling from her chair at home. This information was not incorporated into her care plan to ensure increased supervision when she was sitting in a chair. Resident #1 was observed to promptly stand from her chair when left unsupervised for short periods of time (minutes). Resident #1 did not receive the supervision necessary to protect her from falls.	F 323		
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed ensure residents were provided sufficient access to fluids. This was true for 3 of 7 (#3, #4, and #6) sampled residents residing in the facility. The deficient practice created the potential for residents to become dehydrated or develop urinary tract infections. Findings include:	F 327	The Director of Nursing (DNS) is ultimately responsible for ensuring that residents are provided sufficient access to fluids. Plan of Correction Residents #3, #4 and #6 care plans were reviewed and updated to reflect current status.	6/30/16

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F 327	Continued From page 58 1. Resident #6 was admitted to the facility on 7/25/14 with diagnoses including Parkinson's dementia. Resident #6's 2/1/16 Quarterly MDS assessment indicated he had severely impaired cognition and required extensive assistance from 1 person for eating and drinking. Resident #6's current care plan documented he required one person assistance after set-up to consume meals and fluids. On 4/25/16 at 1:15 through 3:00 pm, Resident #6 was observed in the day room sitting in a recliner. He did not have fluids within his reach, and was positioned in the chair in such a way that he did not have access to either a call bell or the recliner's controls. Resident #6 was not observed to be offered fluids during the 2.75 hour time frame. At 3:00 pm, the Activities Director served Resident #6 popcorn, a salty snack. Resident #6 was not observed to be offered a drink. Resident #6 was not observed to be offered a drink throughout the next half hour. On 4/27/16 at 11:00 am, the DNS stated Resident #6 should have been offered assistance to consume a drink at least once every 2 hours, and any time a salty snack was provided. 2. Resident #3 was admitted to the facility on 5/21/15 with multiple diagnoses, including dementia, diabetes mellitus, and urinary tract infection. Resident #3's most recent Quarterly MDS assessment, dated 2/26/16, documented she	F 327	Residents #3, #4, and #6 are receiving care and services in accordance with their current individual assessments and needs as well as in accordance with physician orders. Residents are provided with assistance as needed and offered fluids per their plan of care. Residents who reside in this facility who require assistance with access to fluids have the potential to be affected by the indicated citation. Current residents care plans have been reviewed and updated to reflect current status related to fluid intake to maintain proper hydration and health. Staff were re-educated on nutrition and hydration practices and the requirement to ensure that individual resident care plans are followed. The Activity personnel will offer residents (according to individual care plans) fluids during scheduled activities. The Activity personnel will document intake on individual residents. An intentional rounding form has been developed for documentation. LTC Staff were provided education for intentional rounding workflow. A review of intentional rounding form will be conducted by the Resident Care Plan Team.	

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F 327	Continued From page 59 required set-up only for eating and one person physical assist for all activities of daily living. Resident #3's 11/15/15 care plan documented risk for complications due to chronic UTI. Approaches included, "Encourage and offer fluids with meals and in between as tolerated ..." On 4/26/16, Resident #3 was observed in the Day Room, as follows: *9:38 am, observed in her wheel chair *10:15 am, observed with eyes closed *10:50 am, assisted to a recliner by two CAPs *11:15 am, sleeping in the recliner *11:30 am, approached by two CAPs to get up, her eyes was closed and she refused to get up. CAPs left and she remained in recliner. The CAPs were not observed to offer fluids to Resident #3. *11:45 am, sleeping in the recliner *12:50 pm, observed with a family member *3:10 pm, observed sleeping in the recliner *3:55 pm - 5:30 pm, observed in the same place as the prior observation. Other residents were pushed to the dining room as the DNS was observed approaching Resident #2 in the recliner. Resident #3 refused to get up. Staff approached Resident #3 two times between	F 327	Weekly Resident at Risk meetings will include review of residents who are identified to be at risk for dehydration. QAPI Integration Charge nurse rounding for hydration of residents every 2 hours x1 week, then 3x a shift x3 weeks, then one day a week x3 months. Results of audits as well as a summary of the Resident Care Plan Team will be reported monthly to the Continual Readiness/Quality Committee. In addition data will be shared with the Quality and Safety Council of St. Luke□s Elmore and the Quality, Safety and Service Excellence Committee of the Board.	

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F 327	Continued From page 60 3:10 pm to 5:30 pm. She was not observed to be offered fluid. On 4/28/16 at 11:00 am, the DNS said Resident #3 had a tendency to yell at staff if awakened from her sleep. 3. Resident #4 admitted on 11/16/09 with multiple diagnoses including Alzheimer's, Diabetes Mellitus, and decreased functional activity. Resident #4's care plan documented an intervention on 4/4/16 to encourage and offer fluids with interactions with Resident #4 due to her inability to communicate thirst. On 4/26/16 from 9:00 am to 12:00 pm, Resident #4 was observed sitting in her Broda chair in the day room without being offered fluids. On 4/26/16 at 12:00 pm, the Activity Director offered fluids to Resident #4 with a straw.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329		6/30/16

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F 329	Continued From page 61 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure a) psychotropic medication were used only with adequate indication for use, monitoring, or gradual dosage reductions; and b) staff followed physician orders to check BP prior to administering an anti-hypertensive medication. This was true for 4 of 4 residents (#3, #4, #5, and #6) sampled for psychotropic medication use. The deficient practice created the potential for harm when residents received medications without clear need or monitoring of the benefit. Findings include: 1. Resident #6 was admitted to the facility on 7/25/14 with diagnoses which included Parkinson's dementia. Resident #6's medication orders at the time of admission documented an order for Seroquel 50 mg every day at 8:00 am for psychosis related to Parkinson's, and 100 mg at bedtime for a	F 329	The attending provider and Pharmacist In Charge (PIC) are ultimately responsible to ensure psychotropic medication is used only with adequate indications for use, monitoring, and gradual dosage reductions. The Director of Nursing (DNS) is ultimately responsible to ensure staff follow physician orders to check blood pressure prior to administering an antihypertension medication. Plan of Correction Resident #6□s orders were adjusted for a gradual dose reduction of Seroquel initiated on 04/26/2016 and further reduction to reduce Seroquel to 50mg at HS only initiated on 05/26/2016. Resident #6□s chart was reviewed and target symptoms identified and documented by the attending provider.	

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F 329	Continued From page 62 diagnosis of insomnia/psychosis related to Parkinson's. Resident #6's April 2016 recapitulation orders also documented the use of two anti-depressant medications (Zoloft 100 mg daily beginning 7/25/14 and Trazodone 50 mg daily beginning 1/28/16), and Tylenol 650 mg twice daily routinely, and 650 mg every 6 hours as needed. Resident #6's H&P, dated 7/25/16, documented he saw a neurologist for his Parkinson's disease in the past, and was using Seroquel for that diagnosis. The H&P documented a "depressed mood," for which the Seroquel was used. Target symptoms related to the depressed mood were not included on the H&P. Resident #6's care plan, dated 7/25/14 documented his behavioral symptoms for the use of psychotropic medications were yelling out at night, unsafe self-transfers, delusions impacting quality of life, combative with cares as evidenced by squeezing arms and punching staff, and refusing medications. A specific description of his delusions or how the delusions impacted his quality of life, were not documented. Interventions included providing reassurance, redirection, reorientation, calling his family, assessing for pain or discomfort, and for staff to sit with him if possible. There were no care plan updates after 7/25/14. On 8/1/15, Resident #6's Annual MDS assessment documented he had severely impaired cognition, no hallucinations or delusions, and no behavioral symptoms. The same results were documented on Resident #6's quarterly MDS assessments from 11/5/15 and	F 329	Resident #6□s sleep monitor was updated to include reason and intervention when awake during sleep hours initiated on 05/13/2016. Resident #6, #3, #4 and #5□s behavior monitors were revised to require charting on each shift with specific description of behaviors and impact on quality of life. Resident #6□s chart was reviewed and orders changed to receive Tylenol routinely at night. Resident #6□s chart was reviewed to provide documented updates to the physician after gradual dose reduction. Resident #3□s antihypertensive medication order was reviewed and revised by attending provider. A letter regarding antipsychotic use in residents with dementia was sent to providers with admitting privileges as well as to pharmacists. Pharmacists will provide education on antipsychotic use with residents with dementia for providers with privileges, as well as the DNS, Licensed Social Worker (LSW), and Resident Services Advocate (RSA). The behavioral/psychopharmacological review form was revised to include de-escalation of behaviors demonstrated	

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F 329	Continued From page 63 2/1/16. Resident #6's Nurses' Notes were reviewed between 1/1/16 and 4/29/16. On 1/9/16, 1/11/16, 1/17/16, and 1/19/16, Resident #6's Nurses' Notes documented he was yelling out at night, and after being given Tylenol the behavior stopped. On 2/1/16, his Nurses' Notes documented he "still yells out in his sleep at times." On 3/6/16, the Nurses' Notes documented he, "has been yelling very loudly." No further behaviors were noted in his Nurses' Notes. Resident #6's behavior monitoring sheets documented target behaviors of Hallucinations/Delusions, Paranoia, Tearfulness, and Resistant to Care/ Angry, Unable to Sleep, and Yelling out in Sleep/Night Terrors. The form offered the opportunity for each of these behaviors to be triggered each shift. The forms were reviewed between 1/1/16 and 4/29/16. With the following exceptions, the forms were blank: *Yelling out in Sleep/Night Terrors was triggered on night shift 1/9/16, 1/11/16, 1/17/16, 1/18/16, and 1/20/16. *Paranoia, with the hand-written addition of "yelling," and Yelling out in Sleep/Unable to Sleep were triggered on night shift 3/5/16 and 3/6/16. On 1/25/16, a "Behavioral/Psychopharmacological Review" form documented Resident #6 had an, "increase in yelling out at night as of 1/9/16." The form did not include documentation that Resident #6's behaviors were altered with the use of Tylenol.	F 329	after intervention. A new comprehensive sleep monitoring document was created and implemented on 05/13/2016. Nursing staff were educated on new sleep documentation process and expectations for completion on 05/12/2016. Sleep Monitors will be reviewed weekly by the Resident Services Advocate (RSA) with concerns reported to the DNS and LSW. The Psychotropic Drug Committee meetings will review sleep monitors and behavior/ psychopharmacological review forms. The Resident at Risk meetings will include review of residents who are identified to have sleep disturbances. Behavior monitors were revised to require charting on each shift. The RSA will review behavior monitors for trends. The LSW will also review behavior monitors to ensure potential concerns are identified. The LSW to attend the Psychotropic Drug Committee meetings to assist in identification of potential concerns. The LSW will attend the Resident at Risk Committee to assist in identification of potential concerns.	

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F 329	Continued From page 64 The physician documented the facility was to change the dosage of one of Resident #6's anti-depressant medications, monitor the effectiveness, and provide an update in 2 weeks and another in 4 weeks. There was no documented evidence the facility provided the updates to the physician. On 3/21/16, a pharmacy medication review noted one episode of yelling out was documented since the last review. The recommendations area of the form included, "Keep Risperidone in mind if the outbursts [increase.] No other drug therapy changes or adjustments." On 4/8/16, an MD progress note for Resident #6 documented, "[The facility's] main concern is that he has a tendency to cry out at nighttime. [Resident #6] is already being treated for his agitation due to the Parkinson's and psychosis due to the Parkinson's with Seroquel. I am not going to increase that medicine at this time..." On 4/15/16, a pharmacy medication review documented a recommendation to change Resident #6's routine dose of Tylenol to Ibuprofen. The physician's response was to discontinue the resident's routine Tylenol order. No medication was ordered in its place. The resident continued with an order for Tylenol as needed. On 4/19/16, a Behavioral/Psychopharmacalogical Review form documented Resident #6, "yells out at night." No information was documented as to how frequently this behavior occurred, how persistent it was when it did occur, what interventions were attempted when the behavior	F 329	Nursing staff was provided education related to assessing blood pressures as ordered by the provider, prior to administrating anti-hypertensives. Residents□ medication administration records (MAR) were checked against provider orders for accuracy. Parameters from orders were added to the current MAR. A clinical documentation form was developed for intentional rounding. Long term care staff were provided education for intentional rounding workflow. A review of intentional rounding form will be conducted by the Resident Care Plan Team. The RSA will review behavior monitors weekly for trends. The LSW will also review behavior monitors monthly to ensure potential concerns are identified. QAPI Integration The DNS or designee will audit medication administration records to ensure compliance daily x 30 days, then weekly x 3 months. The LSWs audits of behavior monitors will be completed daily x 30 days, then weekly x 3 months. This data as well as a summary of the Resident Care Plan Team will be reviewed at the monthly Nursing Staff	

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F 329	Continued From page 65 occurred, or how effective those interventions were. On 4/25/16, the physician signed the form and documented an order to decrease the overall dose of Seroquel for Resident #6 to 25 mg in the morning and 50 mg at bedtime. On 4/25/16, Resident #6 was observed in the day room between 1:15 and 3:00 pm, sitting in a recliner off to the side of the room. He was not observed to be repositioned, assisted to bathroom, or offered a drink. He attempted to gain staff attention multiple times as they passed by his chair. Staff did not stop to attend to him. On 4/29/16 at 8:45 am, the DNS, LSW and RSA discussed Resident #6. The three staff could explain the reason Seroquel was being used for a diagnosis of insomnia, or the reason a medication ordered for insomnia was also used in the morning. The DNS stated the facility had additional monitoring of Resident #6's sleep patterns. The DNS provided a monitoring sheet on which staff documented hourly on the night shift whether Resident #6 was awake or asleep. Documentation was not maintained of how often and how long Resident #6 slept during the day. The DNS stated the behavior monitors would be blank unless the target behaviors had occurred. If the target behaviors occurred the DNS stated there would be a notation in the Nurses' Notes. The RSA stated the nurses charted on Resident #6 "almost every night." The RSA indicated that was where the facility obtained the information used to update the MD on Resident #6's behavioral status. The DNS and RSA stated they had not noticed the nurses' notes documented a pattern of a decrease in Resident #6's yelling out at night when Tylenol was used. The RSA stated	F 329	meetings and Continual Readiness/Quality Committee Meetings on a monthly basis. In addition, audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and Quality, Safety and Service Excellence Committee of the Board.	

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F 329	Continued From page 66 at times the nurses told her he had an increase in his behaviors if he was constipated. The RSA stated it was her responsibility to prepare data for the Psychopharmacalogical Behavioral Review meeting, but it was the pharmacist who made all the decisions and recommendations. The DNS stated the pharmacist was new, and likely unfamiliar with the requirements for anti-psychotic medication use in long term care facilities. The RSA stated that although Resident #6's behavior monitors documented few behaviors, "I don't believe them. I don't think that's right." The LSW stated her one function in the process was to sit in on the monthly meetings. The LSW stated she did not analyze the data prior to the meeting, and did not follow up in after the meetings. The DNS and RSA stated Resident #6 had not been seen by a neurologist since his admission to the facility. The LSW, DNS, and RSA stated they could not explain the need for two anti-depressant medications, Zoloft and Trazadone, except one was to help Resident #6 sleep more effectively. 2. Resident #3 was admitted to the facility on 5/21/15 with multiple diagnoses, including dementia. Resident #3's most recent Quarterly MDS assessment, dated 2/26/16, documented Resident #3 exhibited physical and verbal symptoms directed toward others 1-3 days of the week. Resident #3's 8/31/15 care plan documented she had dementia and psychosis and the following behaviors: striking, yelling, swearing at staff and	F 329		

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F 329	Continued From page 67 visitors, demanding and exit seeking. Interventions included, "Always approach calmly and speak in a calm voice, listen to resident..., when resident is showing abusive behaviors attempt to refocus to positive..., report behaviors on the Behavior Monitors..." Nurses Notes documented the following: *3/1/16 at 2:00 am, "Resident attempted to get OOB several time tonight. She is very confused and agitated. Thinks that she is not sleeping in her own bed..." *3/15/16 at 12:30 am, "Resident continues to sundown but with less agitation. She will yell out for people and yell out [where's my baby]..." *4/5/16 at 9:00 am, "Resident awoke early today and was agitated and asking why her room had to be cleaned. Not easily redirected..." *4/23/16 at 9:50 pm, "Resident experienced increased confusion with paranoia at dinner time. Resident was calling out for her daughter. Resident refused to eat thinking that the food being served was stolen" *4/24/16 at 2:00 am, "Resident confused and confabulating verbally..." Resident #3's March and April 2016 Behavior Monitor documented the following targeted behavior, "Resistant to care, increased confusion with paranoia, looking for her baby and tearful/fearful." The following behaviors were documented:	F 329		

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F 329	Continued From page 68 *3/10/16 "Looking for her baby" *4/23/16 "Increased confusion with paranoia" The incidents noted on 3/1/16, 3/15/16, 4/5/16, and 4/24/16 were not documented on the Behavior Monitor form. On 4/28/16 at 11:00 am, the RSA said the nurses were to document the presence of behavior on the Behavior Monitor form for easy tracking and they were not. b. Resident #3's recapitulated April 2016 physician's orders documented a 11/15/15 order of Losartan 25 mg PO daily, Coreg 3.125 mg PO BID and staff were to hold medications if SBP was less than 100. Resident #3's April 2016 MAR documented, "11/15/15 Losartan 25 mg PO daily. Hold if SBP less than 100 and Coreg 3.125 mg PO BID. Hold if pulse is less than 60 or SBP less than 100." The MAR contained documentation Resident #3 was administered Coreg twice a day at 7:00 am and 4:00 pm, and Losartan 25 mg once a day at 7:00 am, on 4/1/16 through 4/25/16. Resident #3's April 2016 Vital signs record documented, her PR was checked twice a day on 4/13 through 4/25. Resident's BP was checked on the following dates: *4/14/16 at 3:00 pm, 113/70 *4/16/16 at 3:00 pm, 119/68 *4/17/16 at 3:00 pm, 99/65 *4/18/16 at 10:00 am, 138/76 *4/19/16 at 3:00 pm, 128/78	F 329		

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F 329	Continued From page 69 *4/20/16 at 3:00 pm, 126/72 *4/21/16 at 3:00 pm, 124/79 *4/24/16 at 3:00 pm, 108/82 *4/25/16 at 10:00 am, 119/76 *4/25/16 at 3:00 pm 108/44 Resident #3's BP was not checked on 4/15/16, 4/22/16, and 4/23/16. On 8 days her BP was checked once, although Coreg was administered twice, and Losartan once, on those dates. A SBP of 99/65 was recorded on 4/17/16, however, Coreg was administered to Resident #3 twice on that date. Physician orders stated Coreg was to be held if Resident #3's SBP was less than 100. On 4/26/16 at 10:50 am, LN #9 said they were not checking Resident #3's BP before administering the Coreg and Losartan. 3. Resident #4 was admitted on 11/16/09 with multiple diagnoses including, Alzheimer's Disease and depression. Resident #4's physician orders, dated 6/5/13, documented Resident #4 received Celexa 10 mg daily for depression. Resident #4's monthly behavior monitoring sheets from March 1 to April 27, 2016, were blank for her behaviors of tearfulness or sadness. Resident #4's behaviors were not effectively monitored. 4. Resident #5 was admitted on 7/8/15 with multiple diagnoses including, non-Alzheimer's dementia, macular degeneration, and stroke.	F 329		

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F 329	Continued From page 70 Resident #5's physician orders, dated 11/1/15, documented Resident #5 received Lexapro 10mg daily for depression. Resident #5's monthly behavior monitoring sheets from March 1 to April 26, 2016 were blank for her behaviors of crying, paranoia-like behaviors, delusions, or expressions of depression. Resident #5's behaviors were not effectively monitored. Resident #5's monthly behavior monitoring sheets from March 1 to April 26, 2016 were blank for her behaviors of crying, paranoia-like behaviors, delusions, or expressions of depression. Resident #4's behaviors were not effectively monitored. On 4/29/16 at 8:45 am, the RSA stated the nurses documented by exception.	F 329		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure special eating equipment was provided to a resident who needed it. This was true for 1 of 2 (#9) random residents. This deficient practice had the potential to negatively impact a resident's nutritional status. Findings included:	F 369	The Director of Nursing and Dietary Manager are ultimately responsible for ensuring that residents who require special eating equipment are provided with the recommended equipment. Plan of Correction	6/30/16

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F 369	Continued From page 71 1. Resident #9 was admitted to the facility with multiple diagnoses which included Alzheimer's and macular degeneration. Resident #9's OT evaluation, dated 2/5/16, documented she presented with decreased ability to maintain grasp on regular utensils due to decreased strength in her left hand and tremulous activity when using her hand to feed herself. The OT recommended Resident #9 use built up handled utensils for all meals. On 2/5/16, Resident #9's current nutrition care plan documented she needed built up utensils with all meals. On 4/1/16, the Kitchen Special Equipment log and Resident #9's meal card documented she was to be provided grey handled utensils with no sponge. On 4/26/16 at 6:18 pm, Resident #9 was observed at the dining room table using regular utensils She was observed to have tremors in her left hand while holding the fork. The food fell off the fork and onto the plate. She was then observed to push the food around on the plate and attempted again after several seconds to try and get another bite. On 4/29/16 at 9:38 am, the DNS stated Resident #9 refused to use the built up utensils and that it should be documented in the Plan of Care or in the nutrition progress notes section. Resident #9's nutrition notes, dated 2/24/16, 3/8/16, 3/15/16, and plan of care, dated 2/5/16,	F 369	Immediately upon notification of observation by surveyor, Resident #9 was provided appropriate built up utensils. Resident #9 has been re-assessed and the care plan has been reviewed to ensure that the current status of the resident is reflected based on needs. Resident #9 is receiving appropriate equipment for meals. Current residents care planned for use of built up utensils were reassessed and the care plans have been updated to reflect current status. Residents who require modified eating equipment are provided with the recommended equipment as indicated. Resident #9 was reviewed with staff as an educational opportunity and to ensure appropriate special eating equipment is provided for dining. Dietary and unit staff have been provided with additional education related to providing residents with required modified eating equipment and validation of the equipment being available. Referrals to Therapy Services will be provided as needed for evaluation of residents who require special assistance. Food and Nutrition Services performed an inventory of built up utensils to ensure adequate quantity to meet resident needs.	

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F 369	Continued From page 72 did not document her refusal of the adaptive utensils.	F 369	Sets of built up utensils have been relocated so that they are readily accessible to staff for use during meals and snacks that are provided outside of scheduled meal times. QAPI Integration Audits will be conducted by assigned unit staff to ensure residents recommended to use built up utensils are provided with correct utensils. Audits to be conducted at 3 meals per day for 2 weeks and then one meal per week for 3 months. Issues identified during the audit with special equipment will be immediately resolved. Audit data will be reported to the Continual Readiness/Quality Committee on a monthly basis. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and Quality, Safety, and Service Excellence Committee of the Board.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		6/30/16

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F 371	Continued From page 73 by: Based on observation and staff interview, it was determined the facility failed to ensure a) measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen and b) proper cleaning procedures for the facility's popcorn machine to prevent cross-contamination of old food. This was true for 6 of 8 (#1, #2, #3, #4, #5, and #6) sampled residents, as well as, any resident eating food prepared in the facility's kitchen. This had the potential for harm if resident's contracted food bourne illnesses. Findings include: 1. On 4/29/16 at 8:20 am, the dish washing process was observed. Dietary Aid #1 was washing dishes in the dirty side of the washroom. He was wearing scrubs, gloves, and a hat. The apron was not being used throughout the process. The front of his shirt was wet in spots with dirty dish water. Dietary Aid #1 proceeded to take off his gloves and go over to the clean dish side and started putting clean dishes away. On 4/29/16 at 8:45 am, Dietary Aid #1 stated he usually worn an apron, gloves, and a hat, when he was on the dirty dish side. He stated he made sure to always wear an apron when scraping off pots, pans or dishes as was required. On 4/29/16 at 9:15 am, the CDM stated a similar process for cleaning the dishes and stated Dietary Aid #1 should have been wearing an apron. 2. On 4/25/16 at 2:45 pm, the Activities Director was observed in the day room making popcorn in the popcorn machine. The Activities Director	F 371	The Food and Nutrition Services Manager is ultimately responsible for ensuring the facility has measures in place to prevent possible cross-contamination of dirty to clean areas in the kitchen, proper cleaning of food equipment, and prevention of cross-contamination of food. Plan of Correction 1:1 education provided to dietary aide observed during survey. The Food and Nutrition staff members were provided additional education on proper use of PPE and measures to be taken to prevent cross-contamination of clean kitchen areas. 1:1 education was provided to the Activities Director observed during survey on measures to prevent cross-contamination of food and importance of proper cleaning of equipment. The popcorn machine was removed from the facility. QAPI Integration Audits of dietary sanitation practices to be conducted by Food and Nutrition Services Manager or designee to ensure proper use of PPE and measures to prevent cross contamination of clean kitchen areas. Audits to be conducted weekly x 4 weeks, then monthly x 3 months. Audit	

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F 371	Continued From page 74 brought a white plastic lidded bin to the popcorn machine. She removed a bag of popcorn, container of oil, a black measuring cup, and a metal scoop from the bin. She poured oil into the measuring cup, then poured the oil into the popping mechanism inside the machine. She poured popcorn into the same cup, then added it to the oil. When the popcorn was finished popping, she used the metal scoop to portion the popcorn into paper bags, which she distributed to the residents. After distributing the popcorn, she returned to the popcorn machine. The Activities Director pulled several tissues from a nearby box, and used them to wipe off the black cup. Using the same tissues, the Activities Director wiped off the metal scoop and the popcorn machine, both inside and out. She then tossed the tissues inside the popcorn machine, where there was still popcorn ready to be served. On 4/27/16 at 2:15 pm, the Activities Director was observed to bring the popcorn machine into the day room, then left the machine unattended. The inside of the glass doors on the machine were coated with a visible oily substance. The metal base to the hopper was visibly greasy. A pull-out metal panel beneath the glass doors of the machine was covered in a greasy smeared substance. When the Activities Director returned, she stated the machine was in its clean condition, and ready to be used. The Activities Director had the white plastic bin with the popcorn supplies with her when she returned, and removed the lid to show them to the surveyor. When the lid was removed, an odor of rancid oil permeated the air in the room. The Activities Director stated she used a product called "Heet n Kleen", diluted in a spray bottle	F 371	data to be reviewed at Continual Readiness/Quality Committee monthly. In addition, audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and the Quality, Safety, and Service Excellence Committee of the Board.	

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F 371	Continued From page 75 with water, as the cleaner for the machine. The Activities Director stated she had switched to that product as it was less toxic to eat than the product which had previously been used. The label on the product documented, "...designed to remove grease and carbon easily by the heat and soak process, its outstanding detergency emulsifies grease and oil. 2 oz. per gallon of water. Heat solution to 160 degrees F." The Activities Director stated she did not heat the product, or soak the machine. She stated she did not use the product every time she cleaned the machine, but just when it's really dirty, once a month or so. She stated she sprayed the product on the machine, the scoop, and the measuring cup, then wiped them all off with tissues. The Activities Director stated she used tissues rather than paper towels, as the tissues were softer and she thought they scratched the surface of her supplies less. The Activities Director stated she did not know about the sanitization properties of the Heet n Kleen product, and she did not send the supplies or machine to the facility's kitchen to be cleaned. On 4/28/16 at 11:30 am, the Dietary Manager was asked about the cleaning of the popcorn machine. The Dietary Manager stated until the previous day, he had not been aware the facility even had a popcorn machine, and he had made arrangements to make sure it was cleaned in a sanitary manner moving forward.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		6/30/16

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F 431	Continued From page 76 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, it was determined the facility failed to ensure insulin bottles included opened and expiration dates. This is true for 2 of 4 (#3 and #4) sampled	F 431	The Pharmacist In Charge (PIC) is ultimately responsible to ensure insulin bottles include opened and expiration dates.	

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F 431	Continued From page 77 residents and 1 random resident (#10), whose insulin administration was observed. Failure to date insulin bottles could cause potential harm due to ineffectiveness of the medication. Findings include: On 4/26/16 at 4:30 pm, Resident #10's Novolog R bottle was observed in the medication cart without an opened date or expiration date. Resident #3's Lantus insulin bottle was observed without an open date or expiration date. Resident #4's Levemir insulin bottle was observed with bottle open dated 3/17/16 and no expiration date. On 4/26/16 at 4:30 pm, LN #10 said there should have been open dates and expiration dates on the insulin bottles, but there were not.	F 431	Plan of Correction Resident #3, #4, and #10□s insulin bottles were returned to the Pharmacy and replaced with appropriately dated bottles. Insulin bottles in the medication cart were reviewed to ensure appropriate dating. A new type of smear-proof expiration date labels were purchased and will be affixed to insulin products dispensed from the pharmacy. The expiration date is determined by the pharmacy and clearly marked on the label. The long term care staff were educated to track the expiration date, and return the expired insulin products to pharmacy for disposal and replacement. QAPI Integration Unit nurses will audit to ensure correct dates on insulin bottles. Audits will be conducted daily x 30 days, then weekly x 3 months. This data will be reviewed at the monthly Nursing Staff meetings and Continual Readiness/Quality Committee Meetings. In addition, audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and Quality, Safety and Service Excellence Committee of the Board.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		6/30/16

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F 441	Continued From page 78 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 79 Based on observation, staff interview, and review of the infection control protocol manual, the facility failed to ensure an Infection Prevention Control Program was developed, implemented, and maintained to prevent the onset and spread of infections within the facility. This is true for 2 of 7 (#2 and #4) sampled residents residing in the facility, 1 of 1 random resident (#10) and had the potential to impact all other residents residing in the facility. This failed practice resulted in the potential for residents, staff, and visitors to contract preventable infections. Findings include: 1. On 4/26/16 at 5:30 pm, CNA #10 was observed to use the same blood glucose machine with Residents #2, #4, and #10, without disinfecting the blood glucose machine between each resident. On 4/28/16 at 4:30 pm, the FTS stated the blood glucose machine should have been cleaned between each resident. 2. On 4/28/16 at 3:30 pm, the IPR said the March 2016 monthly infection control data collection or tracking and trending had not been collected or documented. She also said, she tracked residents' infections but not employees when they called in sick.	F 441	The manager of Quality and Patient Safety (QPS) is ultimately responsible for the development of the facility wide infection control program. The Director of Nursing (DNS) is ultimately responsible for ensuring the infection control program is implemented and maintained to prevent the onset and spread of infections within the facility. Plan of Correction A single point lesson regarding glucometer disinfection and storage was provided to employees in the skilled nursing unit. The staff were re-educated on proper techniques for low-level disinfection of glucometers after each use on 05/12/2016. A visual guide was placed on each glucometer storage case. Blood glucose monitor disinfection is included in new employee competency and part of existing employee□s annual skills training. Blood glucose monitor disinfection is reviewed by new employees during new clinical employee orientation. Infection prevention data is reviewed monthly by the DNS and QPS department for trending. Infection Prevention meetings are	

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F 441	Continued From page 80	F 441	scheduled quarterly with the LTCU Infection Prevention committee and have been scheduled through the end of 2016. Employee call-offs will be tracked in real-time at the unit level by the DNS. During any 24-hour period if two or more employee call-offs occur a Midas electronic event report will be entered and the DNS or designee will notify the QPS Department for review. Employee call-offs will be reviewed monthly by the DNS and the QPS manager for correlation with any resident illness. March infection data was reviewed with the DNS on 05/02/2016. The March data will be reviewed at the 2nd quarter Infection Prevention meeting on 06/16/2016. Ongoing Infection Prevention monthly data is reviewed with DNS for trending or any clinical suspicion. In addition, an Infection Prevention update is reported monthly to the LTC Continual Readiness/Quality Committee. QAPI Integration The Education department or designee will conduct audits of compliance related to required training monthly. Audit data to be shared with unit leadership. Staff not in compliance will be removed from work schedule until required education is	

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F 441	Continued From page 81	F 441	completed. Unit staff audits of glucometer disinfection conducted daily for x 30 days, then weekly x 3 months. The audit data will be reported monthly to the Continual Readiness/Quality Committee. In addition, data will be shared with the Quality and Safety Council of St. Luke□s Elmore and the Quality, Safety and Service Excellence Committee of the Board.	
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 staff interviews, review of the facility's abuse investigations, review of the facility's policies and procedures on abuse, and record review, it was determined the Administrator, DNS, and management team, failed to manage the facility in a manner that ensured the safety and well being of each resident. They failed to provide psychosocial services and investigate allegations of abuse and report those allegations to the appropriate agencies. These failed practices affected 2 of 8 (#2 and 5) sampled residents and had the potential to affect all residents residing in the facility. Findings include:	F 490	The Administrator, Director of Nursing (DNS) and management team are ultimately responsible to manage the facility in a manner that ensures the safety and well-being of each resident. The Administrator, DNS and management team are ultimately responsible to provide psychosocial services and investigate allegations of abuse and report those allegations to the appropriate agencies. The facility Administrator is ultimately responsible to ensure the effective	6/30/16

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F 490	Continued From page 82 1. Refer to F250 as it related to the facility's failure to ensure residents with social services needs were being monitored, evaluated, counseled and assisted in meeting their psychosocial needs. 2. Refer to F226 as it relates to the facility's failure to ensure allegations of abuse were investigated. 3. Refer to F226 as it relates to the facility's failure to ensure contract employees received training on how to report abuse and neglect within the facility. On 4/29/16 at 11:50 am, the Administrator, VP, and DNS were informed of the concerns regarding the Administrative team and stated they would immediately work on the issues.	F 490	administration for the resident well-being. Plan of Correction The Organizational chart has been updated to reflect the RSAs reporting relationship to the LSW; the LSWs reporting relationship to the hospital CNO; and the LSW matrix reporting to the facility Administrator. The updated chart also shows the Quality and Patient Safety Manager reporting to the System VP of Quality Operations and the Quality and Regulatory Programs Coordinator reporting to the West Region Director of Accreditation/Patient Relations. The refined organizational chart demonstrates enhanced lines of communication. The facility Administrator or designee will continue to meet weekly with the DNS to ensure the safety and well-being of each resident. The facility Administrator or designee has scheduled monthly meetings with the Licensed Social Worker (LSW) to ensure residents with social services needs are being monitored, evaluated, counseled and assisted in meeting the psychosocial needs. The Director of Nursing (DNS) and LSW rounded on current residents on 04/27/2016 and provided written and verbal education regarding abuse and neglect, including what constitutes abuse and neglect, and who to contact with concerns.	

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F 490	Continued From page 83	F 490	Information regarding how to report concerns with care, including photos of the facility Administrator and DNS, were posted at wheelchair height in the common area. The monthly LTC Continual Readiness/Quality Committee reviews audits, trends and concerns regarding resident safety and well-being. Written and verbal education on the Abuse and Neglect policy and reporting requirements have been provided to staff, contractors, volunteers, and students with access to long term care residents. The Resident Services Advocate (RSA) was provided individualized education on abuse and neglect including a competency assessment. The Administrator, DNS, and LSW report and investigate allegations of abuse and neglect in accordance with facility policy and State and Federal regulations. The abuse and neglect training, including reporting of concerns, will continue to be provided during new hire orientation for staff and contractors. Annually, the abuse and neglect training, including reporting of concerns, will be provided for staff and contractors. Based on unit leadership assessment, re-education on abuse and neglect for	

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F 490	Continued From page 84	F 490	staff including assessment of competency will be provided as needed. The Administrator will continue to review and sign LTC Midas incident and accident reports. The facility Administrator or designee will attend Resident at Risk meetings to ensure awareness of any issues and that appropriate follow up is completed. Audit results and quality outcome measures will be provided to the St. Luke□s Health System VP of Quality Operations and the Director of Accreditation monthly x3 months. The St. Luke□s Health System VP of Quality Operations or designee will conduct an onsite visit to ensure compliance and provide oversight of leadership weekly x2 weeks, then monthly x3 months. The LTC Continual Readiness/Quality Committee to review resident quality and safety data on a monthly basis. In addition, data will be shared with the Quality and Safety Council of St. Luke□s Elmore and the Quality, Safety and Service Excellence Committee of the Board.	
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12	F 497		6/30/16

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F 497	Continued From page 85 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to ensure CAPs received competency training and performance reviews for obtaining blood glucose levels (CAP #12) and use of gait belts (CAPs #4, #5, and #7). This failed practice could result in harm if residents did not receive appropriate care for their individual care needs. Findings included: 1. On 4/28/16 at 4:30 pm, the FTS brought the the competency training skills record for the CAPs and said they were current. CAP #12's Orientation/Annual Skills Validation for use of the glucometer expired on 4/10/16. The FTS stated a competency skills test would be held in early May. Orientation/Annual Skills validation for gait belt use were not received. 2. Refer to F298 as it relates to the failure of the facility to ensure CAPs demonstrated	F 497	The Director of Nursing (DNS) is ultimately responsible for ensuring Clinical Assistive Personnel (CAP) receive competency training and performance reviews for obtaining blood glucose levels and the use of gait belts. Plan of Correction CAP #12 was provided with 1:1 education and skills check off, related to blood glucose monitoring including acceptable testing locations for resident privacy. CAPs #4, #5, #7 were provided with 1:1 education on the proper use of a gait belt. Safe patient handling, transferring and movement skills training including gait belt use was provided to staff. The staff will utilize care plans to determine transfer methods appropriate	

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F 497	Continued From page 86 competency in transferring residents and checking blood sugar levels.	F 497	for residents. The staff will continue to receive annual education and training on: blood glucose testing, manual transfers with gait belts, mechanical lift training, dementia, nutrition, hydration, fall prevention, abuse prevention, resident rights and resident-directed care planning. QAPI Integration The Education department or designee will conduct audits of compliance related to required abuse and neglect training monthly. Audit data to be shared with unit leadership. Staff not in compliance will be removed from work schedule until required education is completed. Audits of blood glucose testing by the unit to be done to ensure acceptable testing locations for resident privacy. Audits to be conducted daily x 30 days, then weekly x 3 months. Licensed nursing to audit appropriate gait belt use. Audits to be conducted 10 audits daily x1 week, then 40 audits weekly x3 weeks, and then 40 audits monthly x3 months. Audit data to be reviewed at Continual Readiness/Quality Committee monthly. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and the Quality, Safety, and Service Excellence Committee of the Board.	
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS	F 498		6/30/16

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F 498	Continued From page 87 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure that the CNAs were able to demonstrate competency in skills and techniques necessary to check blood sugar levels and transfer residents correctly. This is true for 4 of 7 (#1, #2, #3, and #4) sampled residents residing in the facility and 1 random resident (#10) whose blood sugar check was observed. These failed practices placed residents at risk infection and injury from falls. Findings include: 1. Resident #3 was admitted to the facility on 5/21/15 with multiple diagnoses, including dementia, diabetes mellitus and urinary tract infection. Resident #3's most recent Quarterly MDS assessment, dated 2/26/16, documented she required set-up only for eating and one person physical assist for all activities of daily living. On 4/26/16 at 6:12 pm, CAP #4 and another CAP were observed as they transferred Resident #3 from the recliner to the wheelchair. CAP lowered the recliner's foot rest and applied the gait belt to Resident #3's waist. CAP #4 was on Resident #3's left side and the other CAP on her right side.	F 498	The Director of Nursing (DNS) is ultimately responsible to ensure Clinical Assistive Personnel (CAP) are able to demonstrate competency in skills and techniques necessary to check blood sugar levels and transfer residents correctly. Plan of Correction CAP #12 was provided with 1:1 education and skills check off, related to blood glucose monitoring including acceptable testing locations for resident privacy. CAPs #4, #5, #7 were provided with 1:1 education on the proper use of a gait belt. Safe patient handling, transferring and movement skills training including gait belt use was provided to staff. The staff will utilize care plans to determine transfer methods appropriate for residents. The staff will continue to receive annual education and training, as well as demonstrate competency on: blood glucose testing, manual transfers with gait	

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F 498	Continued From page 88 CAP on the right side of Resident #3 had her left hand on the gait belt. They then lifted Resident #3 to standing position via her armpits and transferred her to the wheelchair. On 4/28/16 at 11:00 am, the DNS stated CAPs were trained on how to use the gait belt and said the way Resident #3 was transferred was unacceptable. 2. On 4/26/16 at 5:30 pm, CAP #12 was observed to check the blood sugar levels of Residents #2, #4, and #10. CAP #12 did not disinfect the blood glucose machine between residents. CAP #12 checked blood sugar levels for the residents in the day room, where there were other residents and visitors. CNA #12 stated she had been a CAP, and had been checking blood sugar levels, for about a year. On 4/28/16 at 4:30 pm, the FTS brought all competency skills for the CNAs and said they were all current. The FTS indicated blood sugar levels should not be checked completed in the day room. The FTS also indicated the blood glucose machine was to be disinfected before use on another resident. 3. Resident #1 was admitted to the facility on 8/10/15 with multiple diagnoses which included advancing dementia, generalized weakness, frequent falls and UTI's. On 2/17/16 Resident #1's most recent quarterly MDS assessment stated she had a severe cognitive impairment and required extensive	F 498	belts, mechanical lift training, dementia, nutrition, hydration, fall prevention, abuse prevention, resident rights and resident-directed care planning. QAPI Integration The Education department or designee will conduct audits of compliance related to required training monthly. Audit data to be shared with unit leadership. Staff not in compliance will be removed from work schedule until required education is completed. Audits of blood glucose testing by the unit to be done to ensure acceptable testing locations for resident privacy. Audits to be conducted daily x 30 days, then weekly x 3 months. Licensed nursing to audit appropriate gait belt use. Audits to be conducted 10 audits daily x1 week, then 40 audits weekly x3 weeks, and then 40 audits monthly x3 months. Audit data to be reviewed at Continual Readiness/Quality Committee monthly. In addition audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and the Quality, Safety, and Service Excellence Committee of the Board.	

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F 498	Continued From page 89 assistance from one person for transfers and bed mobility. It also noted Resident #1 required a wheelchair or walker for ambulation. On 4/25/16 at 1:33 pm, Resident #1 was sitting in the recliner and the activity bingo was scheduled to start soon. CAP #7 placed her right hand into Resident #1's left armpit to lift her up from the recliner chair. Once Resident #1 was in the upright position, with the walker in front of her, CAP #7 assisted her to walk over to the table with CAP #7 holding onto her elbow and other hand on her back. Resident #1 was lowered into a chair at the table by her armpit. No other assistive devices were used. On 4/26/16 at 5:32 pm, CAP #5 lifted Resident #1 by the armpit from a dining room chair, to a standing position, with Resident #1's walker in front of her. The CAP held onto the back of Resident #1's pants at the waist band, as well as, her elbow. She walked Resident #1 to the day room in that manner and seated her in a chair. No other assistive device were used. On 4/28/16 at 11:00 am, the DNS stated the CAPs were trained to use a gait belt and the way Resident #1 was transferred was unacceptable.	F 498		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		6/30/16

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F 514	Continued From page 90 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure complete and accurate medical records were maintained for each resident. This was true for 4 of 8 (#1, #4, #5 and #6) sampled residents. This failed practice created the potential harm for decisions to be based on incomplete or inaccurate information. Findings included: 1. Resident #1 was admitted to the facility on 8/10/15 with multiple diagnoses which included advancing dementia, generalized weakness, frequent falls and UTI's. On 11/27/15 at 5:00 pm, Resident #1's Physician Orders and Progress Notes section documented a fall with injury. It was reviewed by nursing and the date of the review was documented as 11/22/15 at 8:00 pm. Resident #1's Fall Risk Assessment, dated 2/18/16, documented a score of 17. A score of 10 or higher is at risk. The intervention section on the assessment sheet was incomplete. The Fall Risk Assessment documented a recent fall happening on 2/28/16, after the date of the assessment.	F 514	The Director of Nursing (DNS) and Health Information Management (HIM) manager are ultimately responsible to ensure complete and accurate medical records are maintained for each resident. Plan of Corrections Resident #1□s chart was reviewed to ensure that other required documentation has appropriate signature, date and time. Resident #1□s chart was reviewed and fall risk reassessed and interventions and care plan updated to reflect current status. Residents□ #4 and #5 charts were reviewed and unsigned orders were signed by attending provider. Resident #6□s chart was reviewed and unsigned progress notes were signed by attending provider. Residents□ #1, #4, #5, and #6 charts had a thorough chart review by the HIM department to ensure completion.	

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F 514	Continued From page 91 On 2/28/16 at 5:55 am, Resident #1's nursing notes documented the bed alarm went off in her room. She was found sitting on the floor with her attends wet and there were no injuries noted. On 4/27/16 at 11:00 am the DNS stated the dates were wrong and the intervention section of the Fall Risk Assessment should have been filled out. 2. Resident #4's physician orders, dated 8/8/15 and 8/19/15, were not signed or dated by the physician. 3. Resident #5's physician orders, dated 7/9/15 to 8/6/15 and 8/7/15 to 9/4/15, were not signed or dated by the physician. 4. Resident #6's physician's progress note, dated 4/8/16, was not signed or dated by the physician. On 4/29/16 at 10:00 am, the DNS stated she knew the facility had a problem getting physicians to sign orders and progress notes timely, and they needed to resolve the issue.	F 514	HIM department conducted a thorough chart review for current residents to ensure completion. The long term care unit was incorporated into the hospital□s medical record policies regarding chart deficiencies. HIM staff will audit charts weekly for chart deficiencies to include signatures. LTC Health Unit Clerks will maintain residents□ charts with oversite from HIM manager. HIM staff will conduct chart audits to ensure required chart content monthly x3 months, then quarterly as defined by the hospital medical record policy. Long term care providers who are identified as being deficient with hospital medical record policy are referred to the Chief of Staff for appropriate action.	

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NAME OF PROVIDER OR SUPPLIER

ST LUKE'S ELMORE LONG TERM CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

895 NORTH 6TH EAST
MOUNTAIN HOME, ID 83647

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey from April 25 to April 29, 2016. The surveyors conducting the survey were: Presie C. Billington, RN, Team Coordinator Nina Sanderson, LSW David Scott, RN Jenny Walker, RN Teresa Kobza, RDN, LD Definitions include: ADL- Activities of daily living BID - twice a day BP - Blood Pressure BR - Bed room CAP - Clinical Assistant Personnel CDM- Certified Dietary Manager CP - Care Plan DNS- Director of Nursing Services FTS- Facility Training Specialist H&P- History and Physical IDT- Interdisciplinary Team LSW - License Social Worker MARS - Medication Administration Record MASD - Moisture Associated Skin Damage MD- Physician MDS- Minimum Data Set OMRA- Other Medicare Required Assessment OOB - Out of Bed OT- Occupational Therapy mg - milli grams PR- Pulse Rate RSA- Resident Services Advocate SBP- Systolic Blood Pressure UTI - Urinary Tract Infections	C 000		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MDS001190		04/29/2016

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C 664	Continued From page 1	C 664		
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of the Infection Control Meeting Minutes and staff interview, it was determined the facility failed to ensure a representative from required departments attended Infection Control Meetings. This affected 7 of 7 sampled residents (#s 1-7) and all residents who resided in the facility. Findings included: The December 2015 Infection Control Minutes documented the administrator, pharmacist, dietary services supervisor, housekeeping/laundry representative, maintenance services representative were not in attendance. On 4/29/16 at 2:30 pm, the administrator was informed of the identified concern.	C 664	The Manager of Quality & Patient Safety is ultimately responsible for ensuring a representative from required departments attend the Infection Control meetings. Plan of Correction The Manager of Quality and Patient Safety has reviewed the Infection Control Meeting charter and membership and will ensure required members from 16.03.02.150, 02, including the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative are included in the quarterly committee membership and in attendance as required. Residents who reside in this facility have the potential to be affected by the indicated deficiency. Infection Prevention meetings have been scheduled out for the remainder of 2016. Expectations of attendance will be conveyed to the required committee members.	6/30/16

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C 664	Continued From page 2	C 664	Future meeting dates and any potential conflicts will be reviewed at each meeting. The Quality & Patient Safety Manager will review the attendance log from the minutes to confirm appropriate representatives are in attendance as required. Any variation from required representation or attendance will be addressed with the area leader and the facility Administrator. Alternate meeting dates will be rescheduled as appropriate to assure continued and ongoing compliance.	
C 666	02.150,02,c Quarterly Committee Meetings c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson. This Rule is not met as evidenced by: Based on review of the Infection Control Meeting Minutes and staff interview, it was determined the facility failed to ensure a quarterly Infection Control Meeting was held. This affected 7 of 7 (#'s 1-7) sampled residents and all the residents who resided in the facility. Findings included: On 4/28/16 at 3:30 pm, during the review of the Infection Control Minutes the last meeting was held December 10, 2015. The IPR said there has not been an Infection Control meeting.	C 666	The Manager of Quality & Patient Safety is ultimately responsible for ensuring a quarterly Infection Control Meeting is held within the defined time frame. Plan of Correction Infection Prevention meetings will be scheduled out for the remainder of calendar year 2016 with meeting invites put on member calendars. Residents who reside in this facility have the potential to be affected by the indicated deficiency. Required committee members have	6/30/16

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C 666	Continued From page 3	C 666	received education as to their required attendance and will attend Infection Prevention meetings. Infection Control meeting minutes, including the attendance roster, will be reported to the LTC Continual Readiness/Quality meeting on a quarterly basis for review to confirm required participant attendance. Future meeting dates and potential conflicts will be reviewed at each meeting. The Quality & Patient Safety Manager will review the attendance log from the minutes to confirm appropriate representatives are in attendance as required. Variation from required representation or attendance will be addressed with the area leader and the facility Administrator. Alternate meeting dates will be rescheduled as appropriate to assure continued and ongoing compliance.	
C 893	02.203,02,g,v Incidents/Accidents Reports v. Any incident or accident occurring while the patient/resident is in the facility. This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to investigate and document falls experienced by residents. This was true for 1 of 8 (#2) sampled residents. This deficient practice created the potential for	C 893	The Director of Nursing (DNS) is ultimately responsible to ensure incidents and accidents involving residents are reported and investigated.	6/30/16

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C 893	Continued From page 4 decisions to be based on incomplete information and increased the risk for complications for residents due to inappropriate care or interventions. Findings included: Resident #2 was assessed as at high risk for falls on Fall Risk Evaluation form and the MDS staff documented on the back of the form the resident had fall on 2/12/16 and 3/14/16. There were no further investigation found on the clinical record about this falls. On 4/27/16 at 11:45 am, the DNS did not found any incident and accidents report about Resident #2's falls.	C 893	Plan of Correction Resident #2□s chart was reviewed for any supporting documentation on falls and the care plan was updated to current status. An investigation was completed and employee□s working with Resident #2 were interviewed for recollection of a fall occurring on 2/12/2016. The Licensed Social Worker (LSW) conducted interviews on 04/27/2016 and 04/28/2016 with alert and oriented residents to identify potential concerns and well-being. Non-alert and oriented residents received a full head-to-toe skin assessment on 04/27/2016 by an Emergency Room Registered Nurse to evaluate for signs of potential for undocumented injuries. The Quality and Patient Safety Manager re-educated the unit staff regarding what events should be reported and how to report through the Midas incident and accident electronic event reports. Interdisciplinary Stand Up meetings are being conducted Monday-Friday to discuss current residents□ status and care plan updated accordingly. A Quality and Patient Safety representative will notify the group of Midas incident and accident electronic event reports received. Residents that experience a change of condition, behavior, change in medication	

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C 893	Continued From page 5	C 893	or who are prescribed antibiotics will be placed on alert charting. The alert charting will be reviewed by DNS or designee daily to assure alert charting is complete. QAPI Integration Audits of alert charting will be maintained daily x 30 days, then weekly x 3 months. This data will be reviewed at the monthly Nursing Staff meetings and Continual Readiness/Quality Committee Meetings on a monthly basis. In addition, audit data will be shared with the Quality and Safety Committee of St. Luke□s Elmore and Quality, Safety and Service Excellence Committee of the Board.	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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August 30, 2016

Michael Blauer, Administrator
St Luke's Elmore Long Term Care
PO Box 1270
Mountain Home, ID 83647-1270

Provider #: 135006

Dear Mr. Blauer:

On **April 29, 2016**, an unannounced on-site complaint survey was conducted at St Luke's Elmore Long Term Care. The complaint was investigated in conjunction with the facility's federal recertification and licensure survey from April 25 through April 29, 2016.

Observations were made of the facility's medication pass and the facility's pharmacy. Interviews were conducted with Licensed Nurses in the facility and the Director of Nursing Services. The facility's Quality Assurance program was reviewed. The facility's policy and procedure for obtaining medications from the pharmacy and medication administration were reviewed. The facility's Grievance file was reviewed. Individual resident interviews, a Resident Group interview, and resident family interviews were conducted.The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006995

ALLEGATION:

The Reporting Party stated the facility would use the medication supply from existing residents for newly admitted residents.

The facility stated they had been made aware of this concern over a year before the survey took place. The facility substantiated the practice was taking place as alleged. The issue was brought before the facility's Quality Assurance committee, a plan of action was developed, implemented, and monitored for effectiveness. The Quality Assurance committee found no further issues once the practice had been corrected. Policies and procedures for obtaining and administering medications reflected current standards of practice. None of the residents or resident family members interviewed expressed concerns with medications not being available, or receiving medications intended for another residents. There were no grievances regarding medication availability, or use of one resident's medication supply for another resident. Licensed Nurses interviewed were all aware of the facility's action plan to prevent further recurrence of the incorrect practice, and all stated the plan had been working for at least a year at the time the survey was conducted.

Based on these observations, interviews, and document review, it was determined the facility had identified and corrected the deficient practice, and maintained compliance for a number of months prior to the survey. No deficiencies related to this allegation were cited.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

The allegation was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj