



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

June 22, 2016

Bobette Steffler, Administrator
McCall Rehabilitation & Care Center
418 Floyde Street
Mc Call, ID 83638-4508

Provider #: 135082

Dear Ms. Steffler:

On **June 3, 2016**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **April 29, 2016**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

0155-Right to Refuse: Formulate Advance Directives-483.10(b)(4)
0250-Provision Of Medically Related Social Service-483.15(g)(1)
0431-Drug Records, Label/store Drugs & Biologicals-483.60(b), (d), (e)

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.

Bobette Steffler, Administrator
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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your copy of the Form CMS-2567B, Post-Certification Revisit Report listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 2, 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*.

As noted in the Bureau of Facility Standards' letter of **March 29**, 2016, following the survey of **March 18, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions on **June 20, 2016** and termination of the provider agreement on **September 18, 2016**, if substantial compliance is not

achieved by that time. The findings of non-compliance on **June 3, 2016**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **April 18, 2016**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **June 20, 2016**
- **Civil Monetary Penalty**

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

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 **July 2, 2016**. If your request for informal dispute resolution is received after **July 2, 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,

Bobette Steffler, Administrator
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comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors,
Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "Nina Sanderson for". The signature is written in a cursive style with a large initial "N" and a long, sweeping underline.

[Nina Sanderson, LSW](#), Supervisor
Long Term Care

Enclosures

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

PRINTED: 08/17/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/03/2016
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MC CALL, ID 83638		
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{F 000}	INITIAL COMMENTS The following deficiencies were cited during the revisit survey conducted June 1, 2016 to June 3, 2016. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Amy Barkley, RN, BSN Jenny Walker, RN Abbreviations include: DNS = Director of Nursing Services IDT = Interdisciplinary Team LN = Licensed Nurse LSW = Licensed Social Worker MD = Medical Doctor MDS = Minimum Data Set MMSE = Mini Mental State Examination mg = Milligram(s) mL = MilliLiter(s) P & P = Policy(ies) and Procedure(s) RPh = Registered Pharmacist RSC = Resident Services Coordinator	{F 000}			
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents	F 155			7/5/16

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

TITLE

(X6) DATE

Electronically Signed

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 155	<p>Continued From page 1 concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review, and review of the facility's residents' rights handbook, it was determined the facility failed to ensure each resident was informed of the treatment provided and the resident's right to refuse treatment was acknowledged and respected. This was true for 1 of 6 residents (#4) sampled for social services, and had the potential to affect all residents residing in the facility. This failed practice resulted in Resident #4 receiving a medication without his knowledge or consent and against his expressed refusal. Findings include:</p> <p>Resident #4 was discharged from the hospital and admitted to the facility on 12/24/15, with multiple diagnoses including squamous cell carcinoma of the face, dementia without behavioral disturbance, amnesia, and failure to thrive.</p> <p>A Matter of Rights handbook, dated 2013, provided to residents upon admission, documented the resident had the right to make his/her own medical decisions, the right to be free from interference, coercion, discrimination,</p>	F 155	<p>The facility does ensure that Residents have the right to refuse treatment.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>The Medical Director discontinued on 6/3/16 the liquid form of Prozac for Resident #4, since the resident's primary physician was out of town. The facility Administrator, Assistant Administrator, and Director of Nursing talked with Resident #4 on 6/3/16 and left message for Resident #4 Representative regarding the medication discontinuation on 6/3/16.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p>		

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F 155	<p>Continued From page 2</p> <p>or reprisal; and accept or refuse medical treatment. It also stated it was the facility's policy to permit and encourage a resident's participation in the planning for his/her own care, treatment, and any changes to such planning.</p> <p>A Nursing Facility Services and Admission Agreement, dated 12/24/15, signed by Resident #4 and the RSC, stated Resident #4 was informed of his right to accept or refuse medical treatment both verbally and in writing.</p> <p>The Admission MDS assessment, dated 12/31/15, stated Resident #4 had difficulty hearing; usually had the ability to understand others and was understood; and had moderate memory impairment.</p> <p>A neurology consult, dated 2/9/16, at 10:54 AM, included documentation that Resident #4 was doing "very well up until November and stated he has had mild problems with memory for about the last two months... He reports no family history of dementia and complained of generalized weakness and increased confusion for the last 3 days. He reported flu-like symptoms as have many people at the facility. He is not on medications for dementia and does not report psychotic symptoms. He scored a 9/30 on his MMSE ...Based on the limited amount of information available, it appears the patient suffers from Alzheimer's disease and is in the moderate to severe stage of this. As the patient reports that he is feeling ill and confused, it is unclear if his score today on the MMSE represents his true baseline. It is recommended that this be repeated by his physician when he is feeling better, and prior to final determination</p>	F 155	<p>However, to address other residents who may be affected by this deficiency,</p> <p>The facility's Administrator on 6/8/16 audited medication orders for residents receiving medications with food and/or fluids and obtained consent from Resident and Resident's Representative.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>The facility's Medical Director on 6/8/16 notified via telephone conversation Resident #4's primary physician emphasizing the importance of resident and resident representative consenting to receiving medication in food and/or fluids and their right to refuse.</p> <p>The facility's Medical Director on 6/9/16 provided a 1:1 in-service education to the Director of Nurses, who received the order from Resident #4 physician regarding liquid form of Prozac to be mixed in Resident #4's food and/or fluid, emphasizing the importance of obtaining consent from resident and resident's representative and their right to refuse.</p> <p>The facility's Administrator on 6/8/16-6/9/16 provided an in-service education to all License Nurses regarding F-155 with emphasis on the importance of resident</p>		

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F 155	<p>Continued From page 3 regarding competency.</p> <p>A repeat assessment of Resident #4's cognitive status was not found in Resident #4's clinical record as of 6/3/16.</p> <p>A Physician Visit note, dated 3/7/16, documented that staff noticed Resident #4 had been angry. When the physician asked him if an anti-depressant would help him, his response to the physician was "maybe." The Physician note did not include further assessment or dialogue with Resident #4 regarding his depression or possible treatment options. Resident #4 returned to the facility with a diagnosis of single episode major depression and a physician's order for Paxil 10 mg tablet once a day.</p> <p>Resident #4's depression care plan, dated 3/8/16, documented Resident #4, "Had a tendency towards depression as manifested by yelling at others, cursing, and demanding verbalizations." A behavior flow sheet was initiated on 3/8/16, to track the number of times Resident #4 yelled at others related to depression.</p> <p>A Social Service progress note, dated 3/8/16, stated Resident #4's MPOA agreed to Resident #4 starting Paxil for signs and symptoms of depression as evidenced by yelling at others. Resident #4's record did not include documentation that Resident #4 consented to the use of Paxil.</p> <p>The Medication Administration Record for 3/9/16, showed Resident #4 was administered Paxil in the morning. On 3/10/16 a Nurse's Note stated</p>	F 155	<p>and resident representative consenting to receiving medication in food and/or fluids and their right to refuse.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur;</p> <p>Monitoring will be done through:</p> <p>The Administrator or designee will review at least three (3) residents with orders for residents receiving medication in food and/or fluids to ensure that there is consent from the resident and resident representative.</p> <p>Monitoring will start on 7/4/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Administrator or designee will present during the quarterly the QA&A Committee his/her findings and/or corrective action taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		

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F 155	<p>Continued From page 4</p> <p>Resident #4 had multiple episodes of confusion and was incontinent of bowel and bladder. On 3/11/16 a Nurse's Note documented Resident #4 had one emesis, increased weakness and confusion, and his eyes were without expression. The note documented a call was made to Resident #4's MPOA to explain the decline and "concerns he may pass away." Except for one day, the Medication Administration Record from 3/10/16 to 3/31/16, documented Resident #4's daily refusals to take the Paxil. The LNs documented multiple attempts were made on multiple days with continued refusal from Resident #4. Resident #4 continued to refuse after he was informed of the risk and benefits of the Paxil.</p> <p>A change of condition form, dated 3/16/16, at 3:00 PM, indicated, "Resident #4 is refusing the Paxil... Will ask MD if we will d/c (discontinue) or continue to encourage him to take it."</p> <p>A change of condition form, dated 3/17/16, at 4:15 PM, documented the MD was notified of Resident #4's refusal of Paxil.</p> <p>A Significant Change MDS, dated 3/22/16, documented Resident #4 usually had the ability to understand others and was understood; had some difficulty only in new situations when making decisions related to tasks of daily life; and he had not had a change in his mental status from baseline.</p> <p>In an MDS change of condition note, dated 3/25/16, the Assistant Administrator documented Resident #4 was able to make his needs known verbally and was refusing to take the Paxil.</p>	F 155			

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F 155	<p>Continued From page 5</p> <p>A Nurse's Note, written by the DNS, dated 4/1/16, documented she spoke with Resident #4's MPOA regarding Resident #4's continued refusal of the Paxil. The MPOA said he understood the risk and benefits, and requested Social Services speak to Resident #4.</p> <p>The Medication Administration Record, from 4/1/16 to 4/5/16, documented Resident #4 refused daily to take the Paxil.</p> <p>A Physician Order, dated 4/5/16, documented discontinuation the Paxil due to continued refusal by Resident #4.</p> <p>On 4/12/16, "The resident refused to take anti-depressant" was added to Resident #4's depression care plan.</p> <p>A Condition Change form, dated 5/16/16, written by the DNS, documented Resident #4 was difficult to re-direct and was "hitting and cussing" at staff and was worse during the evening and night shifts. The DNS documented Resident #4 refused all pills and she would request an order from the physician for liquid Prozac.</p> <p>On 5/16/16, "Request liquid Prozac as resident refuses pills" was added to Resident #4's depression care plan.</p> <p>An undated Informed Consent For Psychoactive Medication stated Prozac would be used to decrease Resident #4's behavior of hitting and "cursing" at staff. The consent form for the use of Prozac was signed by the Assistant Administrator. The consent did not include</p>	F 155			

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F 155	<p>Continued From page 6</p> <p>Resident #4's signature or date, or other mark to document his consent. A hand written note, dated 5/16/16, was documented in the resident/resident representative signature section of the form. The note stated a voicemail had been left for the MPOA and the facility was waiting for the MPOA's consent.</p> <p>A Physician telephone order, dated 5/17/16, documented, "Prozac liquid oral solution 20 mg/5 ml - Give 5 mg a day in health shakes or other food/liquid."</p> <p>Resident #4's Medication Administration Record, from 5/17/16 to 6/3/16, documented Resident #4 received liquid Prozac daily for depression.</p> <p>On 6/2/16 at 11:45 AM, when Resident #4 was asked if he was taking any medication for depression, he made direct eye contact with the surveyor and stated, "I am NOT taking any medication for depression." When asked if he would be willing to take an anti-depressant, or felt like he needed to take something for depression, he stated, "I am not willing to take an anti-depressant and I do not need one." When Resident #4 was asked if he could recall being prescribed an anti-depressant in the past, and had refused to take it then, he stated, "Yes, and nothing has changed. I would continue to refuse it."</p> <p>On 6/2/16, at 11:45 AM, when LN #1 was asked how she administered Prozac to Resident #4, she stated the liquid Prozac was administered in Resident #4's hot cocoa. LN #1 stated, "Resident #4 would refuse the Prozac, so I slip it in his hot cocoa without telling him." LN #1 identified this</p>	F 155			

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F 155	<p>Continued From page 7</p> <p>method of administration was routine for Resident #4.</p> <p>On 6/3/16, the survey team requested an interview with Resident #4's physician and was informed by the facility that the physician was unavailable.</p> <p>On 6/3/16 at 1:25 PM, when asked if he was familiar with Resident #4 and the resident's prior refusal to take an anti-depressant, the Medical Director stated he knew there had been some difficulty with getting Resident #4 to take it. When asked if it would be appropriate to administer a medication to a resident without the resident's knowledge or consent, the Medical Director stated, "No, I don't think that is appropriate if the resident is cognizant." When asked if he was aware that Resident #4 was receiving a liquid anti-depressant in his hot cocoa because he refused to take it in pill form, he stated, "This is the first time I have heard about this."</p> <p>On 6/3/16 at 1:45 PM, the DNS stated she discussed the anti-depressant with Resident #4's MPOA and it was her understanding the MPOA was going to discuss it with Resident #4's prior employee/friend, who would then talk to Resident #4 about it. She stated she could not be sure, but did not think anyone else had discussed the anti-depressant with Resident #4. When asked the reason Prozac was ordered in the liquid form, the DNS stated, "Resident #4 would not accept it in the pill form." When asked if she had administered the medication to Resident #4 she stated she had. When asked if she had informed Resident #4, and received permission from him, prior to administration of the anti-depressant, she</p>	F 155			

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F 155	Continued From page 8 stated, "I think I just told him here are your medications." Resident #4's right to refuse medication was abridged. He repeatedly refused anti-depressant medication. Facility staff administered an anti-depressant medication to Resident #4 without his consent or knowledge, and after his prior refusals.	F 155			
{F 250} SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based staff interview and record review, it was determined the facility failed to implement social service interventions necessary to meet a resident's psychosocial and mental health needs. This was true for 1 of 6 (#4) residents sampled for social services. The failed practice created the potential for psychosocial harm to Resident #4 due to a lack of social services necessary to effectively monitor and address his depression and anxiety. Findings include: Resident #4 was admitted to the facility on 12/24/15 with multiple diagnoses including dementia without behavioral disturbance. Resident Admission MDS assessment, dated 12/31/15, stated Resident #4 had difficulty	{F 250}	The facility does provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: " On 6/30/16 the facility's Social Worker updated Resident #4 depression care plan to ensure causative factors are included that may elicit the behavior and the depression care plan is updated to include non-drug interventions.	7/5/16	

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{F 250}	<p>Continued From page 9 hearing, usually had the ability to understand others and was understood, and had moderate memory impairment.</p> <p>A Significant Change MDS assessment, dated 3/22/16, documented Resident #4 usually had the ability to understand others and was understood; had some difficulty only in new situations when making decisions related to tasks of daily life; and he had not had a change in his mental status from baseline.</p> <p>Social Services were not provided consistent with Resident #4's psychosocial and mental health needs. Examples include:</p> <p>a. Resident #4's Admission MDS assessment, dated 12/31/15, stated he felt down, depressed, or hopeless; felt tired or had little energy; felt bad about himself; and had trouble concentrating. Specific social service interventions related to Resident #4's depressed mood, feelings of hopelessness, and feeling bad about himself, were not documented.</p> <p>b. A Social Service progress note, dated 3/24/16, a change of condition MDS note, documented Resident #4 was unable to participate in the Brief Interview for Mental Status or mood assessment due to him, "going off on tangents that [had] nothing to do with the questions being asked. Resident's mood seems to be improving from the last two weeks. Resident is eating better and communicating more than before." The note did not describe the tangents or how it was determined Resident #4's mood was improved and he was communicating better.</p>	{F 250}	<p>" On 7/1/16 the facility's Social Worker updated Resident #4 monthly Behavior Monitoring Flowsheets to include the individualized care plan interventions for each behavior being monitored.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, residents that have a diagnosis of depression may have the potential be affected by this deficiency, therefore;</p> <p>" By 6/30/16 the Social Worker or designee will audit depression care plans to ensure causative factors that may elicit the behavior are included and the depression care plan is updated to include non-drug interventions.</p> <p>" By 6/30/16 the Social Worker or designee will audit all depression Behavior Monitoring Flowsheets to ensure that the interventions that are listed in the behavior care plan are included in the depression Behavior Monitoring Flowsheet and update as needed if interventions are unsuccessful.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not</p>		

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{F 250}	<p>Continued From page 10</p> <p>c. An IDT note, dated 3/29/16, documented Resident #4 showed increased signs and symptoms of depression after his MPOA visited from out of state and informed him he would not be returning to his home and would be staying in the facility. The note did not include documentation of non-pharmacological social service interventions to assist Resident #4 with his increased depression.</p> <p>d. On 4/8/16, at 12:15 PM, the consulting LSW documented Resident #4 had little interest in engaging in activities, felt "low/low mood nearly daily (5-6 times a week)," and had feelings of worthlessness and inappropriate guilt. The LSW documented, "He expressed mixed emotions regarding [people close to him] which included anger. He has hopes of living independently which by report does not look possible at this time. Resident reports incidents of poor safety awareness...He would benefit from activities that would stimulate his mind and challenge him mentally if desired by the resident. Also noted slight anxiety with regards to future which should be monitored." From 4/9/16 to 4/27/16, there was no social service documentation in Resident #4's record. Social service interventions to assist Resident #4 with his expressed concerns of worthlessness, inappropriate guilt, anger, and grief related to his inability to return to his home, were not documented.</p> <p>e. Insufficient behavioral data and data analysis:</p> <p>DEPRESSION - Resident #4's clinical record showed he was monitored for depression as evidenced by yelling at others, starting on 3/8/16. Resident #4's depression care plan, dated</p>	{F 250}	<p>recur includes the following:</p> <p>On 6/29/16 a new Behavior Monitoring Flowsheets was created by the IDT.</p> <p>By 6/30/16 the Administrator or designee will provide an inservice to License Nurses on the new Behavior Monitoring Flowsheets.</p> <p>By 6/30/16, the Administrator or designee will provide 1:1 education with the Social Worker regarding F-250 on ensuring the importance of;</p> <p>" That depression care plans include causative factors that may elicit the behavior and the depression care plan is updated to include non-drug interventions.</p> <p>" That depression Behavior Monitoring flowsheets include the interventions that are listed in the behavior care plan and are updated as needed if interventions are unsuccessful.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The IDT or designee will review at least three (3) residents with depression to ensure;</p>		

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{F 250}	<p>Continued From page 11</p> <p>3/8/16, stated Resident #4, "Had a tendency towards depression as manifested by yelling at others, cursing, and demanding verbalizations." Interventions included: Allow Resident #4 to vent and express his feelings and concerns; verbalize and redirect him to another subject; administer medication as ordered; offer him something to eat or drink; and thank him for allowing you talk to him.</p> <p>* A Monthly Behavior Note, dated March 2016 [date/time not specified], indicated Resident #4 was monitored for depression as evidenced by yelling at others. The note stated Resident #4 had 11 documented behaviors between 3/8/16 and 3/31/16 and that, "Redirection and 1:1 were successful at one point. For the most part interventions [toileting, redirection, 1:1, offering food/fluid, and activity proved unsuccessful] proved unsuccessful." There was no documentation in Resident #4's record to indicate interventions were reviewed and revised when the identified interventions were unsuccessful. Further analysis of the data was not documented.</p> <p>* Resident #4's Monthly Behavioral Flowsheet for March 2016 was reviewed. It showed Resident #4 yelled at others during 5 of 72 shifts. The total number of yelling incidents for the 5 shifts was 11. The interventions, outcome, and side effects, were not documented for 2 of the 5 shifts. Of the other 3 shifts, 1 identified the interventions as successful and 2 identified them as unsuccessful.</p> <p>* Resident #4's Monthly Behavioral Monitoring Flowsheet for April 2016 was reviewed. It documented Resident #4 yelled at others during 6 of 90 shifts. There were a total of 16</p>	{F 250}	<p>" That depression care plans include causative factors that may elicit the behavior and the depression care plan is updated to include non-drug interventions.</p> <p>" That depression Behavior Monitoring flowsheets include the interventions that are listed in the behavior care plan and are updated as needed if interventions are unsuccessful.</p> <p>Monitoring will start on 7/4/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The IDT or designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		

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{F 250}	<p>Continued From page 12 documented incidents of yelling at others in April. The behavioral flowsheet documented interventions were successful during each of the 6 shifts.</p> <p>* Resident #4's Monthly Behavioral Monitoring Flowsheet for May 2016 was reviewed. The documentation on the flowsheet showed Resident # yelled at others during 16 of 90 shifts. The number of incidents per shift ranged from 2-20. The total number of yelling incidents during the 16 shifts was 126. The interventions of offering him toileting, redirection, one-to-one staffing, food/fluid, and/or an activity, were documented as unsuccessful for each of the 16 shifts. There was no documentation in Resident #4's record that the non-pharmacological interventions were reviewed and revised when found unsuccessful.</p> <p>* Resident #4's Monthly Behavioral Monitoring Flowsheet for June 2016 was reviewed. It showed Resident #4 did not yell at others during the 7 shift documented 6/1/16 through 6/3/16.</p> <p>* The care plan intervention of allowing Resident #4 to vent and express his feelings and concerns was not included as an intervention option on the March, April, May, and June Monthly Behavioral Monitoring Flowsheets. Use of the intervention was not documented on the flowsheets.</p> <p>ANXIETY - Resident #4's clinical record showed he was monitored for anxiety as evidenced by self-isolation, and making statements or verbalizations of mistrust, starting on 4/13/16. Resident #4's anxiety care plan, initiated on 4/12/16, documented Resident #4 had the</p>	{F 250}			

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{F 250}	<p>Continued From page 13</p> <p>potential for anxiety due to self-isolation and statements or verbalizations of mistrust. Interventions included: one to one visits with the RSC or other department heads to verbalize anxieties; allowing him to verbalize and validate his feelings; encouraging him to leave his room and socialize with other residents; encouraging Resident #4 to participate in activities; and notifying the RSC if he appeared to have increased anxiety. The care plan also stated, "Resident often refuses medication which might increase his anxiety." On 6/1/16, assess need for psychiatric evaluation or social service consult, was added to the list of interventions.</p> <p>* A Monthly Behavior Note, dated April 2016, stated Resident #4 was monitored for anxiety exhibited by self-isolation. He had zero episodes of self-isolation in April. The note stated Resident #4 had 32 incidents of anxiety exhibited by statements or verbalization of mistrust. Further analysis of the data was not documented.</p> <p>* Resident #4's Monthly Behavioral Monitoring Flowsheet for April 2016, was reviewed. Zero incidents of anxiety exhibited by self-isolation were documented during the 54 shifts (4/13/16-4/30/16). Resident #4 exhibited anxiety by statements or verbalizations of mistrust during 9 of 54 shifts. The frequency of the statements or verbalizations ranged from 1-10. The total number of incidents during the 16 shifts was 32. Four of the 9 shifts, documented improved behavior when redirection was initiated. Five of the 9 shifts documented all interventions attempted were unsuccessful. The successful interventions were documented on the evening shift. The unsuccessful interventions were</p>	{F 250}			

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{F 250}	<p>Continued From page 14 documented in the day shift.</p> <p>* Resident #4's Monthly Behavioral Monitoring Flowsheet for May 2016 was reviewed. It documented anxiety exhibited by self-isolation during 5 of 90 shifts. A total of 13 incidents of self-isolation were documented during the 5 shifts. Resident #4 exhibited anxiety by statements or verbalizations of mistrust during 21 of 90 shifts. The frequency of the statements or verbalizations ranged from 2-20 per shift. The flowsheet documented 152 incidents of anxiety exhibited by statements or verbalizations of mistrust. All incidents were documented from 5/1/16 to 5/18/16. Documentation for each of the 21 shifts showed interventions were unsuccessful. Interventions attempted were offering toileting, redirection, 1:1 staffing, offering food/fluid, and/or an activity.</p> <p>* Resident #4's Monthly Behavioral Monitoring Flowsheet for June 2016 was reviewed. The flowsheet showed Resident #4 did not self-isolate or make statements or verbalizations of mistrust during the 7 shift documented 6/1/16 through 6/3/16.</p> <p>* The care plan intervention of allowing Resident #4 to verbalize and validating his feelings was not included as an intervention option on the March, April, May, and June Monthly Behavioral Monitoring Flowsheets. Use of the intervention was not documented on the flowsheets.</p> <p>The behavioral data for Resident #4 related to depression exhibited by yelling, and anxiety exhibited by self-isolation and statements or verbalizations of mistrust, did not include</p>	{F 250}			

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{F 250}	<p>Continued From page 15</p> <p>documentation of what was occurring prior to each of the incidents. Up to 20 incidents of the behaviors were documented per shift. The effectiveness of the interventions, however, was documented once per shift. The interventions used, and the effectiveness of the intervention(s) for each incident, were not documented. The data did not indicate if the incidents per shift occurred within a short time span or were exhibited repeatedly throughout the shift. The behavioral data did not provide information necessary to determine causative factors that may have elicited the behaviors, such as staff interactions, reactions to specific staff, or unmet psychosocial or physical needs. Data necessary to develop individualized interventions for reducing or eliminating the behaviors of yelling at others, self-isolation, and statements or verbalizations of mistrust, was not documented.</p> <p>Social Service notes did not include documentation of analysis of the behavioral data to identify potential triggering events for the documented behaviors, such as falls, changes in mental and/or physical condition, initiation of medication or medication changes, visits from family, significant life changes, roommate changes, etc.</p> <p>The Administrator was interviewed on 6/2/16 at 10:20 am. The Administrator stated a change in behavior or depression warranted a referral to the social service consultant. The Administrator stated an interview with Resident #4 or formal evaluation to determine the stability of his mood was not completed. The Administrator was asked how a determination of self-isolation was determined, as Resident #4 engaged in similar</p>	{F 250}			

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{F 250}	Continued From page 16 behavior while living at home. The Administrator stated a formal assessment was not completed to determine the stability of a resident experiencing depression. She stated she reviewed the resident's care plan to ensure it included non-pharmacological interventions, reviewed physician orders, and reviewed behavior monitoring flow sheets. The Administrator stated the social worker did not attend, and had not been invited to attend, psychotropic drug review meetings.	{F 250}			
{F 431} SS=D	The facility failed to ensure Resident #4 received social services necessary to meet his psychosocial and mental health needs. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	{F 431}		7/5/16	

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{F 431}	<p>Continued From page 17 have access to the keys.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and policy review, it was determined the facility failed to ensure a schedule IV controlled medication was tracked and disposed of appropriately for 1 of 6 sample residents (#4). Failure to account for and dispose of Ativan created the potential for diversion of the medication and negative outcomes for Resident #4 or other residents. Findings include:</p> <p>Resident #4 was admitted to the facility on 12/24/15 with multiple diagnoses including squamous cell carcinoma of the face.</p> <p>Resident #4's clinical record contained two physician's orders for liquid Ativan by mouth and one order to discontinue the medication.</p> <p>A 5/2/16 order documented the Ativan was to be administered daily as needed for 10 days. An unsigned and undated handwritten note on the order documented, "17 doses not days</p>	{F 431}	<p>The facility does ensure that controlled medications are tracked and disposed of appropriately.</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>" On 6/7/16 the unused Liquid Ativan medication, that was returned from pharmacy, was destroyed by two RNs.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, other residents who have an</p>		

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{F 431}	<p>Continued From page 18 clarification received".</p> <p>A 5/16/16 order documented the liquid Ativan was to be administered daily as needed for 17 doses.</p> <p>A 6/2/16 Physician Telephone Order discontinued the Ativan due to non use.</p> <p>On 6/3/16 at 12:00 pm, the DNS said a controlled substance record for Resident #4's Ativan was not created when the medication was received on 5/4/16. The DNS said the Ativan was not administered to Resident #4 and the unopened bottle of Ativan was returned to the pharmacy in late May. The DNS was asked to provide proof of the disposition of Resident #4's Ativan and the facility's P & P regarding controlled medications.</p> <p>On 6/3/16 at 12:13 pm, RPh #1 returned a call to the surveyor and said Resident #4's unopened bottle of Ativan was found in a refrigerator in the pharmacy. The RPh said there was no signature, no date, and no paper trail of why the Ativan was returned to the pharmacy. The RPh said that narcotics cannot be returned and the pharmacy would send the Ativan back to the facility to be destroyed.</p> <p>On 6/3/16 at 12:15 pm, the DNS provided a record, signed by a facility nurse, that Resident #4's Ativan was delivered to the facility on 5/4/16. The DNS said she did not find any other records to account for the Ativan. The DNS also provided the Pharmacy & Nursing Home P & P, which included:</p> <p>* Documentation of Controlled Substances - "The</p>	{F 431}	<p>order for Liquid Ativan may be affected by this deficiency, therefore;</p> <p>" By 6/30/16, the Clinical Case Manager/Staff Development Coordinator will audit all Liquid Ativan orders to ensure that they are logged in the Controlled Substance Record log and unused bottles are disposed of appropriately.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>" On 6/30/16 the Administrator provided 1:1 education to the Director of Nursing regarding F-431 on ensuring all liquid Ativan orders are logged in the Controlled Substance Record log and unused bottles are disposed of appropriately.</p> <p>" By 6/30/16 the Clinical Case Manager/Staff Development Coordinator will inservice all License Nurses regarding F-431 on ensuring all liquid Ativan orders are logged in the Controlled Substance Record log and unused bottles are disposed of appropriately.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>" The Clinical Case Manager/Staff Development Coordinator or License</p>		

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{F 431}	<p>Continued From page 19</p> <p>'controlled substances record' refers to the document(s) utilized to track controlled substances on a shift to shift basis from the point of receipt through destruction/discharge. These documents may be referred to as a 'controlled substances book' or 'proof of use sheet'. Procedure: 1. The Director of Nursing Services is responsible for the Controlled Substances Record... 3. As received, and as required by law, the controlled substances are logged into the Controlled Substances Record or similar log at the respective nursing station. 4. An up-to-date index is kept as part of each Controlled Substances Record... 5. Controlled substances should not be returned to the pharmacy..."</p> <p>* Credits For Returned Medication (Where Allowed by State Law) - "...Credit will NOT be given in the following circumstances: a... b. When medications are not documented on a delivery manifest or medication disposition form... g. Controlled substances. h. Any liquid or topical..."</p> <p>* Discontinued Medications: Segregation, Record Keeping, and Disposal - "...Discontinued, controlled/scheduled medications may not be returned to the pharmacy..."</p> <p>The facility failed to track and account for Resident #4's Ativan.</p>	{F 431}	<p>Nurse designee will review at least three (3) Liquid Ativan orders to ensure they are logged in the Controlled Substance Record log and unused bottles are disposed of appropriately.</p> <p>Monitoring will start on 7/4/16. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Clinical Case Manager/Staff Development Coordinator or License Nurse designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001590	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/03/2016
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{C 000}	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the revisit survey conducted June 1, 2016 to June 3, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Amy Barkley, RN, BSN Jenny Walker, RN</p> <p>Abbreviations include: DNS = Director of Nursing Services IDT = Interdisciplinary Team LN = Licensed Nurse LSW = Licensed Social Worker MD = Medical Doctor MDS = Minimun Data Set MMSE = Mini Mental State Examination mg = Milligram(s) mL = MilliLiter(s) P & P = Policy(ies) and Procedure(s) RPh = Registered Pharmacist RSC = Resident Services Coordinator</p>	{C 000}		
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE
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