



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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July 1, 2016

James Vorous, Administrator
Clearwater Health & Rehabilitation
1204 Shriver Road
Orofino, ID 83544-9033

Provider #: 135048

FILE COPY

Dear Mr. Vorous:

On **June 10, 2016**, a survey was conducted at Clearwater Health & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements.

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 **July 11, 2016**. Failure to submit an acceptable PoC by **July 11, 2016**, may result in the imposition of civil monetary penalties by **August 3, 2016**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- **A civil money penalty of \$1,500 per instance.**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 10, 2016**, if substantial compliance is not achieved by that time. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the

James Vorous, Administrator
July 1, 2016
Page 3 of 3

PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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

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

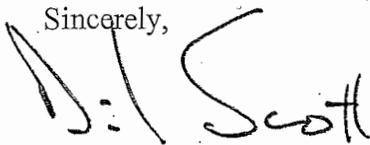
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **July 11, 2016**. If your request for informal dispute resolution is received after **July 11, 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,



David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 07/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2016
NAME OF PROVIDER OR SUPPLIER CLEARWATER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Federal recertification and complaint survey of your facility conducted from June 5, 2016 to June 10, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Evelyn Floyd, JD, MS, RN, Team Coordinator Sherrie McElwain, RN</p> <p>Survey Abbreviations and Definitions:</p> <p>ADL = Activities of Daily Living CAT = categories cc = cubic centimeter CNA = Certified Nursing Assistant CVA = Cerebral Vascular Accident DCS = Director of Clinical Services E = Employee g = grams I&A = Incident and Accident Report ICD = International Coding of Diseases IDCS = Interim Director of Clinical Services IDT = Interdisciplinary Team Kcal = Calories lbs. = pounds LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set Assessment Med Pass = Fortified Nutritional Shakes ml = milliliter mg = milligram OT = Occupational Therapy PT = Physical Therapy RNP = Restorative Nursing Program ROM = Range of Motion SBAR = Situation, Background, Assessment and</p>	F 000	<p>This Plan of Correction does not constitute an agreement by the provider of facts or conclusions set forth in this Statement of Deficiencies. The Plan of Correction is prepared solely because it is required by Federal and State law.</p> <p style="text-align: center;">RECEIVED JUL 08 2016 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 7/8/16

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

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F 000 F 155 SS=D	Continued From page 1 Recommendation form 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 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure advance directives were honored for 1 of 11 residents reviewed for advance directives (#11). This resulted in Resident #11 receiving therapies averse to his advance directives. Findings include: Resident #11 was admitted on 2/11/16 on comfort measures. The National Institute on Aging	F 000 F 155	Element #1 Resident #11 no longer resides in the facility Element #2 The Social Services Director reviewed current facility residents Advanced Directives to include the POSTS (Idaho Specific Do not Resuscitate) to ensure resident's wishes were clearly marked on the form. The facility will speak with the resident and/or Responsible party prior to initiating antibiotic therapy or other treatment that is different from the Idaho Physician Orders for Scope of Treatment (POST) and document if the resident and/or Responsible party wishes to receive the treatment.	7/25/16	

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F 155	<p>Continued From page 2</p> <p>website, accessed on 6/22/16, describes comfort care as, "Comfort care is care that helps or soothes a person who is dying. The goal is to prevent or relieve suffering as much as possible while respecting the dying person's wishes."</p> <p>On 2/10/16, Resident #11's power of attorney and physician signed an Idaho Physician Orders for Scope of Treatment (POST). The POST documented Resident #11 did not want resuscitation, was on comfort measures and did not want artificial fluids, nutrition, antibiotics or blood products. Resident #11's medical record did not contain documentation that a medical power of attorney had been designated.</p> <p>The facility's Advance Directives Policy, dated 7/2013, stated, "The facility Social Service staff will abide by resident advance directives, if known."</p> <p>On 5/21/16, a Physician Order for an antibiotic was documented. The order stated "Levaquin 750 mg now and 500 mg once a day for 10 days."</p> <p>IDT notes from 5/23/16-6/3/16, documented Resident #11 was receiving antibiotic treatment without any signs or symptoms of adverse reactions.</p> <p>On 6/9/16 at 5:30 pm, the DCS and RNC stated Resident #11 received antibiotic treatment for an upper respiratory infection. They stated they did not know the reason Resident #11's advance directives for no antibiotics was not followed.</p> <p>On 6/10/16 at 11:00 am, the Medical Director stated Resident #11 had changed his mind about receiving antibiotics, but he (the Medical Director)</p>	F 155	<p>Element #3</p> <p>The Licensed Nurses were re-educated to ensure he/she speaks with the resident and/or Responsible party prior to initiating antibiotic therapy or treatment that is different from the POST and document if the resident and/or Responsible party wishes to receive the treatment.</p> <p>Element #4</p> <p>The Director of Clinical Services or designee will QA residents with a physician's order for antibiotic therapy or treatment that is different from the POST to ensure resident's wishes are followed and documentation is completed as appropriate during the Daily Clinical Meeting 3-5 times weekly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.</p>		

F-155 Right to refuse treatment (Advanced Directives) – addendum to element 4

IDT will review current resident's orders and progress notes at the daily clinical meeting. New orders will be reviewed against the resident's POST to ensure their wishes are followed and documented. Discrepancies will be brought to the attention of the physician, resident, and responsible party to clarify resident's wishes.

RECEIVED
JUL 13 2016

FACILITY STANDARDS

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F 155	Continued From page 3 had not documented the conversation with Resident #11.	F 155		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157	Element #1 Resident #10 no longer resides at the facility. Element #2 The facility will ensure the Responsible Party is notified when a resident experiences a change in condition or injury and documentation is completed. If initial attempts to contact the Responsible Party fails then the Licensed Nurse will pass on to next shift and he/she will continue to attempt to reach responsible party until successful; if still unsuccessful a Registered Letter will be sent to the Responsible Party to contact the facility.	7/25/16

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F 157	Continued From page 4 by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a resident's family and physician were notified immediately of an accident with injury. This was true for 1 of 7 residents reviewed for family notification of injuries (#10). This failed practiced resulted in Resident #10's family not knowing the resident had sustained an injury, which subsequently required transport to a hospital emergency room. Findings include: Resident #10 was admitted on 6/19/11 with diagnoses which included dementia, and osteoporosis. Review of facility's Change in Resident Condition policy, dated 11/30/14, documented the charge nurse was responsible to contact the agent/surrogate/contact person and physician when a resident experienced a change of condition, such as an accident and incident. An IDT Progress Note, dated 5/15/15 at 9:30 am, documented Resident #10 had bumped her left foot against the bookcase while being wheeled in her wheelchair. An IDT Progress Note, documented on 5/16/15 at 8:00 am, stated Resident #10 complained of left leg pain. Pain medication was administered. An IDT Progress Note, dated 5/17/15, documented Resident #10 complained of left leg pain when bending her knee and when touched. At 11:20 am, she was transported to a hospital emergency room for evaluation. On 5/17/15 at 11:30 am, a message was left for Resident #10's family to call the facility. At 1:00 pm, Resident #10's family called the facility and was notified of the 5/15/15 accident.	F 157	Element #3 Licensed Nurses were re-educated regarding expectations of documentation and notification when there is a change in condition or injury. If initial attempts to contact the Responsible Party fails then the Licensed Nurse will pass on to next shift and he/she will continue to attempt to reach responsible party until successful; if still unsuccessful a Registered Letter will be sent to the Responsible Party to contact the facility. Element #4 The Director of Clinical Services or designee will QA residents who have a change in condition or injury to ensure the Responsible Party has been notified or a Registered Letter has been sent as appropriate during the morning clinical meeting 3-5 times weekly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.		

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F 157	Continued From page 5	F 157			
F 222 SS=D	<p>On 6/7/16 at 3:40 pm, the DCS and RNC stated an accident or incident required the nurse to complete an I&A packet and notify the physician and family of the resident involved.</p> <p>483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS</p> <p>The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>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 resident was free from chemical restraints. This was true for 1 of 3 residents (#12) sampled for antipsychotic medication use. This resulted in Resident #12 being prescribed and administered an antipsychotic as a chemical restraint to prevent her from wandering and eloping from the facility. Findings include:</p> <p>Resident #12's medical record documented she was originally admitted to the facility on 3/18/16, with a diagnosis of Dementia. An Elopement Risk Evaluation completed for Resident #12, dated 3/18/16, documented she was "determined to be AT RISK for elopement."</p> <p>Resident #12's Admission Care Plan, dated 3/18/16, included: Falls/Safety/Elopement Risks - The goal was for Resident #12 to remain free of injuries and falls. A handwritten entry stated "Elopement initiated."</p>	F 222	<p>Element #1 Resident #12 no longer resides in the facility.</p> <p>Element #2 Currently facility resident's antipsychotic medications were reviewed to ensure medications were being used as appropriate and with appropriate diagnosis.</p> <p>Element #3 The Interdisciplinary Team and Licensed Nurses were re-educated to ensure antipsychotic medications prescribed are used as appropriate and with appropriate diagnosis.</p>	7/25/16	

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F 222	Continued From page 6 A Behavior symptom Monitoring Flow Record, dated March, 2016, documented the behavior of "Wandering-Elopement," with the following interventions: * Pharmacologic Intervention: Seroquel. (antipsychotic medication) * Non-pharmacologic Interventions: re-orient; redirect with an activity such as knitting, coffee; reassure her she is ok and that her children are ok; and 15 min. checks (line of sight). Daily Skilled Nurse Notes, dated 3/20/16, documented Resident #12 was "easily redirected." A Daily Skilled Nurse Note, dated 3/21/16, documented Resident #12 was "re-directable." An IDT Progress Note, dated 5/3/16, stated, "Goes out front door. Must be directed back into facility. Redirects well." The facility initiated the use of an antipsychotic medication, Seroquel, in lieu of staff supervision.	F 222	Element #4 The Director of Clinical Services will QA resident antipsychotic medications to ensure they are used appropriately and with appropriate diagnosis weekly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by:	F 223	Element #1 Resident #4 was interviewed by the Social Services Director and feels safe in the facility. The Agency Nurse (LN #5) no longer works at the facility.	7/25/16

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F 223	<p>Continued From page 7</p> <p>Based on observation, resident and staff interview, and review of medical records, the facility failed to ensure residents were provided an environment free from abuse, intimidation, and free of harm. This was true for 1 of 3 residents (#4) reviewed for abuse. This resulted in Resident #4 being forced to urinate in her pants while a nurse performed a wound debridement procedure against her will. Findings include:</p> <p>An observation and interview was completed with Resident #4 on 6/6/16 at 11:20 am. Resident #4 was observed to be alert and oriented and sitting in a wheelchair in her room reading the newspaper. During the interview, Resident #4 was questioned as how the facility encourages her to do as much as she can for herself. Resident #4 made the statement, "Yes (staff) take me to the bathroom and I call for them to come help (her out of bathroom)." Resident #4 continued to state, "I can take care of things (toileting) except the night that the nurse had them hold my leg. I kept telling them I had to go to the bathroom. She (nurse) told me to shut up and I had no choice but wet the bed."</p> <p>Resident #4's Quarterly MDS assessments, dated 1/5/16 and 2/9/16, documented she was cognitively intact. The assessments documented there were no behaviors demonstrated by Resident #4 and she was continent of bladder.</p> <p>A Witness Statement, dated 2/29/16, documented an incident that occurred on 2/26/16 with Resident #4. The statement documented that Resident #4 was held down against her will, while a nurse performed debridement of a wound on Resident #4's right leg. E #9, who indicated she was present during the incident, documented the</p>	F 223	<p>Element #2 Current facility residents with a BIMs score of 12 or greater were interviewed by the Social Services Director or designee to ensure residents feel safe in the facility. The facility will ensure residents are not treated against his/her or Responsible Party's wishes.</p> <p>Element #3 Facility staff were re-educated on the Abuse Policy and Procedure with an emphasis on not treating residents against his/her or Responsible Party's wishes and reporting incidents of abuse immediately to his/her supervisor and when abuse involves a supervisor to call the Executive Director and/or the Director of Clinical Services.</p>		

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F 223	Continued From page 8 following statement, "I participated in the wrapping of resident (Resident #4's) leg with Agency Nurse (LN #5) and another (E #8). This procedure took a lot of time and (E #9 and E #8) had to take turns holding (Resident #4's) leg so the nurse could have access to the wound. The procedure took so long and it was making (Resident #4's) angry and she needed to use the bathroom the whole time, but didn't say anything and consequently wet her pants. She (Resident #4) could not understand why the nurse was doing the procedure and it made her upset." During a meeting with the Administrator, the IDCS, and the DCS, on 6/9/16 at 5:30 pm, the IDCS verified Resident #4 was continent of bladder and was not allowed to go to the bathroom while the nurse performed a new wound care procedure that took over 1 hour to complete.	F 223	Element #4 The Executive Director or designee will QA through interview with residents to ensure the resident feels safe and are not receiving treatment against his/her or the Responsible Party's wishes 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225	.		

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F 225	<p>Continued From page 9</p> <p>including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of personnel records, the facility failed to perform a thorough background investigation before hiring 1 of 12 employees (LN #5) whose personnel records were reviewed. This created the potential for an employee with a history of abuse, neglect, and/or mistreatment to have direct contact with residents. Findings include:</p> <p>During an interview with the Administrator on 6/8/16 at 4:00 pm, the Administrator demonstrated understanding of the importance of procuring proof of a thorough criminal history background check before before hiring an employee who would have direct contact with</p>	F 225	<p>Element #1 The Agency Nurse (LN #5) no longer works at the facility.</p> <p>Element #2 Facility staff employee records were reviewed by the Human Resource Director and each employee has had a Criminal History Background Check completed. The facility will ensure facility staff will have a Criminal History Background Check completed prior to working in the facility.</p> <p>Element #3 Department Managers were re-educated to ensure that an employee has a complete Criminal History Background Check completed prior to working in the facility.</p>	7/25/16	

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F 225	Continued From page 10 residents. Personnel files were reviewed. LN #5's file did not include evidence of a criminal history background check. LN #5's file did not include a hire or termination date. On 6/9/16 at 6:15 pm, the Administrator provided a standard background check for LN #5 from the contract company she was employed by. The background check was obtained from the company during the survey. The facility failed to ensure a contract staff's background check met Idaho's state law requirements. On 6/9/16 at 6:15 pm, the Administrator stated LN #5 no longer worked for the facility. The Administrator was unable to provide evidence that a background check was completed for LN #1 prior to her date of hire. LN #5's dates of hire and termination were not provided.	F 225	Element #4 The Executive Director or designee will QA new employee files to ensure he/she has had a complete Criminal History Background Check completed prior to working in the facility weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.		
F 241 SS=D	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, staff and resident interview, and review of the medical records, it was determined the facility failed to ensure the dignity of residents was promoted and residents were provided care to maintain their dignity. This was true for 3 of 9 sampled residents residing in the facility (#5, #8, and #9). This resulted in lack	F 241	Element #1 Residents #5, 8, & 9 have been shaved. Care Plans and Kardexes have been reviewed and updated as appropriate. CNA #8, LN #2, LN #4 were re-educated to ensure residents receive appropriate grooming with an emphasis on ensuring resident facial hair is removed as appropriate. Resident #4 was interviewed by the Executive Director and had no additional concerns. There have	7/25/16	

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F 241	<p>Continued From page 11 of grooming for three women noted to have long facial hair. Findings include:</p> <p>1. Resident #5's Nurse Tech Information Kardex did not specify shaving was to be performed. An MDS assessment, dated 3/27/16, documented Resident #5 was totally dependent on staff for bathing and grooming. The assessment documented Resident #5 was rarely or never understood, and was not interviewable. During the survey, there was no family present for an interview.</p> <p>Resident #5, an elderly woman, was observed on 6/5/16 at 6:15 pm, sitting in the dining room waiting for the evening meal along with other residents. There was noticeable facial hair beneath her nose and on her chin. Resident #5 was observed on 6/6/16 at 8:00 am, sitting in the dining room awaiting breakfast with the other residents. She continued to have obvious hair beneath her nose and on her chin. Resident #5 was observed on 6/7/16 at 8:30 am, sitting in the dining room with other residents eating breakfast. Resident #5 had obvious hair growth beneath her nose and on her chin. Resident #5 was observed on 6/8/16 at 5:30 pm sitting near the nurses' desk as other residents and visitors walked by. She had facial hair growth beneath her nose and her chin.</p> <p>During an interview on 6/8/16 at 5:15 pm, CNA #8 stated she was aware the instructions for patient care were on the Nurse Tech Information Kardex. CNA #8 stated that she "shaves or plucks facial hair," when she performs residents' personal care. An interview with LN #2 and LN #4 confirmed Resident #5 had facial hair that required shaving by the CNAs. LN #2 and LN #4</p>	F 241	<p>been no further issues or concerns with her care and she feels safe in facility.</p> <p>Element #2 Current facility residents were reviewed by the Director of Clinical Services or designee and received grooming as appropriate. Care Plans and Kardexes have been reviewed and updated as appropriate. The facility will ensure residents are groomed as appropriate. Current facility residents with a BIMs score of 12 or greater were interviewed by the Social Services Director or designee to ensure residents feel safe in the facility. The facility will ensure residents are not treated against his/her or Responsible Party's wishes.</p> <p>Element #3 Licensed Nurses and Certified Nursing Assistants were re-educated to ensure residents receive appropriate grooming with an emphasis on ensuring resident facial hair is removed as appropriate.</p>		

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F 241	<p>Continued From page 12</p> <p>both stated that they were unsure if shaving the facial hair was directed on the Nurse Tech Information Kardex.</p> <p>2. Resident #9's Nurse Tech Information Kardex , documented a checkmark beside the direction for "shaving." Resident #9's MDS assessment, dated 4/27/16, documented she required extensive assistance with bathing and grooming.</p> <p>Resident #9 was observed, on 6/7/16 at 10:00 am, in a wheelchair in a hallway where residents and visitors passed by. Resident #9 had noticeable hair beneath her nose and on her chin. When Resident #9 was asked whether she would like it removed, she nodded her head, "yes." On 6/8/16 at 11:17 am, Resident #9 was observed in her wheelchair in the activity room watching a movie with other residents. She continued to have noticeable facial hair beneath her nose and on her chin.</p> <p>During an interview on 6/8/16 at 5:15 pm, CNA #8 stated she was aware the instructions for patient care were on the Nurse Tech Information Kardex. CNA #8 stated that she "shaves or plucks facial hair," when she performs residents' personal care. An interview with LN #2 and LN #4 confirmed Resident #9 had facial hair that required shaving by the CNAs. LN #2 and LN #4 both stated that they were unsure if shaving the facial hair was directed on the Nurse Tech Information Kardex.</p> <p>3. Resident #8 was admitted to the facility on 3/1/12, with diagnoses which included mild mental retardation and epilepsy. On 6/6/16 at 8:30 am, Resident #8, a woman, was observed in the A hallway with long facial hair. On 6/7/16 at 10</p>	F 241	<p>The Interdisciplinary Team was re-educated to ensure residents have received appropriate grooming while conducting daily rounds and to notify the Certified Nursing Assistant caring for the resident when a resident needs grooming. Facility staff were re-educated on the Abuse Policy and Procedure with an emphasis on not treating residents against his/her or Responsible Party's wishes and reporting incidents of abuse immediately to his/her supervisor and when abuse involves a supervisor to call the Executive Director and/or the Director of Clinical Services.</p> <p>Element #4</p> <p>The Director of Clinical Services or designee will QA residents to ensure residents are properly groomed 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.</p>		

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F 241	Continued From page 13 am, Resident #8 was observed in the dining room with long facial hair. On 6/8/16 at 7:55 am, Resident #8 was observed in the dining room with long facial hair.	F 241	Element #1 Resident #3 no longer resides in the facility.	7/25/16
F 246 SS=G	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff, family member, and resident interviews, it was determined the facility failed to ensure residents had access to, and the ability to use, a call light. This was true for 1 of 9 sampled residents (#3) residing in the facility. The deficient practice resulted in Resident #3 being unable to alert staff of pain or other needs. Findings include: Resident #3 was admitted to the facility on 12/11/14, with diagnoses which included malignant neoplasm (cancerous tumor that tends to grow, invade, and metastasize) breast cancer, DM II, heart disease, CVA and dysphasia (difficulty with swallowing). Resident #3's history and physical, dated 12/08/14, documented Resident #3 had a history of dementia, anxiety, CVA with left side hemiparesis, and had received chemotherapy for	F 246	Element #2 Residents were reviewed by the Director of Clinical Services or designee and no adverse effects were noted r/t the potential of not having the call light within reach. The facility will ensure resident call lights are within reach of the resident when in his/her room. Element #3 Facility staff was re-educated to ensure resident call lights are within reach of the resident when the resident is in his/her room.	

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F 246	<p>Continued From page 14 breast cancer.</p> <p>Resident #3's Quarterly MDS assessment, dated 5/19/16, documented Resident #3 was severely cognitively impaired and totally dependent for mobility, eating and all cares.</p> <p>Resident #3's Care Plan, revised 8/20/15, identified her as requiring assistance with all ADL's. Interventions included placing the call light within reach and answering the call light promptly.</p> <p>On 6/6/16 at 7:00 am, Resident #3 was observed in bed moaning and crying out. At that time, her husband stated his wife was, "in a lot of pain." Resident #3's push button call light was observed to be over the corner of the upper left side of the bed mattress, above Resident #3's affected left side, and out of the reach of her right hand and arm. At 11:30 am, Resident #3 continued to moan and cry out. Resident #3's call light remained on her left side out of reach. At 2:35 pm, Resident #3's call light was observed hanging over the upper left corner of the mattress, out of her reach.</p> <p>On 6/7/16 at 8:15 am, Resident #3 was observed crying out. Her call light was observed placed to the upper left side of the bed by her head and out of reach of Resident #3's right hand. At 12:15 pm, Resident #3's call light was observed in the same position as the previous observation at 8:15 am.</p> <p>On 6/7/16 at 4:30 pm, Resident #3 was asked if she could reach her call light or knew where it was. Resident #3 stated, "I don't know...I don't know."</p> <p>On 6/8/16 at 2:30 pm, Resident #3's husband was asked if his wife could use her call light. He</p>	F 246	<p>Element #4</p> <p>The Executive Director or designee will QA residents when in his/her room to ensure his/her call light is within reach 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.</p>		

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F 246	Continued From page 15 stated he was unsure if she could reach or use the call light. He said he did not recall the last time she had called for help. He stated he often pushed his call light to get help for his wife. On 6/9/16 at 7:45 am, Resident #3's call light was observed flipped back over her pillow and hanging off the front end of the bed out of her reach. At 2:15 pm, Resident #3's call light was observed on the top of her pillow to the right of her head. Resident #3 stated she "I don't know," when asked where her call light was. On 6/9/16 at 5:30 pm, the IDCS and DCS stated Resident #3 could use her right hand and Resident #3's husband often called for help for his wife.	F 246			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272	Element #1 Resident #3 and #10 no longer reside in the facility. The IDCS no longer works at the facility. Element #2 Current facility residents MDS' were reviewed for accuracy and corrected as appropriate.	7/25/16	

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F 272	Continued From page 16 Continance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, family, and staff interviews, it was determined the facility failed to ensure residents' MDS assessments accurately assessed and identified issues related to weight and skin integrity. This was true for 2 of 9 residents, (#3 and #10) whose MDS assessments were reviewed. The deficient practice resulted in an MDS assessment of Resident #3 which did not accurately reflect her significant weight loss and diagnoses. It also resulted in an MDS assessment for Resident #10 which incorrectly documented that she did not have a pressure ulcer. Findings include: 1. Resident #3 was admitted to the facility on 12/11/14 with diagnoses which included	F 272	Element #3 The MDS Coordinator was re-educated to ensure MDS' accurately reflect the resident's condition Element #4 The Director of Clinical Services will QA MDS' to ensure Pressure Ulcers and Weight loss is accurately coded 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.		

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F 272	<p>Continued From page 17</p> <p>malignant neoplasm breast cancer, diabetes, heart disease, cerebral vascular accident, and dysphasia (difficulty with swallowing).</p> <p>An Admission Nutritional Evaluation, dated 12/11/14, documented Resident #3 weighed 137 lbs.</p> <p>Resident #3's Admission MDS assessment, dated 12/18/14, documented she was moderately cognitively impaired and was totally dependent on staff for eating. Resident #3's admission weight was 135 lbs. The MDS assessment documented Resident #3 did not have a condition or disease that may result in a life expectancy of less than 6 months, was not on hospice care, and did not have a diagnosis of malnutrition.</p> <p>On 4/21/15, a Physician Progress Note documented palliative care for Resident #3 and a diagnosis of chronic pain syndrome.</p> <p>"Palliative care is when a resident has reached a stage in their illness in which cure is no longer possible or when they refuse further treatment. Palliative care does not mean nothing more will be done...Palliative care is actually aggressively planned comfort care." Treas, L. S. & Wilkinson, J. M. (2014). Basic Nursing: Concepts, Skills & Reasoning. F.A. Davis Company: Philadelphia.</p> <p>Resident #3's record included a Nutritional Review, dated 9/15/15, which documented Resident #3 weighed 105.8 lbs on 6/2/15.</p> <p>Resident #3's Quarterly MDS assessment, dated 6/8/15, documented her most recent weight in the last 30 days was 135 lbs. The MDS assessment documented the response to whether Resident</p>	F 272			

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F 272	<p>Continued From page 18</p> <p>#3 experienced a weight loss of 5% or more in the last month or 10% or more in last 6 months, was "no or unknown." The MDS assessment did not reflect Resident #3's documented weight of 105.8 lbs on 6/2/15, a loss of 31.2 lbs (22.7%) since her since admission on 12/11/14, or 29.2 lbs (21.6%) since the 12/18/15 Admission MDS assessment.</p> <p>On 12/29/15, malnutrition was identified on Resident #3's care plan and the intervention of clear Ensure to be provided three times a day on Resident #3's room tray and per her request, was added.</p> <p>A Physician Progress Note in Resident #3's record, dated 5/4/16, documented palliative care, skin ulcer and cachexia (general physical wasting with loss of weight and muscle mass due to a disease).</p> <p>Resident #3's Quarterly MDS assessment, dated 5/19/16, documented Resident #3 was severely cognitively impaired, totally dependent on others for mobility, eating and all cares. The MDS assessment documented Resident #3's most recent weight in the last 30 days was 135 lbs. The assessment documented Resident #3 did not have a condition or disease that may result in a life expectancy of less than 6 months, was not on hospice care, and did not have a diagnosis of malnutrition. The assessment did not document additional diagnoses of palliative care and cachexia, as noted in prior Physician Progress Notes on 4/21/15 and 5/4/16.</p> <p>On 6/6/16 at 2:35 pm, Resident #3 was observed lying in bed. She was observed to be extremely thin and contractures of one arm and both legs</p>	F 272		

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F 272	<p>Continued From page 19 were noted.</p> <p>On 6/9/16 at 5:00 pm, the RD stated Resident #3's weight on the MDS assessment was the admission weight, since Resident #3 had not been weighed since admission.</p> <p>Resident #3's Quarterly MDS assessments did not accurately document her weight, diagnoses, and physical status.</p> <p>b. On 4/2/16 a Braden Pressure Sore Risk Assessment identified Resident #3 as at risk for pressure sores.</p> <p>Resident 3's Quarterly MDS assessment, dated 5/19/16, documented Resident #3 was severely cognitively impaired, totally dependent on others for mobility, eating and all cares. The MDS assessment documented Resident #3 was at risk for pressure ulcers, did not have any stageable pressure ulcers, and had one unstageable pressure ulcer. The dimensions of Resident #3's stage IV pressure ulcer or eschar was 3.5 cm x 4.0 cm. The assessment documented Resident #3 had pressure relieving devices on her bed and chair, was on a turning program (repositioning to prevent pressure ulcers), and had nutrition and hydration interventions to manage skin problems.</p> <p>On 6/5/16 a Non-Pressure Skin Condition Record documented a 1.2 x 2.5 x 0.1 reddened area to the right side of Resident #3's back, and two areas on her right hip measuring 0.5 x 0.3 x 0.1 and 1.3 x 1.5 x 0.1.</p> <p>On 6/6/16 at 2:35 pm, Resident #3 was observed to have approximately a 2 cm x 2 cm stage II open area on her right side, mid-back over a rib</p>	F 272			

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F 272	<p>Continued From page 20</p> <p>adjacent to her back bone, and approximately a 1 cm x 1 cm stage II open area directly on the end of her coccyx. An approximately 1 cm x 3 cm elongated open area extended upward from the open area on the coccyx. Resident #3's left large toe metatarsal had a large black eschar area. Resident #3's left hip had a reddened areas over her hip bone and ilium crest. LN #3 stated the area on the back of Resident #3 had not been identified as a pressure sore, but as a scratch. LN #3 stated it did not matter whether the area was identified as a scratch or pressure sore, the treatment was the same per Resident #3's physician. Resident #3 did not attempt to scratch at the open area on her back rib during the observation.</p> <p>On 6/8/16 at 11:15 am, the IDCS stated she had made the decision not to distinguish between pressure sores and non-pressure sores. The IDCS stated the treatment would be the same for either per the physician and, therefore, the facility did not want to cause Resident #3 more discomfort by measuring the wound weekly. The IDCS confirmed that even a non-pressure area would receive weekly monitoring and treatment. The IDCS had no comment on whether the area would be documented on the MDS assessment as a pressure sore, since it had been identified as a scratch.</p> <p>2. Resident #10 was admitted to the facility on 6/19/11, with diagnoses which included severe osteoporosis, dementia, post-polio, and chronic pain.</p> <p>On 11/14/15, an I&A report documented Resident #10 had an open area below her coccyx. The report documented Resident #10 was incontinent,</p>	F 272			

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F 272	<p>Continued From page 21</p> <p>chose to be on her back only, and had "this area open approx. 3 x's [times] and healed, so is fragile." The Pressure Ulcer Record, dated 11/14/15, documented a stage II 0.4 cm x 0.3 cm x 0.2 cm, open area. The record did not contain further documentation.</p> <p>On 11/15/15, a Non-Pressure Skin Condition Record was initiated for excoriation on the "crease buttocks below coccyx...0.5 cm x 0.5 cm x 0.1 cm," area with purulent drainage. On 12/5/15, the area was identified as a "split,"..."0.3 cm x 0.6 cm x 0.1 cm."</p> <p>Nursing Progress Notes documented the following:</p> <ul style="list-style-type: none"> * On 11/14/15, a "new pressure area to sacrum with small open area...encourage pressure relief thru shift rotating side to side." * On 11/15/15, "open area noted below coccyx, not on bony prominence, this area has been open before..." * On 12/10/15, "coccyx area reopened", new order for Duoderm and donut in wheelchair. * On 12/11/15, "turning schedule up and down schedule implemented beginning today." <p>A Non-Pressure Skin Condition Record documented that on 1/3/16 the coccyx wound remained open.</p> <p>Resident #10's Significant Change MDS assessment, dated 1/5/16, documented Resident #10 was severely cognitively impaired and was totally dependant on others for mobility and cares.</p>	F 272			

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F 272	Continued From page 22 The assessment documented Resident #10 was at risk for pressure ulcers, did not have any pressure ulcers, and did not have any pressure ulcer on the prior assessment. The Significant Change MDS assessment did not include documentation of the pressure ulcer on Resident #10's coccyx, which was present at the time the assessment was completed. On 6/9/16 at 5:30 pm, the Administrator stated the MDS Coordinator was on medical leave and was unavailable for interview. Resident #10's MDS assessment did not accurately document her skin condition.	F 272		7/25/16	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	Element #1 Resident #3 and #10 no longer reside at the facility. Element #2 Current facility residents' Care Plans and Kardexes were reviewed for accuracy and interventions to guide the staff when caring for the resident. Element #3 The Interdisciplinary Team and Licensed Nurses were re-educated to ensure resident Care Plans and Kardexes are accurate and have interventions that guide staff when caring for the resident.		

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F 279	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on policy review and record review, it was determined the facility failed to ensure residents' care plans were revised and updated to meet the residents' needs. This was true for 2 of 9 sampled residents (#3 and #10) residing in the facility. These deficient practices resulted in residents experiencing pain, injuries, and lack of care. Findings include: 1. Resident #3 was admitted on 12/11/14, with diagnoses which included malignant neoplasm breast cancer, diabetes, heart disease, cerebral vascular accident and dysphasia. On 4/21/15, a Physician Progress Note document Resident #3 had chronic pain syndrome and was on palliative care. "Palliative care is when a resident has reached a stage in their illness in which cure is no longer possible or when they refuse further treatment. Palliative care does not mean nothing more will be done...Palliative care is actually aggressively planned comfort care." Treas, L. S. & Wilkinson, J. M. (2014). Basic Nursing: Concepts, Skills & Reasoning. F.A. Davis Company: Philadelphia. The facility's Resident at or Approaching End of Life Policy, dated 11/30/14, documented the management and adapting of approaches to meet the resident's physical and emotional needs at the end of life management requirements as: * Assess regularly and systematically for pain and other symptoms (such as dyspnea, fatigue,	F 279	Element #4 The Director of Clinical Services or designee will QA Resident Care plans and Kardexes to ensure they are accurate and have interventions that guide the staff when care for the resident weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	

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F 279	<p>Continued From page 24</p> <p>declining function, anorexia/eating difficulties/weight loss, pain, loneliness, anxiety/apprehension, depression, constipation, and delirium) related to end of life and their impact on the resident.</p> <p>* Assess the individual's report of pain or other symptoms, what precipitates it or makes it worse, and what relieves it</p> <p>* Choose symptom control options that are appropriate for the resident</p> <p>* Deliver interventions in a timely, logical, and coordinated manner</p> <p>* Empower the resident to participate in defining goals of treatment and planning the interventions to the extent possible and evaluate the effectiveness of chosen interventions.</p> <p>* Care Planning: Use the resident's goals and preferences as a basis for selecting and implementing care and services at end of life.</p> <p>Resident #3's record included Recapitulated Physician Orders, dated 6/1/16, which documented the following pain medication orders:</p> <p>* Percocet 5/325 mg tablets, 1 tablet every 4 hours as needed for pain</p> <p>* Tylenol 325 mg tablets, 1-2 tablets every 4 hours as needed for pain</p> <p>Resident #3's Pain Flow Sheets assessments and medication administration records documented the following:</p> <p>* April 2016: Percocet was administered 15 times</p>	F 279			

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F 279	<p>Continued From page 25 for a mean pain rating of 8 out of 10. * May 2016: No pain flow sheet was available. * June 2016: From 6/2-6/8, Percocet was administered 4 times for a mean pain of 6 out of 10.</p> <p>On 6/6/16, 6/7/16, 6/8/16, and 6/9/16, Resident #3 was observed to moan and cry out in pain as follows:</p> <ul style="list-style-type: none"> * 6/6/16 at 7:00 am, 11:30 am to 12:50 pm, and 2:35 pm during wound dressing changes * 6/7/16 at 4:30 pm * 6/8/16 at 12:00 pm and 5:30 to 6:30 pm * 6/9/16 at 7:45 am, 8:20 am, 9:00 am, and 1:40 pm <p>Resident #3's Care Plan did not identify pain as an issue or contain interventions related to pain.</p> <p>On 4/21/15, a Physician Progress Note document palliative care for Resident #3.</p> <p>Resident #3's Care Plan did not identify that Resident #3 was on palliative care or include related interventions to direct staff on how to care for Resident #3.</p> <p>The Nurse Tech Information Kardex, undated, documented the following related to Resident #3:</p> <ul style="list-style-type: none"> * Ambulation-under the category of other "comfort care" * Personal Hygiene-dentures (no notation whether Resident #3 used them) * Eating-regular diet/no salt and dependant on staff * Fluids-no documentation (blank) 	F 279			

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F 279	<p>Continued From page 26</p> <p>The Kardex did not provide nursing staff guidance or direction in caring for Resident #3 regarding: palliative or comfort care; food intake, fluids; supplements; preferences; frequency of offering food and fluids; oral care; or pain.</p> <p>On 6/9/16 at 5:30 pm, the IDCS confirmed Resident #3's care plan did not address pain or palliative care measures.</p> <p>2. Resident #10 was admitted to the facility on 6/19/11, with diagnoses which included severe osteoporosis, dementia, post-polio, and chronic pain.</p> <p>Resident #10's Quarterly MDS assessment, dated 4/15/16, documented she was severely cognitively impaired and was totally dependant on others for mobility and cares.</p> <p>Resident #10 sustained the following 5 injuries, 4 with fractures, as the result of cares or transfers by facility staff:</p> <p>* On 5/15/15, an SBAR communication form documented Resident #10 complained of left lower leg and mid-shin pain. An investigation report documented that on 5/15/15 at 9:30 am, a CNA had bumped Resident #10's foot on the edge of a bookshelf. On 5/17/15 an X-ray report documented a distal tibia fracture.</p> <p>* SBAR and I&A documentation noted that on 7/20/15 at 9:10 pm, Resident #10 was being transferred from her wheelchair to her bed via Hoyer lift when the sling pad got hung up on Resident #10's arm. The CNA used the Hoyer lift without assistance and against facility policy. Resident #10 sustained a left humerus fracture.</p>	F 279		

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F 279	Continued From page 27 Resident #10's care plan was updated to include a 2 person assist with all ADLS and transfers with Hoyer lift. * An I&A and SBAR documented that on 12/6/15, Resident #10 experienced a possible left leg fracture while two CNA's were transferring Resident #10 into her wheelchair via the Hoyer lift. Resident #10 sustained a left distal femur fracture. Resident #10's care plan was updated to include a non-slip pad in her wheelchair. * On 1/23/16 at 7:30 am, an I&A documented Resident #10 was found with a bruise to her left eye during morning cares. The Hoyer lift bar lines matched the placement of the bruise. * I&A and SBAR documentation noted that on 4/13/16, Resident #10 was found to have bruising to her left hand. X-ray reports documented a left wrist fracture of undocumented origin. Resident #10's care plan identified her as at risk for falls due to wheelchair dependency, medications, diagnoses of polio, non-weight bearing and severe osteopenia. Resident #10 had severe osteopenia and osteoporosis, and had been identified as a fall risk, however, she was not identified as a high risk for injuries due to her diagnoses. Resident #10's care plan and interventions did not provide staff guidance or interventions that addressed prevention of further injuries.	F 279			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309			

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F 309	<p>Continued From page 28</p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, resident, and family interviews, it was determined the facility failed to ensure residents received necessary care and services. This was true for 4 of 9 sampled residents (#1, #3, #7, and #10) residing in the facility. This resulted in a) harm to Resident #1 and Resident #10 when treatment was delayed following accidents, 2) Resident #3 when she experienced ongoing pain due to lack of pain management by the facility; and 3) psychosocial harm to Resident #7 due to the manner in which a loved one's body was removed from the facility, and subsequent lack of therapeutic services to assist Resident #7 through the grief and trauma of his loved one's death. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 12/11/14, with diagnoses which included malignant neoplasm breast cancer, diabetes, heart disease, CVA and dysphasia.</p> <p>Resident #3's history and physical, dated 12/08/14, documented Resident #3 had a history of dementia, anxiety, CVA with left side hemiparesis, and had received chemotherapy for breast cancer.</p> <p>Resident #3's Quarterly MDS assessment, dated</p>	F 309	<p>Element #1</p> <p>Resident #3 no longer resides at the facility.</p> <p>LN #3 was re-educated to ensure when a resident receives a pain medication to ensure effectiveness is documented.</p> <p>The IDCS no longer works at the facility.</p> <p>The DCS and Administrator were re-educated by the Regional Director of Clinical Services that when a resident is crying out in pain; to ensure the Primary Care Physician is notified for further orders and to actively assist the nursing staff in attempting to assist the resident in becoming more comfortable.</p> <p>Resident #10 no longer resides at the facility.</p> <p>Resident #1 remains at the facility and is stable at this time.</p>	7/25/16	

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F 309	<p>Continued From page 29</p> <p>5/19/16, documented Resident #3 was severely cognitively impaired, totally dependent on others for mobility, eating and all cares. The MDS assessment documented Resident #3 did not have a condition or disease that may result in a life expectancy of less than 6 months. The assessment documented Resident #3 had received prn pain medication or had been offered pain medication and refused, and had denied pain when asked in the last 5 days.</p> <p>Resident #3's Care Plan did not identify pain as an issue or contain documentation related to: pain; pain related diagnoses; pain assessment; pain monitoring; pain interventions, or pain medications.</p> <p>On 4/21/15, Physician Notes documented Resident #3 was having pain, but only taking pain medication intermittently and may need a fentanyl patch. The note documented the diagnosis of chronic pain syndrome. The note included recommendations that long acting narcotics (fentanyl patch) were not indicted for a patient not already on high doses of narcotics and to continue with Percocet as needed. Long acting medications would be considered if taking the Percocet more than 3 times a day.</p> <p>On 10/30/15, Physician Notes documented that pain had been an issue with Resident #3, but Resident #3 had declined narcotics because of the way they made her feel and therefore, the physician was uncomfortable in ordering a fentanyl patch against Resident #3's will. The note documented Resident #3 did have a terminal diagnosis and did have pain, but the physician would not order fentanyl unless Resident #3 desired it.</p>	F 309	<p>The DCS and Administrator were re-educated by the Regional Director of Clinical Services to ensure residents are assessed timely when experiencing a potential injury.</p> <p>Resident #7 remains at the facility and is stable at this time.</p> <p>Element #2 Residents who receive a pain medication were reviewed by the Director of Clinical Services or designee to ensure pain medication is effective; the Primary Care Physician will be notified for further orders if pain medication is not effective when administered.</p> <p>Current facility residents were reviewed by the Director of Clinical Services or designee and no adverse effects were noted r/t the potential of not having the call light within reach.</p>		

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PRINTED: 07/07/2016
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 30</p> <p>On 5/6/16, Physician Notes documented "breast cancer appears to advancing...fungating lesion on chest wall", and an "ulcerated mass filling much of left axilla (armpit) with hyperpigmentation and puckering from axilla to nipple...active bleeding from the axilla." A fungating wound is when cancer that is growing under the skin breaks through the skin to create a wound.</p> <p>Physician Orders documented the following pain medication orders:</p> <ul style="list-style-type: none"> * Percocet 5/325 mg tablets, 1 tablet every 4 hours as needed for pain; and * Tylenol 325 mg tablets, 1-2 tablets every 4 hours as needed for pain. <p>Resident #3's Pain Flow Sheet assessments and medication administration record documented the following:</p> <ul style="list-style-type: none"> * April 2016: Percocet was administered 15 times for a mean pain rating of 8 out of 10. * May 2016: No pain flow sheet were available. * June 2016: From 6/2-6/8, Percocet was administered 4 times for a mean pain of 6 out of 10. <p>On 6/6/16 at 7:00 am, Resident #3 was observed in bed moaning and crying out. She had arm and leg contractures and appeared very thin. At that time, her husband stated his wife was, "in a lot of pain,"</p> <p>On 6/6/16 at 9:15 am, LN #3 stated Resident #3 had fungating breast cancer and would often cry out in pain. From 11:30 am to 12:50 pm, Resident #3 continued to moan in pain. During this time,</p>	F 309	<p>The facility will ensure resident call lights are within reach of the resident when in his/her room.</p> <p>The facility will ensure the Responsible Party is notified when a resident experiences a change in condition or injury and documentation is completed. If initial attempts to contact the Responsible Party fails then the Licensed Nurse will pass on to next shift and he/she will continue to attempt to reach responsible party until successful; if still unsuccessful a Registered Letter will be sent to the Responsible Party to contact the facility.</p> <p>The facility will ensure residents who experience a change in condition are assessed and the Primary Care Physician is notified for further orders.</p>	

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F 309	<p>Continued From page 31</p> <p>two CNA's entered the room to assist Resident #3's husband to the bathroom. The CNAs and husband then left the room. At 12:15 pm, a CNA delivered a lunch tray and told Resident #3 she would ask the nurse if there was something they could give Resident #3[for pain]. Resident #3's husband returned to the room at 12:50 pm.</p> <p>On 6/6/16 at 1:15 pm, LN #3 stated even though Resident #3 was crying out in pain and saying she was hurting, if directly asked she would often deny pain and refuse pain medication. LN #3 stated pain was assessed on the MAR every shift and the narcotic sign out sheet documented Resident #3 had received a Percocet at 11:15 am, however, the medication's effectiveness was not documented.</p> <p>On 6/6/16 at 2:35 pm, Resident #3 was observed during pressure sore dressing changes. Resident #3's legs were contracted upwards at her hips and knees preventing her from straightening her legs. Resident #3's left arm was edematous and immobile with dark tumorous tissue protruding out from her deltoid (the muscle forming the rounded contour of the shoulder). Resident #3's left axillary had raw, dark purple and red tumorous tissue extending out and through the extent of her armpit. Resident #3 had pressure ulcers and open areas on her coccyx, back and left foot. Resident #3 cried out with pain and "leave me alone," with each movement during the dressing change.</p> <p>On 6/7/16 at 4:30 pm, Resident #3 was observed moaning and crying out. When asked if she was in pain, Resident #3 stated, "I don't know." When asked if she could reach her call light or knew where it was, Resident #3 stated, "I don't know."</p>	F 309	<p>The facility will ensure when a resident passes; the facility will ensure loved ones are allowed time to spend with the resident after he/she passes and the loved ones are not in the room when the resident is placed in the "body bag" and if the loved one refuses to leave the room; the facility will strongly encourage them to not be present and will document the refusal in the Medical Record.</p> <p>The facility will provide therapeutic services to residents who are grieving the loss of a loved one by increasing the visit with the Social Worker as the resident allows/requests.</p>		

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F 309	<p>Continued From page 32</p> <p>On 6/7/16 at 4:50 pm, LN #3 stated she had asked Resident #3 about taking a pain pill before a dressing change and Resident #3 had refused. When asked about other forms of pain medication, LN #3 stated a patch had been discussed, but the physician was worried about overdosing Resident #3. LN #3 stated liquid pain medication such as Roxanol (liquid opioid pain medication) had not been discussed.</p> <p>On 6/8/16 at 12:00 pm, Resident #3 was moaning, "ow, ow, hurts, hurts...oh god, ow, please, please, ow, ow, ow!" At 12:17 pm, CNA #6 was observed taking a lunch tray into Resident #3. CNA #6 asked Resident #3 if she wanted "strawberry shortcake." Resident #3 yelled, "No, hurts! Oh god!" CNA #6 told Resident #3, "We'll get you a pill," and continued to prepare the tray. CNA #6 told Resident #3 to drink some juice and she would get a pain pill. Resident #3 yelled, "Hurts, hurts!" At 12:19 pm, CNA #6 left the room. Medication records documented Resident #3 received a Percocet at 11:30 am for pain rated a 6/10. The pain flow sheet documented reduced pain intensity (untimed). No one other than CNA #6 was observed to enter Resident #3's room from 12:00 pm to 12:45 pm. Resident #3's medication administration record documented Resident #3 receive pain medication again at 6:30 pm, 7 hours later.</p> <p>On 6/8/16 from 5:30 to 6:30 pm, Resident #3 continued moaning and crying out. During this time, the Administrator, IDCS and DCS were in the room across from Resident #3's room meeting with the survey team. Neither the Administrator, IDCS nor the DCS responded to Resident #3 before or during the meeting.</p>	F 309	<p>Element #3</p> <p>Facility staff was re-educated to ensure resident call lights are within reach of the resident when the resident is in his/her room.</p> <p>Licensed Nurses were re-educated regarding expectations of documentation and notification when there is a change in condition or injury. If initial attempts to contact the Responsible Party fails then the Licensed Nurse will pass on to next shift and he/she will continue to attempt to reach responsible party until successful; if still unsuccessful a Registered Letter will be sent to the Responsible Party to contact the facility.</p> <p>Licensed Nurses were re-educated that when a resident is crying out in pain or experiencing a change in condition to ensure the Primary Care Physician is notified for further orders and to actively assist in attempting to assist the resident in becoming more comfortable.</p>		

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F 309	<p>Continued From page 33</p> <p>On 6/9/16 at 7:45 am, 8:20 am, 9:00 am, and 1:40 pm, Resident #3 was observed crying out "ow, ow," and moaning. At 5:00 pm, the Administrator and RD stated Resident #3 directed her own care, and did not want to be bothered, or badgered. The Administrator stated it was her [Resident #3] "right to refuse, leave her alone and choose to die."</p> <p>2. Resident #10 was admitted to the facility on 6/19/11, with diagnoses which included osteoporosis, dementia, post-polio, and chronic pain.</p> <p>On 5/15/15 an SBAR communication form documented Resident #10 complained of left lower leg and mid-shin pain.</p> <p>An investigation report documented that on 5/15/15 at 9:30 am, a CNA had bumped Resident #10's foot on the edge of a bookshelf. The CNA and Resident #10 both heard a "pop." Resident #10 was medicated for pain on 5/15/15. On 5/16/15, Resident #10 continued to complain of pain. On 5/17/15, Resident #10 complained of pain to the touch and when lifting her leg. On 5/17/15 at 11:20 am Resident #10 was sent to the emergency room for an X-ray and evaluation. X-rays of Resident #10's left leg identified a distal tibia fracture.</p> <p>On 6/9/16 at 5:30 pm, the Administrator, IDCS, and DCS, could not explain the reason medical evaluation of Resident #10's injury was delayed 2 days. The DCS stated Resident #10 should have been sent right away to be evaluated.</p> <p>3. Resident #1 was admitted to the facility on</p>	F 309	<p>Licensed Nurses were re-educated to ensure residents are assessed timely when experiencing a potential injury.</p> <p>The Social Services Director was re-educated to ensure therapeutic services are provided to residents who are grieving the loss of a loved one with increased visits with the Social Worker as the resident allows/requests.</p> <p>Licensed Nurses were re-educated to ensure when a resident passes; to allow loved ones time to spend with the resident after he/she passes and the loved ones are not in the room when the resident is placed in the "body bag" and if the loved one refuses to leave the room; to strongly encourage them to not be present and document the refusal in the Medical Record.</p>		

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F 309	<p>Continued From page 34</p> <p>3/19/14, with diagnoses which included left cerebral vascular accident, osteoporosis, and chronic pain.</p> <p>On 12/19/15 at 3:55 pm, an Incident and Accident report documented Resident #1 had fallen while coming out of the bathroom.</p> <p>Nursing Progress Notes documented on 12/19/15, stated Resident #1 was complaining of left knee intermittent sharp pain that increased with bending her knee. The next note, documented on 12/21/16, stated Resident #1 complained of pain. Resident #1's left knee was swollen, painful to the touch and with movement. At 2:00 pm, Resident #1 was sent to the emergency room for an evaluation. X-rays of Resident #1's left leg showed Resident #1 had a fractured tibia.</p> <p>On 6/9/16 at 5:30 pm, the Administrator, IDCS, and DCS, could not explain the reason medical evaluation of Resident #1's injury was delayed 2 days. The DCS stated Resident #1 should have been sent right away to be evaluated.</p> <p>4. During an initial observation and interview with Resident #7 on 6/6/16 at 9:30 am, he was teary eyed when speaking about his husband (with whom he had been life partner for over 40 years). Resident #7's voice was cracking as he pointed to numerous pictures on the wall of his loved one and described how his husband was also a resident of the facility when he died in December of 2015 (6 months prior).</p> <p>Resident #7's medical record documented diagnoses of Chronic Obstructive Pulmonary Disease and Bipolar Disorder. Resident #7 was</p>	F 309	<p>Element #4</p> <p>The Executive Director or designee will QA residents when in his/her room to ensure his/her call light is within reach 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.</p> <p>The Director of Clinical Services or designee will QA residents who have a change in condition or injury to ensure assessment was completed timely, the Physician was notified and the Responsible Party has been notified or a Registered Letter has been sent as appropriate during the morning clinical meeting 3-5 times weekly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.</p>		

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F 309	<p>Continued From page 35</p> <p>admitted to the facility on 10/14/15 with his husband. The Admission/Readmission Data Collection, documented "Depends on life partner for emotional stability." After the death of his husband on 12/3/15, Resident #7 continued to live in the facility. On 12/8/15, social services met with Resident #7 and discussed moving to an assisted living facility. According to the Consent to Room Transfer form, dated 1/12/16, Resident #7 was moved to another room as Resident #7 stated he could not sleep in the room with the new roommate. Resident #7's medical record did not contain documentation regarding the death of Resident's #7's husband.</p> <p>Review of Resident #7's History and Physical, dated 1/27/16, documented "Staff does report that he has been eating and drinking less and there has been some concern with him grieving for the loss of his long-term partner who recently died of COPD related issues. "</p> <p>On 6/5/16 at 6:30 pm, Resident #7, pointing to pictures on the wall, stated he had shared his room with his husband before his death around Christmas. Resident #7 began to cry and became distraught and stated they had been together for 44 years. He stated they [facility] had "put his husband in the body bag right in front of him ...didn't close the curtains or anything." Resident #7 stated he could not "get the image out of his head" of his husband being put in the bag, sealed up and taken off. Resident #7 stated he did not have a chance to say his goodbyes and tell him how much he loved him.</p> <p>On 6/8/16 at 7:15 pm, CNA #5 stated Resident #7 and his partner were married at the facility. CNA #5 stated Resident #7 was having difficulty</p>	F 309	<p>The Executive Director or designee will QA to ensure when a resident passes that another resident or loved one does not witness a deceased resident being placed in the body bag and a resident who is grieving the loss of a loved one is receiving therapeutic services as appropriate weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.</p>		

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F 309	<p>Continued From page 36</p> <p>dealing with the death and often talked about seeing his husband placed in the body bag.</p> <p>On 6/9/16 at 5:00 pm, the Administrator, DCS, and interim DCS, stated the facility followed the standard protocol for after death care. The Administer stated Resident #7 was in therapy, but had been in therapy prior to his husband's death and not specifically for this issue. They stated they were not aware of a policy that specifically addressed this issue, and a resident should not have to experience what Resident #7 did.</p> <p>On 6/10/16 at 10:10 am, Resident #7 began crying and stated that no one should have to experience what he did when his husband died. Resident #7 again stated he could not get "the image out of his head." Resident #7 stated he was told by a nurse, who no longer worked at the facility, that his husband had passed and he would be able to be with him after they cleaned and prepared his husband. Resident #7 stated he was able to hold his husband's hand for about 10 minutes and then the mortician came in the room and he was told by the nurse that they had to take his husband. Resident #7 stated he and his husband had met with the mortuary to make arrangements prior to his husband's death, so he recognized the mortician. Resident #7 stated he did not remember being asked to leave, or a suggestion that he leave, while the mortician took the body. Resident #7 stated he did not remember all the details, but he remembers them placing his husband's body in the bag and sealing it up. Resident #7 stated the facility usually dealt with single people and he did not believe they [facility] knew what to do with couples. He stated the facility needed to know what to do, so no one else would have to go through what he went</p>	F 309			

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F 314 SS=G	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: Based on observation, record review and staff interviews, it was determined the facility failed to ensure residents did not develop multiple pressure ulcers. This was true for 1 of 5 residents sampled for pressure ulcers (#3) and resulted in harm to Resident #3, who developed multiple pressure sores, including one Stage III ulcer. Findings include: 1. Resident #3 was admitted to the facility on 12/11/14, with diagnoses that included malignant breast cancer, diabetes, heart disease, cerebral vascular accident with left-sided hemiparesis, dementia, and dysphasia. A 5/19/16 quarterly MDS assessment documented Resident #3 was severely cognitively impaired; totally dependent on at least two staff for mobility, transfers, and toileting; "always" incontinent of bowel and bladder; equipped with pressure reducing devices to her chair and bed;	F 314	Element #1 Resident #3 no longer resides at the facility. . LN #3 was re-educated on Pressure Ulcer Identification and documentation. . The IDCS no longer works at the facility. . Resident #14 and #2 were assessed by the Director of Clinical Services or designee and appropriate documentation was completed with appropriate treatment and interventions are in place. The Care Plan and Kardex was reviewed and updated as appropriate. . LN #4 was re-educated on the facility's skin policy. . Resident #10 no longer resides in the facility.	7/25/16

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F 314	<p>Continued From page 38</p> <p>on a turning/repositioning program; had nutritional and hydration interventions in place; and had one unstageable pressure ulcer.</p> <p>a. A Braden Pressure Sore Risk Assessment, dated 12/6/15, documented Resident #3 was at "severe risk" of developing pressure ulcers. A 12/9/15 Braden Pressure Sore Risk Assessment documented she was at "high risk" for developing pressure sores.</p> <p>Pressure Ulcer Records, dated 12/29/15 and 1/5/16, documented Resident #3 developed a Stage I ulcer to the left "foot/great toe" and included a diagram with the ball of the left foot marked with an "x."</p> <p>A 12/30/15, a Nurse's Note documented the IDT conducted a wound care meeting for Resident #3's left foot and noted, "Will continue current POC [Plan of Care]. Will monitor for care."</p> <p>Pressure Ulcer Records, dated 1/6/16, 1/25/16, 2/2/16, 2/9/16, and 2/16/16, documented Resident #3's Stage I ulcer was now "unstageable," but that classification had a hand-drawn line through it and a handwritten "DTI" [deep tissue injury] had been substituted on each assessment date.</p> <p>A Nurse's Note, dated 1/6/16, documented the IDT met to discuss the "pressure wound" to Resident #3's "left lateral ball of foot" and decided to "continue with current POC will monitor weekly for improvement."</p> <p>Nurse's Notes documented additional IDT wound care meetings for Resident #3's various wounds were conducted regularly.</p>	F 314	<p>Element #2</p> <p>Current facility residents with Pressure Ulcers and/or Non-Pressure skin impairments were assessed by the Director of Clinical Services or designee to ensure documentation was completed on correct form and treatments were in place as appropriate. Care Plans and Kardexes were reviewed and updated as appropriate.</p> <p>Currently facility residents had a Braden Scale completed and residents deemed at risk for skin breakdown was assessed by the Director of Clinical Services or designee to ensure interventions were in place to assist in preventing skin breakdown. Care Plans and Kardexes were reviewed and updated as appropriate.</p>		

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F 314	<p>Continued From page 39</p> <p>A 1/27/16 Nurse's Note, documented Resident #3's left foot/toe pressure ulcer now "met [the] criteria for [an] unavoidable wound" and recommended placing Resident #3 on "pallative care." Neither the facility's classification of the wound as "unavoidable" nor the rationale for placing the resident on pallative care were explained.</p> <p>The wound was classified as a DTI on the Pressure Ulcer Records weekly from 2/24/16 through 3/22/16, and for 4/3/16. Pressure Ulcer Records dated 4/8/16, 4/12/16, 4/17/16, 5/2/16, 5/10/16, and 5/17/16 each documented the wound was "UTS" [unable to stage].</p> <p>Each Pressure Ulcer Record from 12/29/15 through 5/17/16 documented Resident #3's left foot/toe pressure ulcer was not present upon admission to the facility, and recorded the wound first measured 0.3 cm by 0.3 cm, but grew to 3 cm X 3 cm by 0.1 cm, when it was at its largest.</p> <p>b. A Pressure Ulcer Record, dated 3/23/16, documented Resident #3 developed a Stage II pressure ulcer to her coccyx that measured 0.2 cm by 0.2 cm by 0.1 cm.</p> <p>A 3/22/16 Nurse's Note documented, "Late Entry: [Physician] in to see resident today for new coccyx wound."</p> <p>c. Pressure Ulcer Records, dated 2/22/16, 3/1/16, and 3/15/16, documented Resident #3 developed a Stage II pressure ulcer to her left hip that measured 2 cm by 2 cm by 0.1 cm at its largest, and 0.3 cm by 0.3 cm by 0.1 cm at its smallest.</p>	F 314	<p>Element #3 Licensed Nurses were re-educated on Pressure Ulcer Identification and documentation and the facility's skin policy.</p> <p>Element #4 The Director of Clinical Services or designee will QA residents with alterations in skin integrity to ensure documentation is completed on the appropriate form with appropriate interventions in place 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.</p>		

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F 314	<p>Continued From page 40</p> <p>A 2/23/16 Nurse's Note documented, "New wound on [left] hip. Stage II. Interventions turn [every two hours] and optifoam to site. MD [physician] notified and unavoidable worksheet completed ..." No explanation was provided for classifying the left hip pressure ulcer at "unavoidable."</p> <p>A 3/8/16 Nurse's Note documented, "IDT met today in regards to her wounds. [Left] hip [and left] foot pressure related ulcers. [No] improvements noted at this time. Continue [with] current interventions. Monitoring, remains on comfort measures, MD states unavoidable wounds."</p> <p>d. A Pressure Ulcer Record, dated 6/2/16, documented Resident #3 developed a an "unstageable" pressure sore to her right hip that measured 1.5 cm by 1.8 cm with black eschar covering the wound bed.</p> <p>e. A Non-Pressure Skin Condition Record, dated 6/5/16, documented a "1.2 x 2.5 x 0.1" reddened area on the right side of Resident #3's back and two areas on her right hip measuring "0.5 x 0.3 x 0.1" and "1.3 x 1.5 x 0.1."</p> <p>Resident #3's Care Plan, dated 8/20/15, and in effect at the time of survey, documented the following:</p> <p>* "Problem: [Resident #3] is at risk for pressure related ulcers d/t self care deficit, fragile skin, muscle weakness, w/c [wheelchair] dependant, incontinent of B&B [bowel and bladder], dx [diagnosis] of cancer, prefers to spend most of time in bed sleeping."</p>	F 314			

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F 314	<p>Continued From page 41</p> <p>* "Goal: [Resident #3] will exhibit no s/s [signs and symptoms] of skin breakdown by next review, X [for] 90 days."</p> <p>* "Interventions/Approaches: Pressure reducing mattress to bed; weekly skin sweep; Braden assessment quarterly; monitor labs; skilled therapies as ordered; cushion for w/c; offer and encourage fluids throughout the day; check positioning frequently during rounds; reposition ... [every] 2 hours and as needed; treatments as ordered; off-loading boot on left foot; turn onto side, prop [with] pillows, treat per orders until healed as patient allows; 'she is on comfort care;' treat as ordered for pressure ulcer to [left] great toe."</p> <p>On 6/6/16 at 2:35 pm, Resident #3 was observed with a Stage II pressure ulcer on the middle of her back over a rib adjacent to the backbone. The open area of the wound measured approximately 2 cm x 2 cm in size, and a Stage II ulcer on her coccyx measured approximately 1 cm x 1 cm. An elongated open area extending upward from the coccyx measured approximately 1 cm x 3 cm. Resident #3's left large toe was observed with a large black eschar area; her left hip had reddened areas over the hip bone and ilium crest. LN #3 stated the area on Resident #3's back was not a pressure sore, but rather was a self-inflicted scratch. LN #3 stated at this time that the area on the back of Resident #3 was not a pressure sore, but a scratch. LN #3 stated it did not matter whether the area was identified as a scratch or pressure sore, the treatment was the same per Resident #3's physician. Resident #3 did not attempt to scratch at the open area on her back rib during the observation.</p>	F 314			

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F 314	Continued From page 42 On 6/7/16 at 4:30 pm, LN #3 measured the open area on Resident #3's mid-right back at "1.9 cm x 2.5 cm x 0.3 cm." When assessing the coccyx wound, LN #3 stated "the areas were merging together," and measured "4 cm x 1.75 cm." Resident #3's right hip bone area measured "3 cm x 1.5 cm," and the ilium crest area measured "5 cm x 2 cm." Resident #3's right hip areas remained reddened consistent with the 6/6/16 observation.	F 314			
F 317 SS=G	On 6/8/16 at 11:15 am, the IDCS stated the facility does not distinguish between pressure sores and non-pressure sores. The IDCS stated the treatment would be the same for either per the physician and, therefore, the facility did not want to cause Resident #3 more discomfort by measuring the wounds weekly. The IDCS stated that even a non-pressure area would receive weekly monitoring and treatment. 483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents did not develop contractures. This was true for 2 of 9 residents (#3 and #5)	F 317	Element #1 Resident #3 no longer resides at the facility. Resident #5 has been provided foot supports for her wheelchair and a Restorative Program has been established and implemented for Resident #5.	7/25/16	

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F 317	<p>Continued From page 43</p> <p>sampled for range-of-motion concerns. The deficient practice resulted in harm when residents experienced pain and a decrease in mobility. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 12/11/14 with diagnoses that included malignant neoplasm breast cancer, diabetes, heart disease, cerebral vascular accident, and dysphasia.</p> <p>The resident's admission MDS assessment, dated 12/18/14, documented Resident #3 did not have range-of-motion impairments in her upper or lower extremities, was receiving PT, and was not in a restorative program.</p> <p>A Physical Therapy Discharge Summary, dated 12/19/14, documented Resident #3 refused treatment and seldom rose from bed. The summary documented a referral to RNP to maintain strength and reduce the risk for contractures.</p> <p>A quarterly MDS assessment, dated 5/19/16, documented Resident #3 had impaired ROM in her upper and lower extremities and was totally dependent on staff for mobility.</p> <p>On 6/6/16 at 7:00 am, Resident #3 was observed lying in bed. Resident #3's left arm was immobile and her left leg contracted at the hip and knee in a fixed position with limited movement. Resident #3's right leg was also contracted at the hip and knee. At 2:35 pm, during a dressing change to a pressure ulcer on the left foot, Resident #3 cried in pain during movement. LN #3 stated Resident #3 did not like to be moved and could not straighten her legs due to contractures.</p>	F 317	<p>Element #2</p> <p>Current facility residents who are not participating in a Therapy Program were screened by Therapy to establish if the residents require a Restorative Program. The Restorative Program was initiated and documented on residents as appropriate. The Assistant Director of Clinical Services will be responsible to oversee the Restorative Program.</p> <p>Element #3</p> <p>The Assistant Director of Services and the Restorative Certified Nursing Assistant were educated by the Regional Director of Clinical Services on the Facility's Restorative Program to include but not limited to the documentation requirements.</p> <p style="text-align: right;"><i>CLINICAL SW</i></p>		

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F 317	<p>Continued From page 44</p> <p>On 6/9/16 at 5:30 pm, the IDCS stated the facility did not have a restorative program because the facility did not have anyone to oversee the program. The IDCS and DCS confirmed there were no restorative records for Resident #3 and she had not received ROM.</p> <p>2. Resident #5's medical record documented she fractured her right hip on 3/17/15, and underwent surgery on 3/18/15. Resident #5 was admitted to the facility on 3/20/15 for OT and PT evaluation and treatment. After the completion of PT, RNP was to continue working on exercises and strengthening with Resident #5.</p> <p>Resident #5's MDS assessment, dated 3/16/16, documented range-of-motion impairment to the lower extremity on one side. The MDS assessment documented Resident #5 required extensive assistance with transfers and did not ambulate.</p> <p>Resident #5 was observed on 6/6/16 at 8:00 am seated in a wheelchair with her feet dangling. There were no foot supports available.</p> <p>On 6/8/16 at 8:55 am, Resident #5 was observed seated in the wheelchair with her feet dangling and the toes of her right foot touching the floor. The wheelchair was not equipped with foot rests. A CNA pushed the wheelchair forward to Resident #5's room with her feet hanging and occasionally touching the floor.</p> <p>On 6/8/16 at 3:50 pm, the IDCS stated the facility did not have a restorative nursing program and that there was no restorative documentation for Resident #5.</p>	F 317	<p>Element #4</p> <p>The Director of Clinical Services or designee will QA to ensure the Restorative Program is functioning per policy with appropriate documentation weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.</p>		

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F 323 F 323 SS=G	Continued From page 45 483.25(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, record review, and interviews, it was determined the facility failed to ensure residents were free adequately supervised to prevent accidents. This was true for 2 of 12 residents reviewed for accidents and supervision (#10 and #12). The deficient practice resulted in harm when a) Resident #10 sustained 4 fractures during care and transfers by facility staff, and b) Resident #12, with a diagnosis of dementia, left the facility unsupervised and was subsequently found on a busy roadway. Findings include: 1. Resident #10 was admitted to the facility on 6/19/11 with diagnoses that included severe osteoporosis, dementia, history of polio, and chronic pain. Resident #10's quarterly MDS assessment, dated 4/15/16, documented severe cognitive impairment and total dependance on staff for mobility and cares. Resident #10 sustained 5 injuries, 4 with fractures, as the result of cares or transfers	F 323 F 323	Element #1 Resident #10 and Resident #12 no longer reside at the facility. Element #2 Current facility residents were reviewed for transfer/lift needs by the Director of Clinical Services or designee. Care Plans and Kardexes were reviewed and updated as appropriate. Current facility residents had an Elopement Risk Assessment Completed. Residents deemed at risk for Elopement have been placed on 15 minute checks. The facility doors are alarmed and sounds when opened without inputting the appropriate code. Residents deemed at risk for Elopement Care Plans and Kardexes have been reviewed and updated as appropriate.	7/25/16

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F 323	<p>Continued From page 46 provided by facility staff:</p> <p>* On 5/15/15, an SBAR communication form documented Resident #10 complained of left lower leg and mid-shin pain. An investigation report documented that on 5/15/15 at 9:30 am, a CNA had bumped Resident #10's foot on the edge of a bookshelf. The CNA and Resident #10 both heard a "pop." Resident #10 was medicated for pain that day, but on 5/16/15 the resident continued to complain of pain. On 5/17/15, Resident #10 complained of pain to the touch and when lifting her leg. At 11:20 am, Resident #10 was sent to the emergency room for an X-ray and evaluation. X-rays of Resident #10's left leg identified a distal tibia fracture.</p> <p>* An I&A and SBAR noted that on 7/20/15 at 9:10 pm, Resident #10 was being transferred from her wheelchair to bed via Hoyer mechanical lift when the sling pad became entangled with Resident #10's arm. The CNA used the Hoyer lift without assistance and against facility policy. Resident #10 sustained a left humerus fracture. Resident #10's care plan was updated to to include a 2-person assist with all ADLS and transfers with Hoyer lift.</p> <p>* On 12/6/15, an SBAR documented a possible left leg fracture while two CNA's were transferring Resident #10 into her wheelchair via the Hoyer lift. Resident #10 slid out of her chair and onto the floor and her left leg was bent back. On 12/7/15, a left distal femur fracture was documented. On 12/8/15, facility staff were trained on proper use of the Hoyer lift. Resident #10's care plan was updated to include a non-slip pad in her wheelchair.</p>	F 323	<p>Element #3 Licensed Nurses and Certified Nursing Assistants were re-educated on transfer techniques which included the use of Mechanical Lifts with a return demonstration completed.</p> <p>Facility staff have been re-educated on the Facility's Elopement Policy and Procedure with an emphasis on completing Elopement Risk Assessments and placing on 15 minute checks if deemed an Elopement Risk..</p> <p>Element #4 The Director of Clinical Services or designee will QA to ensure residents are transferred using correct technique 5-7 times weekly for four weeks then 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.</p>		

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F 323	<p>Continued From page 47</p> <p>*On 1/23/16 at 7:30 am, Resident #10 was found with a bruise to her left eye during morning cares. The Hoyer lift bar lines matched the placement of the bruise and CNAs were trained on how to transfer with the Hoyer to avoid future injuries. The I&A noted misuse of equipment.</p> <p>*I&A and SBAR reports, noted that on 4/13/16, Resident #10 was found with bruising to her left hand. X-ray reports documented a left wrist fracture of unknown origin.</p> <p>Resident #10's care plan identified her as at risk for falls due to wheelchair dependency, medications, diagnoses of polio, non-weight bearing and severe osteopenia. Interventions included:</p> <ul style="list-style-type: none"> * Complete quarterly fall risk assessments * Observe for changed in cognition/function * Environment free of clutter * Observe medications for side effects * Call light within reach and remind to use call light for assistance * Assure adequate lighting and clear pathways * Hoyer lift for all transfers * Skilled therapies as ordered * Personal items within reach * Dycem pad to chair <p>Resident #10's care plan identified specific problems related to a left humerus fracture, vertical fracture of humeral head, left knee fracture, and a left wrist fracture. Interventions included: 2-staff assistance with all ADLS; transfers with Hoyer lift; use of draw sheets; positioning; braces; splints; and immobilizer.</p> <p>Resident #10 was diagnosed with severe</p>	F 323	The Interdisciplinary Team will review new residents to determine if the new resident is an elopement risk during the Morning Clinical Meeting; if resident is deemed to be an Elopement Risk the resident will be placed on 15 minute checks and the Care Plan and Kardex will be updated with Elopement Interventions.		

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F 323	<p>Continued From page 48</p> <p>osteopenia and osteoporosis, and had been identified as a fall risk, but was not identified as a high risk for injuries due to her diagnoses. Resident #10's care plan and interventions did not provide staff guidance or interventions addressing prevention of further injuries.</p> <p>On 6/9/16 at 5:30 pm, the IDCS and DCS stated staff had received in-services on using the Hoyer lift.</p> <p>2. Resident #12 was admitted to the facility on 3/18/16 with a diagnosis of dementia.</p> <p>An Elopement Risk Evaluation, dated 3/18/16, documented Resident #12 was determined to be "at risk for elopement."</p> <p>Resident #12's Admission Care Plan, dated 3/18/16, included:</p> <p>* Falls/Safety/Elopement Risks - Goal: Remain free of injuries and falls. A handwritten entry documented, "Elopement initiated."</p> <p>A Behavior Symptom Monitoring Flow Record, dated March, 2016, documented the behavior of "Wandering-Elopement," and included pharmacological interventions (an anti-psychotic medication), as well as non-pharmacological interventions, including re-orienting; redirecting with an activity such as knitting; offering coffee; reassurance that she and her children were safe; and 15 minute checks (line of sight).</p> <p>A Resident Safety Check form, dated 5/18/16, documented that 15-minute checks were performed from 2:00 pm until 10:00 pm. Fifteen minute checks were not documented between</p>	F 323			

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F 323	Continued From page 49 5/18/16 at 10:01 pm and 6/5/16 at 9:59 am. Documentation of 15-minute check resumed on 6/5/16 at 10:00 am. An I&A Report, dated 6/5/16, documented that Resident #12 left the facility unsupervised at 10:35 am. On 06/9/16 at 2:18 pm, the Administrator, DCS, and surveyor followed CNA #4 to the site where CNA #4 found Resident #12 on 6/5/16. The road where the resident was found was a main road leading into and out of the town; the speed limit was 45 mph. The site was approximately 0.2 miles from the facility parking lot. On 6/9/16 at 9:07 am, the Social Services Manager stated Resident #4 was found on the road alone and that she wanted to go home, especially when her husband left, at which time Resident #4 would "pack up." The Social Services Manager stated the facility's wander guards were ineffective and the system was not working. On 6/9/16 at 9:25 am, CNA #4 stated that on 6/5/16 at about 9:45 am, a former employee walked through the staff breakroom and stated Resident #12 had her bag and was walking alongside the road. CNA #4 stated she, LN #2, and the activities staff member retrieved Resident #4 by car. CNA #4 was unsure if any type of alarm system was functioning at the time of Resident #12's elopement. The facility failed to ensure Resident #4 received the supervision necessary to keep her safe.	F 323		
F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325		

F-323 Free of Accident hazards/supervision/Devices

Regarding alarmed egress: Exit doors are equipped with a 15 second egress delay alarm. Should a resident push on the door, it will lock down for 15 seconds with an audible alarm. The nurses' station is centrally located to view all three corridors and the associated exits. The main entrance, not visible at the nursing station, is equipped with an egress "screaming" alarm that is audible throughout the facility. The door alarms are being checked daily to ensure system operation.

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F 325 SS=G	Continued From page 50 UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident/family member interviews, it was determined the facility failed to ensure a resident on palliative care received monitoring and care planning necessary to support the resident's nutritional needs. This was true for 1 of 9 sampled residents (#3) residing in the facility. This deficient practice resulted in Resident #3 experiencing an undeterminable weight loss and severely compromised nutritional status. Findings include: Resident #3 was admitted to the facility on 12/11/14 with diagnoses which included malignant neoplasm breast cancer, diabetes, heart disease, cerebral vascular accident, and dysphasia. Resident #3's History and Physical, dated 12/8/14, documented a history of dementia, anxiety, CVA with left-side hemiparesis, history of chemotherapy.	F 325	Element #1 Resident #3 no longer resides at the facility. CNA #6 & CNA #4 were re-educated to return to the resident and offer more food when a resident has not eaten at least 75% of the meal and/or supplement and if the resident does not like what is on his/her tray to offer the resident alternative selections. Element #2 Current facility residents were weighed and residents who have experienced a weight loss were reviewed by the Registered Dietician and a Nutritional Assessment was completed to ensure residents were provided the appropriate diet and Nutritional Supplements to assist in preventing further weight loss. These residents Care Plans and Kardexes were reviewed and updated as appropriate to include suggestions on what to do if the resident refuses meals and/or	7/25/16	

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F 325	<p>Continued From page 51</p> <p>An Admission Nutritional Evaluation, dated 12/11/14, documented Resident #3 weighed 137 lbs with assessed caloric needs of 1868 Kcal, 49-75 g of protein, and 1800 cc of fluids per day. Resident #3's Admission Lab values did not include albumin or pre-albumin protein levels. The evaluation identified inadequate intake due to percentage of oral intake. The evaluation stated Resident #3 had dentures, ate in her room, and required assistance and cueing to eat. The evaluation documented her nutritional status would be difficult to assess using weights due to edema and congestive heart failure. Recommendations included a regular diet with fortified meals, whole milk, weights per policy, and the RD was to monitor her anticipated decline.</p> <p>Resident #3's admission MDS assessment, dated 12/18/14, documented moderate cognitive impairment and total dependence on staff for eating. Resident #3's admission weight was 135 lbs. The MDS assessment, and subsequent MDS assessments, dated 6/8/15 and 2/28/16, noted Resident #3 did not have a condition or disease that would result in a life expectancy of less than 6 months, was not on hospice care, did not have a diagnosis of malnutrition, palliative care, or significant weight loss or a weight other than her admission weight.</p> <p>A 4/21/15 Physician Progress Note documented palliative care and chronic pain syndrome with diagnostic ICD coding.</p> <p>"Palliative care is when a resident has reached a stage in their illness in which cure is no longer possible or when they refuse further treatment.</p>	F 325	<p>supplements. The Registered Dietician will review these residents at a minimum of monthly to make further dietary recommendations as appropriate.</p> <p>The facility will weigh residents per policy-New admissions will be weighed upon admission and then weekly for four weeks and then monthly. Residents deemed at risk for weight loss by the Registered Dietician or residents who have experienced a significant weight loss will be weighed weekly until weight is stable or resident has gained weight.</p> <p>Element #3 Licensed Nurses and Certified Nursing Assistants were re-educated regarding documentation of resident meal and supplement intake.</p>	

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F 325	<p>Continued From page 52</p> <p>Palliative care does not mean nothing more will be done...Palliative care is actually aggressively planned comfort care." Treas, L. S. & Wilkinson, J. M. (2014). Basic Nursing: Concepts, Skills & Reasoning. F.A. Davis Company: Philadelphia.</p> <p>Resident #3's Care Plan did not contain documentation related to palliative care, comfort care, or end-of-life care.</p> <p>Resident #3's Care Plan, revised 8/20/15, identified Resident #3 was at risk for altered nutrition related to a diagnosis of cancer. Interventions included:</p> <ul style="list-style-type: none"> * Diet as ordered; * Allow time to complete meal; * Monitor intake; * Monitor weight for significant changes monthly/prn (crossed out); * Set up assist for meals (crossed out), dependent on staff at meals (added); * Food preferences as provided/available; * Staff assist as needed; * Skilled therapies as ordered; * Adjust food portions as needed; * Supplements as needed per order; * Notify physician if weight decreases by more than 5 pounds; * Offer alternative if refuses meal; * Labs as ordered; * Assess for malnutrition-cachexia, eyes dull/sunken, gums swollen, muscle wasting, skin turgor tent, pale skin color, dry oral/nasal mucosa. <p>Resident #3's Care Plan did not address what staff were to do when she refused fluids or food.</p>	F 325	<p>The Clinical Interdisciplinary Team was re-educated to review the meal and supplemental intake documentation to ensure documentation is completed and to notify the Registered Dietician for further recommendations of residents who experience weight loss and/or have frequent refusal of meals and/or supplements.</p> <p>Licensed Nurses and Certified Nursing Assistants were re-educated to return to the resident and offer more food when a resident has not eaten at least 75% of the meal and/or supplement and if the resident does not like what is on his/her tray to offer the resident alternative selections.</p>	

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F 325	<p>Continued From page 53</p> <p>The Nurse Tech Information Kardex, undated, documented the following regarding Resident #3:</p> <ul style="list-style-type: none"> * Ambulation - under the category of other "comfort care" * Personal Hygiene - dentures (documentation did not indicate if Resident #3 wore them) * Eating - regular diet/no salt and dependant on staff * Fluids - no documentation (blank) <p>The Kardex did not provide nursing staff guidance or direction in caring for Resident #3 regarding palliative/comfort care, food intake, fluids intake, supplements, preferences, frequency of offering food and fluids, intake assistance, or oral care.</p> <p>Quarterly Nutritional Reviews were not documented between Resident #3's 12/11/14 Initial Nutritional Assessment and 9/15/15, when the next Quarterly Nutritional Review was documented. The 9/15/15 Quarterly Nutritional Review documented that on 6/2/15 Resident #3 weighed 105.8 lbs.</p> <p>Resident #3's quarterly MDS assessment, dated 6/8/15, documented her most recent weight in the previous 30 days as 135 lbs. The response to the assessment question of whether Resident #3 had "weight loss of 5% or more in the last month or 10% or more in last 6 months" was documented as, "No or unknown." The assessment did not reflect Resident #3's weight on 6/2/15 of 105.8 lbs, a loss of 31.2 lbs (22.7%) since admission, or loss of 29.2 lbs (21.6%) since the admission MDS assessment on 12/18/15.</p> <p>A 6/17/15 Physician's Order documented, "No weights, loss expected d/t [due to] terminal</p>	F 325	<p>Element #4</p> <p>The Director of Clinical Services or designee will QA resident's with weight loss or at risk for weight loss meal and/or supplement intake to ensure the Registered Dietitian has been notified and further recommendations are documented 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.</p>		

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F 325	<p>Continued From page 54 illness."</p> <p>Resident #3's Quarterly Nutritional Review, dated 9/15/15, documented Resident #3 consumed 60% of her regular meal and 180-240 cc of fluids per meal. The review documented Resident #3 was independent in eating and ate in her room. The review documented the continuation of the plan of care, regular diet per physician's order, and anticipated nutritional decline with terminal diagnosis. Dentures were not noted or assessed. Additional dietary interventions were not implemented.</p> <p>A 9/15/15 Quarterly Nutritional Review and subsequent Quarterly Nutritional Reviews and dietary notes did not address Resident #3's 6/2/15 weight of 105.8 lbs, or include further weights, assessments of her nutritional status, or new interventions. Resident #3's medical record did not include further documentation related to her 6/2/15 weight of 105.8 lbs.</p> <p>An IDT Progress Note, dated 10/10/15, documented Resident #3's weight loss was expected with terminal illness and that on 6/17/15 weights were discontinued. The note documented Resident #3 ate in her room, and averaged 25-30% intake with meals with 5 refusals in 7 days. A regular diet for Resident #3 was continued with the addition of "Med Pass 2 oz" three times a day. An IDT Progress Note, dated 11/11/15, documented Resident #3 had refused the health shakes.</p> <p>On 12/29/15, a Nutritional Evaluation documented Resident #3 consumed 45% of meals, providing 1000 kcal a day and that based on her last weight she needed to consume 55%.</p>	F 325	<p>The Director of Clinical Services or designee will QA resident meal intake to ensure the resident was offered an alternative if he/she did not eat at least 75% of the meal 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.</p>		

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F 325	<p>Continued From page 55</p> <p>The evaluation noted Resident #3 remained on a regular diet and ate independently in her room. Recommendations were to continue the plan of care.</p> <p>On 12/29/15, malnutrition was identified on the care plan, and the intervention of providing "clear Ensure three times a day on [Resident #3's] room tray per resident request" was added.</p> <p>On 3/4/16, a quarterly Nutritional Review documented Resident #3 remained on a regular diet and Ensure three times a day, providing 540 Kcal and 27 g of protein. Resident #3 consumed 25% of meals, required assistance for eating in her room, and had pressure sores to her left toe and left hip. Recommendation were "Med Pass 2 oz." three times a day to add extra Kcal and protein for wounds.</p> <p>An IDT Progress Note, dated 4/28/16, documented a decrease in Resident #3's intake in the previous 7 days of 15% with poor fluid intake. The note stated Resident #3 was in pain, but refused medication as well as supplements and assistance.</p> <p>A 5/4/16 Physician Progress Note documented palliative care, skin ulcer and cachexia.</p> <p>On 5/16/16, a quarterly Nutritional Review documented Resident #3 had no dietary changes. The review documented Resident #3 consumed 10% of meals and verbalized "No" to staff attempts to assist with meals, and to continued attempt to assist with meals. The review documented pressure sore treatments continued and the wounds were considered unavoidable.</p>	F 325			

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F 325	<p>Continued From page 56</p> <p>Quarterly Nutritional Reviews since admission documented progressive declines in intake with the implementation of:</p> <p>*12/19/14- fortified meals and whole milk; *10/10/15 and 3/4/16- Med pass 2 oz. three times a day; and *3/4/16-clear Ensure three times a day.</p> <p>Resident #3's quarterly MDS assessment, dated 5/19/16, documented severe cognitive impairment, and total dependence for mobility, eating and all cares. The assessment documented Resident #3's most recent weight in the previous 30 days was 135 lbs. The assessment documented Resident #3 did not have a condition or disease that results in a life expectancy of less than 6 months, was not on hospice care, and did not have a diagnosis of malnutrition or significant weight loss. The MDS assessment did not document additional diagnoses of palliative care and cachexia.</p> <p>On 6/6/16 at 7:00 am, Ensure, 75% full (180 cc); 2 glasses of juice, one full and one half full, were observed on the resident's nightstand. At 11:20 am, no change in the level of fluids was noted. At 12:00 pm, a CNA brought Resident #3's lunch tray. At 12:15 pm, the CNA left the room with the lunch tray. The half full glass of juice was no longer in the room. ADL sheets for 6/6/16 documented Resident #3 refused lunch.</p> <p>On 6/6/16 at 2:35 pm, Resident #3 was observed lying in bed. She appeared extremely thin and had contractures of one arm and both legs. Resident #3's dentures were observed to remain in a cup at the sink during the survey from 6/6/16 - 6/10/16.</p>	F 325			

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F 325	<p>Continued From page 57</p> <p>On 6/7/16 at 8:15 am, Resident #3 had an unopened container of Ensure and a full glass of juice on her night stand. Her family member stated he was not sure whether the resident had breakfast yet. He stated he usually waited until the resident's breakfast arrived before he left for the dining room. At 12:15 pm, a full Ensure, full glass of thickened water, and juice were on the night stand. At 4:50 pm, a full Ensure, full glass of thickened water, and juice were observed on the night stand.</p> <p>On 6/8/16 at 12:20 pm, CNA #6 was observed taking a lunch tray into Resident #3's room. CNA #6 left the room with the tray after a few minutes. The lunch tray had pieces of chicken, mashed potatoes, and a green vegetable. CNA #6 stated Resident #3 took a few small bites of potatoes and drank her juice,"160 cc glass." CNA #6 stated Resident #3 had not been eating and she did not return to offer Resident #3 more food or alternatives. CNA #6 stated Resident #3 usually drank the red juice.</p> <p>On 6/9/16 at 8:00 am, CNA #4 was observed delivering a breakfast tray of French toast, bacon, creamed cereal, and juice to Resident #3. CNA #4 stated Resident #3 did not wear her dentures because they did not fit, needed to be re-evaluated, and because she rarely ate. CNA #4 stated she was unsure why the cereal and bacon was on the tray because Resident #3 could not eat the bacon and did not like cereal. When asked the reason Resident #3's trays were not left in the room and whether staff came back and periodically offered Resident #3 more food, CNA #4 stated meal trays were not to be left in the rooms. CNA #4 stated Resident #3 usually drank</p>	F 325			

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F 325	<p>Continued From page 58</p> <p>an Ensure at each meal. When asked how CNA #4 knew about offering food and fluids or comfort care, she stated she did not know if something was written, other than on the Kardex. CNA #4 said she usually tried to get Resident #3 to drink the Ensure and her juice.</p> <p>On 6/8/16 at 9:30 am, the RD stated she had reviewed all of Resident #3's nutritional information and did not know what more the facility could have done to meet the resident's nutritional needs. The RD stated Resident #3 was in "control" of her care.</p> <p>On 6/9/16 at 5:00 pm, the RD stated Resident #3 directed her care although she was severely cognitively impaired. The RD stated Resident #3 refused to eat, spit out food at staff, and would tell staff to get out of her room. The RD stated the facility was following Resident #3's direction and that the only weight available to complete a nutritional assessment was Resident #3's admission weight. The RD stated a telephone order was obtained on 6/7/15 to discontinue weighing Resident #3.</p> <p>The RD stated Resident #3 did not wear her dentures because she did not want to wear them and that her diet had not changed from a regular diet because she did not want to take away that option from her. The RD stated she believed it was possible Resident #3 could eat a regular meal without her dentures. The RD stated Resident #3 was in pain and pain could affect her eating. The RD stated Resident #3's only real caloric intake was clear Ensure, which she received three times a day. She stated she had not calculated Resident #3's actual caloric intake, but a regular meal provided approximately 1800</p>	F 325			

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F 325	<p>Continued From page 59</p> <p>Kcal and Resident #3 was consuming approximately 10%, therefore her intake would be approximately 180 Kcal. The RD stated Med Pass was tried, but Resident #3 did not like it. When asked about returning and offering food or more fluids throughout the day, the RD stated Resident #3 did not want it and she "spits out her food at you." The RD stated she was unsure what else could be done as Resident #3 refused care and wanted to be left alone, noting, "[Resident #3] directs her care."</p> <p>On 6/9/16 at 5:30 pm, the OT stated Resident #3 probably did not wear her dentures because they fell out due to weight loss. The OT stated she had just attempted a speech evaluation, but Resident #3 refused. The OT stated a speech evaluation had not been done or attempted previously.</p> <p>On 6/9/16 at 5:30 pm, the Administrator and RD stated Resident #3 had lost a significant amount of weight, but Resident #3 directed her own care, and "did not want to be bothered or badgered." The Administrator stated it was her [Resident #3] "right to refuse, to leave her alone and choose to die."</p> <p>On 6/10/16 at 9:30 am, Resident #3 was observed lying in bed with her dentures in her mouth. When asked a question, Resident #3 attempted to reply, but her dentures kept dropping down.</p> <p>On 6/10/16 at 9:30 am, the IDCS and DCS stated residents were usually weighed on shower days on a wheelchair scale, which did not require extra manipulation of the resident. The IDCS and DCS could not provide an explanation why weights had not been obtained when Resident #3 was</p>	F 325			

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F 325	Continued From page 60	F 325		7/25/16	
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interviews, it was determined the facility failed to ensure residents did not receive medication without adequate indications for use or in excess dosage. This was true for 2 of 11 residents (#11 and #12), whose medications were reviewed.</p>	<p>F 329</p> <p>Element #1 Resident #11 no longer resides at the facility.</p> <p>Element #2 The facility will ensure when a Medication Error occurs; the resident will have documentation completed in the Nursing Progress notes which will include but not limited to adverse reactions and related monitoring for a minimum of 72 hours post medication error.</p> <p>Element #3 Licensed Nurses were re-educated to ensure when a Medication Error occurs; the resident is to have documentation completed in the Nursing Progress notes which will include but not limited to adverse reactions and related monitoring for a minimum of 72 hours post medication error.</p>			

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F 329	<p>Continued From page 61</p> <p>This resulted in Resident #11 receiving 10 times the ordered dose of Morphine, creating the potential of an overdose reaction; and Resident #12 receiving an antipsychotic medication for elopement and wandering. Findings include:</p> <p>Resident #11 was admitted to the facility on 2/11/16 on comfort measures.</p> <p>The facility's Adverse Drug Reactions and Medication Discrepancy Policy documented "medication discrepancies and adverse drug reactions are documented and reported."</p> <p>Resident #11's 2/11/16 hospital discharge to a skilled nursing facility orders documented an order for Morphine Sulfate 5 mg (100 mg/5 ml) or 0.25 ml.</p> <p>On 2/12/16, an untimed Medication Incident report documented Resident #11 was administered Morphine Sulfate "2.5 ml" instead of 0.25 ml. The Incident report documented the nurse was educated to use a syringe to dispense the medication rather than a medication cup.</p> <p>Daily Skilled Nurse's Notes, dated 2/12/16, 2/13/16, and 2/14/16, did not contain documentation of the medication error, adverse reactions, or related monitoring.</p> <p>Resident Safety Checks every 30 minutes contained documentation for 2/12/16, 2/13/16, 2/14/16, however the checks conducted by CNAs were for "restless/high fall risk."</p> <p>On 6/9/16 at 5:30 pm, the DCS stated a medication error should be documented in nursing progress notes and placed on 72 hour</p>	F 329	<p>Element #4</p> <p>The Director of Clinical Services will QA to ensure when a Medication error occurs, that documentation is completed appropriately during the Daily Clinical Meeting after a medication error has occurred. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director with each occurrence and to the Quality Assurance Performance Improvement Committee monthly.</p>		

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F 329	<p>Continued From page 62 alert charting.</p> <p>2. Resident #12 was admitted to the facility on 3/18/16 with a diagnosis of dementia.</p> <p>An Elopement Risk Evaluation, dated 3/18/16, documented Resident #12 was determined to be "at risk for elopement."</p> <p>Resident #12's Admission Care Plan, dated 3/18/16, included: Falls/Safety/Elopement Risks - The goal was for Resident #12 to remain free of injuries and falls. A handwritten entry stated "Elopement initiated."</p> <p>A Behavior Symptom Monitoring Flow Record, dated March 2016, documented the behavior of "Wandering-Elopement" with the following interventions:</p> <ul style="list-style-type: none"> * Pharmacologic Intervention: Seroquel. (antipsychotic medication) * Non-pharmacologic Interventions: re-orient; redirect with an activity such as knitting, coffee; reassure her she is ok and that her children are ok; and 15-minute checks (line of sight). <p>Daily Skilled Nurse Notes, dated 3/20/16, documented Resident #12 was "easily redirected." A Daily Skilled Nurse Note, dated 3/21/16, documented Resident #12 was "re-directable." An IDT Progress Note, dated 5/3/16, documented, "Goes out front door. Must be directed back into facility. Redirects well."</p> <p>Resident #12's medical record did not contain documentation supporting the use of an antipsychotic medication to prevent wandering</p>	F 329			

F-329 Unnecessary Drugs (Regarding resident #12)

Element #1

Resident #12 no longer resides in the facility.

Element #2

Currently facility resident's antipsychotic medications were reviewed to ensure medications were being used as appropriate and with appropriate diagnosis.

Element #3

The Interdisciplinary Team and Licensed Nurses were re-educated to ensure antipsychotic medications prescribed are used as appropriate and with appropriate diagnosis.

Element #4

The Director of Clinical Services will QA resident antipsychotic medications to ensure they are used appropriately and with appropriate diagnosis weekly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.

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F 329	Continued From page 63 and elopement from the facility.	F 329		7/25/16	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to 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.	F 431	Element #1 The Medication Ipratropium, Albuterol sulfate Inhalation Solution, the two suppositories of Promethazine HD and the 43 red blood collection tubes were disposed. Element #2 The Medication Room and Medication Carts were reviewed and no other expired medications were observed. The facility will ensure medications and blood collection tubes are disposed of prior to expiration dates. Element #3 Licensed Nurses were re-educated to ensure Medications and blood collection tubes are disposed of prior to expiration dates.		

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F 431	Continued From page 64 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure expired medications were not available for administration to residents. Expired medications were identified in 1 of 1 medication room. This created the potential for sub-optimal efficacy for residents who received the expired medications. Findings include: On 6/8/16 at 11:30 am, the medication Ipratropium Bromide with an expiration date of 5/2016 was observed in the Medication Room with a container of Albuterol sulfate Inhalation Solution that expired January 2016. Also observed was an emergency box containing 2 suppositories of Promethazine HD that expired September 2015, and 43 of 100 red blood collection tubes that had expired in February 2016.	F 431	Element #4 The Director of Clinical Services or designee will QA the Medication Room and Medication Carts to ensure there are no expired medications or blood collection tubes 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.		
F 441 SS=D	On 6/8/16 at 11:30 am, LN #3 stated all of the above listed medications were expired. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F441 F 441	Element #1 Resident #16 and #17 were assessed by the Director of Clinical Services or designee and no adverse reactions were observed related to the potential of exposure to body fluids. The grab bar was repaired by extending the bar out so Resident #16 did not scape his hand on the wall when using the grab bar. There has been no further issues with the grab bar.	7/25/16	

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F 441	<p>Continued From page 65 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, it was determined the facility failed to ensure residents' bathrooms were maintained to prevent exposure to body fluids. This was true for 2 of 2 residents (#16 and #17) who shared an adjoining bathroom and created the potential for spread of infections. Findings include:</p> <p>On 6/5/16 at 4:15 pm, the shared bathroom between Resident #16's room and Resident #17's</p>	F 441	<p>Element #2 Resident's bathroom grab bars were reviewed to ensure there was enough space between the bars and wall so resident's hands do not rub against the wall potentially causing injury which could potentially cause exposure to body fluids.</p> <p>Element #3 Facility staff were re-educated to notify the maintenance Director when equipment needs to be repaired or adjusted to prevent resident injury and potential exposure to body fluids so repairs and/or adjustments can be made.</p> <p>Licensed Nurses, Certified Nursing Assistants and Housekeeping staff were re-educated on how to properly clean areas with possible body fluids to prevent exposure.</p>		

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F 441	Continued From page 66 room was noted to have approximately 24" grab bars located on both sides of the toilet. The left grab bar was wrapped and observed with dried blood along its length. On 6/6/16 at 11:00 am, the blood observed the previous day was still on the wall and grab bar, but at 1:30 pm housekeeping had cleaned the rooms and the wall and grab bar were observed to be clean. On 6/7/16 at 10:30 am, Resident #17 stated he was aware of the blood on the wall and thought it was his roommate's. He stated he thought his roommate slipped on the grab bar so the facility had taped the bar to keep his hand from slipping. On 6/9/16 at 7:45 am, the bathroom wall behind the grab bar was observed to have a light smearing of blood. Resident #16 was observed to have open areas on the middle and index fingers of his right hand and a skin tear on the top of his left hand. Resident #16 stated he often took himself to the bathroom and his hands rubbed against the wall. On 6/9/16 at 5:30 pm, the Administrator stated he had spoken with Resident #16 about extending the bar to avoid hitting his hand on the wall.	F 441	Element #4 The Executive Director or designee will QA facility grab bars and bathrooms to ensure there is not a potential for exposure to body fluids 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly. The Director of Clinical Services will QA staff's knowledge on cleaning up areas with potential body fluids weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.		
F 524 SS=F	483.75(s) FACILITY CLOSURE The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (r) of this section. This REQUIREMENT is not met as evidenced	F 524			

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F 524	Continued From page 67 by: Based on policy review and staff interviews, it was determined the facility failed to ensure a functional Facility Closure Policy was in place. In the case of a voluntary or involuntarily closure of the facility, this deficient practice had the potential to result in unmet resident needs; inappropriate and/or unsafe discharge of residents; loss of residents' property, records, and funds; and lack of timely notification to all involved entities. Findings include: On 6/5/16 at 4:00 pm, the facility's closure policy was requested upon entrance. On 6/7/16, at 2:00 pm, the Administrator provided a memorandum on Facility Closure Guidance. The Administrator stated the facility's corporate office had just sent over the plan and approved the plan's disclosure. The undated memorandum restated the requirements of notification and included a total of 3 sentences. The memorandum did not include detailed plans and procedures pertaining to notification; preparation; implementation; safety; appropriateness of transfers; or record keeping to ensure continuity of care and that all necessary goods and services were provided for residents during the closure process.	F 524	Element #1 No specific residents were cited in this citation. Element #2 The facility has developed a Facility Closure Plan which includes plans and procedures as to notification; safety; appropriateness of transfers; record keeping to ensure continuity of care, and that all necessary goods and services are provided for the residents during the closure process. Element #3 Facility staff have been educated on the Facility Closure Plan. Element #4 The Executive Director or designee will QA staff knowledge of the Facility Closure Plan weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	7/25/16	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
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August 23, 2016

James Vorous, Administrator
Clearwater Health & Rehabilitation
1204 Shriver Road,
Orofino, ID 83544-9033

Provider #: 135048

Dear Mr. Vorous:

On **June 10, 2016**, an unannounced on-site complaint survey was conducted at Clearwater Health & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007021

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from June 5, 2016 to June 10, 2016.

The following observations were completed:

Resident cares, transports, and transfers;

The following documents were reviewed:

The identified resident's medical record;

Incident and accident reports from January 2016 to June 5, 2016;

Abuse and neglect investigation from January 2016 to June 5, 2016;

The facility's Grievance file from January 2016 to June 5, 2016; and

Resident Council minutes from March 2016 to May 2016.

The following interviews were completed:

Three residents were interviewed regarding staff, safety, and notification;

Two family members were interviewed regarding staff, safety, and notification;

Nine residents in the Group Interview regarding staff, safety, and notification;

Nursing staff were interviewed regarding staff training, safety and notification; and

Administration was interviewed regarding staff training, safety and notification.

Allegation #1: The Reporting Party alleged an identified resident had sustained a fracture after a staff member propelled the resident's wheelchair into a bookcase. The identified resident was not taken for X-rays for two days after the event. The resident's family was not notified until the resident had returned to the facility after the X-rays were obtained .

Findings #1: The identified resident was no longer at the facility. Review of the identified resident's medical record revealed the resident had sustained a fractured tibia after a CNA had bumped her foot into a bookcase while transporting the resident in her wheelchair. The medical record documented the resident had complained of pain. The resident was sent for an evaluation of her foot/leg two days after the incident. The medical record further documented family had not been contacted until the resident was on her way back to the facility.

Substantiated. Federal deficiencies related to the allegation are cited. Please refer to F 279, F 309 and F 323 regarding the failed practices.

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: The Reporting Party alleged the facility had not trained staff sufficiently to care for residents, including an identified resident. The Reporting Party alleged this was particularly noticeable on weekends.

Findings #2: The identified resident was no longer at the facility at the time of the investigation. The investigation was initiated on a weekend. The identified resident's medical record and incident and accident report investigations documented staff were untrained in caring for the identified resident.

Substantiated. Federal deficiencies related to the allegation are cited. Please refer to F 279 and F 323 regarding the failed practices.

Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: The Reporting Party alleged the identified resident's physician visits were too fast, done in the dining room and family was not notified in advance so they could attend visits.

Findings #3: The identified resident was no longer at the facility at the time of the complaint investigation. Review of the identified resident's medical record documented regular physician visits. However, the documentation did not provide information as to the extent, environment or notification of those visits. Interviews with residents, family, staff and administration did not reveal issues with physician visits.

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

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

James Vorous, Administrator
August 23, 2016
Page 3 of 3

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it was addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink, appearing to read "Nina Sanderson". The signature is written in a cursive style with a large initial "N".

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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August 24, 2016

James Vorous, Administrator
Clearwater Health & Rehabilitation
1204 Shriver Road,
Orofino, ID 83544-9033

Provider #: 135048

Dear Mr. Vorous:

On **June 10, 2016**, an unannounced on-site complaint survey was conducted at Clearwater Health & Rehabilitation. The complaint allegation, findings and conclusions are as follows:

Complaint #ID00007293

The complaint was investigated in conjunction with the federal recertification and state licensure survey conducted between June 6, 2016, and June 10, 2016.

Observations were made regarding hot water availability, hot water heaters and electrical panels, and the facility's showering practices. The facility's Grievance file and Resident Council meeting minutes between January 2016 and June 2016 were reviewed. Interviews were conducted with three individual residents, two resident family members, and nine residents in a Resident Group. Direct care staff in the facility were interviewed, as well as facility Administrative staff. The facility Maintenance Director was interviewed. All interviews included questions regarding hot water availability and facility showering practices.

Allegation: The Reporting Party alleged the facility had an electrical problem that resulted in residents not having hot water, and electrical breakers were being tripped and turned off by untrained staff.

James Vorous, Administrator

August 24, 2016

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Findings: Interviews with maintenance, residents, family members, staff, and administration revealed the facility had an issue with hot water when an employee turned off the wrong electrical breaker, which was to the supplemental hot water heater. The facility determined the problem was not related to an electrical problem. The maintenance manager stated the heating system was old and the air thermostat used to control room temperatures did not work properly, so if the electric boilers were on, the facility was receiving heat. At the time of the incident, staff had attempted to turn off the boilers by flipping the breaker, but had flipped the wrong breaker. Residents were without hot water from the time of discovery and until the supplemental water heater could recover. Resident showers were delayed during this time. Staff were educated on what breaker supplied and breakers were clearly marked for the future. While the investigation determined the facility was without hot water for showers on one occasion, the facility identified the incident as soon as it happened, determined the root cause of the problem, and implemented a plan of correction to prevent further occurrence.

Conclusion: 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/pmt