



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P.O. Box 83720  
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PHONE: (208) 334-6626  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

July 11, 2016

Julie Johansen, Administrator  
Good Samaritan Society-- Silver Wood Village  
PO Box 358  
Silverton, ID 83867-0358

FILE COPY

Provider #: 135058

Dear Ms. Johansen:

On **June 24, 2016**, a survey was conducted at Good Samaritan Society-- Silver Wood Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 21, 2016**. Failure to submit an acceptable PoC by **July 21, 2016**, may result in the imposition of civil monetary penalties by **August 13, 2016**.

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

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

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

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 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*.

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

- A civil money penalty.

If substantial compliance has not been achieved by September 22, 2016, the following remedy will be recommended:

- Denial of payment for new admissions effective September 22, 2016. [42 CFR §488.417(a)]

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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 24, 2016**, if substantial compliance is not achieved by that time.

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

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

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

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

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

- BFS Letters (06/30/11)

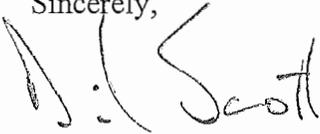
[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

This request must be received by **July 21, 2016**. If your request for informal dispute resolution is received after **July 21, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a stylized "S".

David Scott, RN, Supervisor  
Long Term Care Program

DS/lj  
Enclosures

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

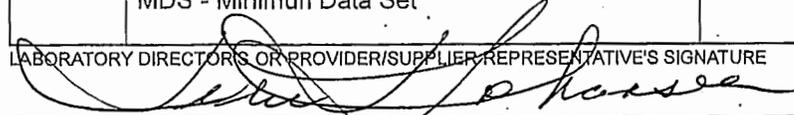
PRINTED: 07/11/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/24/2016
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility June 20, 2016 to June 24, 2016.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Nina Sanderson, LSW, Co-Supervisor LTC survey team Teresa Kobza, RDN, LD</p> <p>Definitions included: ADL - Activities of Daily Living A-Fib - Atrial Fibrillation BEERS - Potentially Inappropriate Medication Use in Older Adults BID- two times a day BOM - Business Office Manager Bruit- Thrill and Bruit (humming heard through stethoscope) CDC - Center Disease Control CKD - Chronic Kidney Disease CNA - Certified Nursing Assistant c/o Complains of D/C - Discontinue DNS - Director Nursing Services ER - Emergency Room FDA- Food and Drug Administration FSI - Fall Scene Investigation GDR- Gradual Dose Reduction H&amp;P- History and Physical L3 - Lumbar vertebra #3 LPM - Liters Per Minute LSW - Licensed Social Worker MARS - Medication Administration Record MD - Physician MDS - Minimum Data Set</p>	F 000	<p>RECEIVED AUG 17 2016 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adm	(X6) DATE 7/21/2016
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Mg - Milligrams MI - Myocardial Infarction MSK - musculoskeletal MWF - Monday, Wednesday, Friday NC - Nasal Cannula NN - Nurses Note Nsg - Nursing NSAID's - Non-Steroidal Anti-Inflammatory Drugs O2 - Oxygen Osteophyte(s) or bone spur - bony outgrowth associated with degeneration of a cartilage joint. PAINAD - Pain Assessment in Advanced Dementia POA - Power of Attorney PRN - as needed PT- Physical Therapy RN - Registered Nurse ROM - Range of Motion OT - Occupational Therapy SSPN - Social Service Progress Note SSD - Social Services Director s/s - Signs and Symptoms T12 - Thoracic vertebra #12 TARS - Treatment Administration Record w/c - Wheelchair Symbol II - Two	F 000			
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS  The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.	F 154	<b>F154 D</b>  1. Resident #6 and # 10 have had permission for antipsychotic medications signed and Black box warnings reviewed and signed by Resident or Family. 2. All Residents on antipsychotic medications have the possibility of being affected. 3. All Residents on antipsychotic medications have had their charts audited to ensure black box warnings have been explained and that permission for use has been obtained. LN were Educated 07/26/2016 on documenting informed consent for medications with BB warnings. 4. HIM will audit all new admits for signed permission and black box warnings for antipsychotic medications. LSW and MDS coordinator will audit Residents receiving antipsychotic meds with the care conference calendar. Audit findings will be compiled weekly x 4 weeks and monthly x 2 months and forwarded top QAPI for additional modification/monitoring. 5. Compliance date on or before 08/11/2016.		

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F 154	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents and/or their guardians gave consent for psychotropic medications and were informed of the FDA Black Box Warning regarding antipsychotic use and their right to decline usage based on that information. This was true for 2 of 7 residents (#6 and #10) sampled for antipsychotic medication use. The deficient practice placed residents' at increased risk of unknowingly experiencing adverse reactions to the medications. Findings include:  The FDA documented a Black Box warning for the usage of the medication Risperdal in elderly persons with dementia to include, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death."  1. Resident #10 was admitted to the facility on 6/30/15, with diagnoses which included dementia with behaviors, delusional disorder, and violent behavior.  Resident #10's May 2016 physician recapitulation orders documented an order for Risperdal 0.25 mg at bedtime for dementia with behaviors.  Resident #10's records did not contain a signed consent form from the resident's guardian. The record did not document whether the guardian was informed of the specific contents of the FDA black box warning, or that the guardian had the right to refuse its usage.	F 154			

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F 154	Continued From page 3  On 6/23/16 at 3:45 pm, the DNS stated the FDA Black Box warning and the consent were not in Resident #10's records.  2. Resident # 6 was admitted to the facility on 6/29/15 with diagnoses to include Parkinson's disease.  A physician's order, dated 2/22/16 at 1:13 pm, documented Resident #6 was started on Seroquel 25 mg daily for dementia related to Parkinson's disease. A physician's order dated 2/26/16 at 1:36 pm, documented Resident #6 was started on Zyprexa 5 mg daily for a diagnosis of paranoid thoughts related to dementia with Lewy bodies.  A consent form in Resident #6's record dated on 2/28/16, documented Resident #6's son agreed to the use of Seroquel. The form documented a list of potential side effects, but did not include documentation the medication carried a FDA Black Box warning.  On 6/23/16 at 2:30 pm, the DNS stated the facility had evidence the POA had been educated specifically to the Black Box warning, and she would provide documentation to that effect.  An undated document in Resident #6's record documented "Black box Warning Details" for Zyprexa. There was no documented evidence these warnings were brought to the attention of Resident #6's POA. The form was signed, but not dated, by the LSW.	F 154			
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	F 155			

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F 155	Continued From page 4 .  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 observation, staff and resident interview, and record review, it was determined the facility failed to ensure physician's orders and treatment plans were consistent with residents' stated goals. This was true for 2 of 11 (# 3 and # 11) residents sampled for resident choice. The deficient practice created the potential for residents to experience increased distress when pain medications and hospice services were discontinued without resident consent. Findings included:  1. Resident #11 was re-admitted to the facility on 3/7/16 with diagnoses to include MI and	F 155	F155  1. Resident #11 passed away on 05/28/2016.  Resident # 3 Care Plan has been updated to include alternative pain interventions and Resident rights have been reviewed with him on 05/17/2016.  2. Residents receiving Hospice benefits have the potential to be affected by this practice. Residents with PCP using fentanyl patches have the potential to be affected by this practice.  3. Residents receiving Hospice will be educated regarding discontinuance of hospice services prior to discontinuance. Resident's (PCP) having fentanyl patches will receive education of intent to discontinue and alternative interventions, prior to being discontinued. All education and resident response to education will be documented at time of education. Education completed 08/11/2016 Education completed for administrative and licensed staff regarding responsibility to advocate for a residents well-being including the right of the resident to have input into their treatment. Education for administrative and licensed staff included how the staff should respond when there is a treatment order conflict with the residents' expressed wishes , including the chain of command.  4. Hospice education audits will be completed weekly x4 and month x2 by SW or designee. Audits will be forwarded to QAPI for additional modification/monitoring DNS or designee will audit (PCP) Residents who have had fentanyl patch discontinued to ensure education and interventions are in place Weekly x4 and Monthly x2. All audit results will be reported to QAPI committee for additional modification/monitoring.  5. Compliance date on or before 8/11/2016		

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F 155	<p>Continued From page 5</p> <p>pulmonary edema. A 3/6/16 hospital physician's progress note documented Resident #11 and her family were planning on accessing hospice services. Resident #11's 3/7/16 re-admission orders to the facility documented a hospice consult. On 3/8/16, Resident #11 enrolled in hospice services.</p> <p>Resident # 11's record documented she received skilled nursing, nurse's aide, social work, and chaplain services between 3/8/16 and 5/26/16.</p> <p>On 5/26/16, a Physician's Monthly Update documented the resident's main complaint was "heartburn." The MD notes area of the form documented hospice would be discontinued. That same date, a medication and treatment orders page documented, "D/C hospice."</p> <p>On 5/26/16 at 4:26 pm, a SSPN documented the hospice agency was contacted to inform them of the discontinuation of services, and the discharge order was faxed. The note documented a message was left for Resident #11's POA.</p> <p>On 5/27/16 at 10:00 am, Resident #11's NN documented Resident #11 was informed that hospice services had been discontinued. Resident #11 stated she liked having hospice, and wanted them to continue.</p> <p>On 5/27/16 at 11:46 am, Resident #11's NNs documented the IDT had a conference call with Resident #11's POA, who also requested hospice be continued.</p> <p>There were no further hospice visits noted in Resident #11's record. On 5/29/16, Resident #11's NN documented she had passed away, her</p>	F 155			

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F 155	<p>Continued From page 6</p> <p>POA was called, and was overwhelmed with grief. There was no documentation that hospice was called at the time of Resident #11's death.</p> <p>On 6/21/16 at 3:50 pm, the hospice social worker stated the hospice agency had not been involved with the discontinuation of services, but had simply received a fax and a phone call from the facility that their services had been discontinued. The hospice social worker stated the hospice agency would not have discharged Resident #11 from services without first talking to her, but did not have the opportunity to do so because Resident #11 passed away before that conversation could take place.</p> <p>On 6/22/16 at 4:40 pm, the facility LSW stated after Resident #11 enrolled in hospice services, she appeared to benefit from them. The LSW stated when she was informed the physician had discontinued hospice, she "struggled" with the discontinuation, but did not talk to either Resident #11 or the physician about her concerns. The LSW stated that since the order was brought to her attention so late in the work day, she used her remaining work time to ensure the order was faxed to the hospice agency, and left a message for Resident #11's POA. The LSW stated she met with Resident #11 the next work day, and she was "very unhappy" that hospice had been discontinued without someone first talking with her, and requested the service be re-instated.</p> <p>On 6/23/16 at 8:35 am, the Administrator stated when the physician had discontinued hospice services for Resident #11, it was a "misunderstanding." The Administrator stated she had asked the physician to review the appropriateness of hospice services for another</p>	F 155			

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F 155	<p>Continued From page 7</p> <p>resident, and as long as he was doing that, suggested he review Resident #11's hospice services as well. The Administrator stated the physician interpreted her request as an indication that the facility thought hospice should be discontinued, and acted on that interpretation. The Administrator stated she spoke with Resident #11 after the physician had written the discontinuation order, Resident #11 stated she wanted to keep hospice. The Administrator stated she contacted the physician after talking to Resident #11, and the physician the resident could remain on hospice. The Administrator stated she did not have a chance to communicate that information to the LSW before she left for the day, and did not realize the order had been faxed to hospice or the POA had been contacted. The Administrator stated she had not documented either her conversation with Resident #11 or the physician. The Administrator stated Resident #11 was never "officially discharged" from hospice, so there was no real consequence to her. The facility was unable to produce a physician's order or progress note authorizing the continuation of hospice services.</p> <p>2. Resident #3 was admitted to the facility with multiple diagnoses including thoracic and lumbar compression fractures, low back pain, osteoarthritis, chronic pain, and degenerative disk disease.</p> <p>The Annual MDS assessment, dated 3/19/16, noted Resident #3 was cognitively intact.</p> <p>Physician Orders from 10/1/15 through 5/10/16 included, Fentanyl 12.5 mcg patch to be applied transdermal every 72 hours for pain related to</p>	F 155		

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F 155	<p>Continued From page 8</p> <p>collapsed vertebra and low back pain. The physician order noted Resident #3 had been prescribed and using the Fentanyl patch since 8/20/14.</p> <p>Physician Progress notes, dated 12/30/15 and 1/29/16 documented Resident #3's Fentanyl (pain) patch appeared to handle Resident #3's chronic pain adequately without untoward side effects.</p> <p>A Physician Progress note, dated 2/26/16, documented Resident #3 was "focused" on his arthritic pain, and the resident stated he was in pain on a daily basis; however, the pain medication was helping to reduce it to a 4 on a scale of 1-10, with 10 being the worst pain. The physician stated, "I informed him that he is on a narcotic pain medication and that I will not increase it due to safety issues."</p> <p>A Physician Progress note, dated 3/25/16, documented, "Continued to focus on his [Resident #3] chronic pain in his back, hip, and knees. He is on the lowest dose of fentanyl currently and I clearly discussed with him my reasoning of not increasing it due to increased risk for falls and other side effects."</p> <p>A Physician Progress note, dated 4/30/16, documented, Resident #3 continued to have primary complaint of chronic MSK pain. The note stated, "I informed him of the new CDC guidelines and the fact we will wean him off narcotics."</p> <p>A Physician Order, dated 5/10/16, documented the pharmacy was to dispense two 12 mcg Fentanyl patches to finish titration. Apply the</p>	F 155			

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F 155	<p>Continued From page 9</p> <p>patch every four days times eight days and then discontinue. On 5/21/16 Resident #3's final dose of the Fentanyl patch was removed.</p> <p>A Physician Progress note, dated 5/27/16, documented, Resident #3 was being "weaned off" of the Fentanyl patch. The note stated, "The patient speaks of nothing other than his pain in his back, hip, knees, shoulders and upper extremities. I had a lengthy discussion with him regarding the CDC guidelines regarding pain medication."</p> <p>On 6/22/16, at 10:50 am, when asked if Resident #3 had participated in the decision making process to discontinue the Fentanyl patch, RN #1 stated it was not discussed with him. RN #1 stated Resident #3 was told by the physician his patch would be discontinued based on the CDC's guidelines. RN #1 stated when nursing staff attempted to advocate for Resident #3 to keep the Fentanyl patch the physician said absolutely not.</p> <p>On 6/24/16, at 11:00 am, when asked who was involved in Resident #3's pain management process, the physician stated, "I was." When asked if Resident #3 was involved in the process, the physician stated, "No, I made the decision and informed the resident I was discontinuing his pain patch." When asked if he had considered how discontinuation of the pain patch would impact Resident #3's function and quality of life, the physician stated Resident #3 had not had a dose reduction of his narcotic medications and that chronic narcotic use was not recommended.</p> <p>The facility failed to ensure Resident #3 was involved in the decision making process related to</p>	F 155			

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F 155	Continued From page 10	F 155			
F 157 SS=D	<p>his individual pain management treatment.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 157	<p><b>F157</b></p> <ol style="list-style-type: none"> <li>Resident #11 has passed away 05/28/2016. Resident #6 was never transferred to ER on 5/17/16.</li> <li>All residents have the potential to be affected by this practice.</li> <li>Nursing staff will inform the resident timely, consult with the resident's physician and notify the residents' legal representative or an interested family member when there is an accident or change of condition or, need to alter treatment or a decision to transfer/discharge the resident. Documentation will occur at the time of changes to ensure that discussion and notification has occurred. Clinical standup will review for documentation.</li> </ol> <p>Licensed Nurses were retrained on this process on, or before 7/26/2016.</p> <ol style="list-style-type: none"> <li>Audits for documentation of notification of changes will be done Weekly X 4, Monthly X2. DNS and/or designee will ensure compliance. Audit findings will be reported to QAPI Committee for further monitoring and modification.</li> <li>Compliance on or before August 11 2016.</li> </ol>		

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F 157	<p>Continued From page 11</p> <p>Based on record review, review of facility suggestion and concern forms, and staff interview, it was determined the facility failed to ensure a resident's family and physician were notified timely following acute changes in her medical condition. This was true for 1 of 11 residents (#11) sampled for family and physician notification. The deficient practice created the potential for harm when Resident #11 did not have guidance to make a treatment decision following a heart attack or when sent to the ER. Findings include:</p> <p>Resident #11 was initially admitted to the facility on 2/1/12 following a stroke, with additional diagnoses including hypertension and type 2 diabetes.</p> <p>On 12/4/13, Resident #11's care plan documented a focus area of altered thought process related to her stroke, involving forgetfulness, impulsivity, impaired safety awareness, and poor judgement.</p> <p>Resident #11's Annual MDS assessment, dated 2/8/16, documented she was able to answer orientation questions correctly.</p> <p>a. On 3/4/16 at 4:00 am, a facility incident report stated Resident #11 had a fall from bed following an acute change in her medical status, due to leaning forward and to the right to cough.</p> <p>On 3/4/16 at 7:15 am, Resident #11's NN documented she had difficulty breathing in the night, with decreased oxygen saturations in the nighttime which continued in the morning. The NN documented Resident #11's oxygen saturations at 83-percent, and she was on 5 liters</p>	F 157			

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F 157	<p>Continued From page 12 of oxygen. The note documented the physician was notified at that time, and a new order for a chest x-ray was obtained.</p> <p>Resident #11's NN, dated 3/4/16 at 7:25 am, documented the facility called her family with information that she had fallen from bed in the night and was being sent to the hospital for a chest x-ray.</p> <p>On 3/7/16, a hospital H&amp;P noted Resident #11 had a heart attack with the complication of pulmonary edema, with the onset of symptoms at 7:00 am or earlier.</p> <p>On 6/23/16 at 8:35 am, the DNS stated that on 3/4/16 at approximately 3:00 am, Resident #11 awoke with shortness of breath, decreased oxygen saturations, and was coughing up orange and yellow sputum. The DNS stated Resident #11 fell from bed at 4:00 am. The DNS stated that though the onset of symptoms was 3:00 am, the physician was not notified until 7:00 am, and the family not notified until 7:25 am. The DNS stated the facility considered Resident #11 to be able to speak for herself, so did not feel the facility needed to notify the physician or family because she was refusing to go to the hospital. The DNS was unable to explain how Resident #11 was assessed for decision making capacity at the time of her refusals. At the time of refusal Resident #11 had impaired judgement at baseline, low oxygen saturation levels and was ill.</p> <p>b. Resident #6's NN, dated 5/17/16 at 2:53 am documented she was sent to the ER for evaluation due to complaints of nausea and vomiting. Resident #6's medical record did not include documentation that her family was</p>	F 157		

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F 157	Continued From page 13 notified she was being sent to the hospital.  A facility Suggestion or Concern form, dated 5/17/16, documented a concern of, "[Family] was not called by nursing when [Resident #6] went to the hospital." The Investigation area of the form documented, "...Hospice was notified by charge nurse. Charge nurse did not notify [Family]." The Resolution area of the form documented, "...Charge nurse assumed Hospice would call [Family]..."	F 157			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, it was determined the facility failed to ensure two reference checks were completed prior to starting work in the facility for 2 of 5 new employees (RA #1 and CNA #1). The failure placed 10 of 11 sample residents (#1 - #10) under RA #1's and CNA #1's care at increased risk of adverse events. Findings include:  On 6/23/16, review of five new employee	F 226	<b>F226</b>  1. Reference checks on RA#1 And C.N.A. #1 have been Completed and placed in their personnel files.  Reference check audits have been completed on all employees hired since 1/1/16 - all audits are compliant.  2. All resident have the potential to be affected by this practice.  3. All new hire reference checks will be completed prior to starting work. HR/Business office and Center leadership have been reeducated on the requirements of this Policy, 07/20/2016.  4. Audits will be completed as new employees are hired and audits reported to QAPI Committee for further monitoring and modification. Office Manager/HR will audit. Administrator will ensure compliance.  5. Compliance on or before August 11 2016.		

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F 226	Continued From page 14 personnel files noted the following:  a. RA #1 was hired 4/12/16. The RA's file contained 1 reference check at the time of the review, 72 days after hire.  b. CNA #1 was hired on 5/24/16. The CNA's file did not contain reference checks at the time of the review, 30 days after hire.  On 6/23/16 at 10:25 am, the Human Resources Specialist and the DNS reviewed the employee files and could not find the reference checks. The DNS stated she remembered calling the references for both and could not find where the documents were placed.	F 226		
F 242 SS=G	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: .Based on family, staff, Ombudsman, hospice staff interview, review of Suggestion and Concern forms, and record review, it was determined the facility failed to recognize the importance of a resident's right to meet privately with a hospice agency for an informational visit, and the choice to utilize hospice services at the end of her life. This was true for 1 of 2 residents (# 11) sampled	F 242	F242  1. Resident #11 has passed away 05/28/2016  2. Residents who wish to meet privately with a hospice and utilize hospice services have the potential to be affected by this practice.  3. SYSTEM CHANGE: Upon notification of a desire to meet, Hospice agencies will be allowed to meet with residents privately, for informational visits and to determine the choice to utilize hospice services at the end of life. Hospice will be immediately informed when a resident receiving benefits passes.  EDUCATION: Social Services, Business Office in-serviced 07/20/2016 and Licensed Nurses have been in- serviced on 07/26/2016 regarding requirements to ensure that Residents notifying the Center of a desire to meet with Hospice have the opportunity to do so privately. In-service also reviewed GSS Policy and Procedure for Hospice use in Long term care. Administrative staff have been re-educated on residents right to elect hospice benefit and the destruction of documents 08/11/2016.  4. Audits will be begun as a resident notifies Center of intent for hospice services. It will include notation on date of initial meeting, election of benefit, date of conversation of discontinuation, if appropriate, and notification of hospice regarding resident passing. Audits will be completed Monthly X 6 months. Audit results will be reported to QAPI Committee for further monitoring and modification. Regional RVP will participate in the monitoring of administrative staff. Monitoring will be in regard to resident's right to select hospice benefits and the destruction of hospice documents pertaining to the care of a resident. Audits will be submitted to RVP by DNS or QA nurse. Audits will be done weekly X4 bimonthly X2, monthly X3 then as determined by the QA and RVP.  5. Compliance in or before August 11, 2016	

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F 242	<p>Continued From page 15</p> <p>for hospice services. Resident #11 experienced psychosocial harm when a) she and her family experienced an interrupted grief process while attempting to enroll in hospice services; b) when hospice services were ordered to be discontinued without her input or consent, two days prior to her death; and c) when the hospice agency was not contacted to provide support to Resident #11's family so as to allow them to be with Resident #11 in the moments after she passed away. Findings include:</p> <p>Resident #11 was re-admitted to the facility on 3/7/16, following a heart attack. Her diagnoses also included a history of stroke, pulmonary edema, and hemiplegia. Resident #11's readmission orders to the facility documented a hospice consultation.</p> <p>On 3/8/16 at 12:43 pm, a SSPN documented Resident #11 and her family met with a hospice agency. The SSPN documented, "...Hospice Team excluded all facility staff who have taken care of [Resident #11] since admission from care planning. [Hospice MSW] was [misinformed] in regards to Medicare billing. [Resident #11] was admitted on 3/7/16 and was competent in understanding the paperwork she was signing upon admit. [Resident #11] signed all of her paperwork including Medicare authorization..."</p> <p>On 3/8/16 at 3:47 pm, Resident #11's SSPN's documented the facility placed a call to hospice to inform them that the LSW and DNS had met with Resident #11's family and they were ready to proceed with enrollment in hospice.</p> <p>On 3/8/16, a facility Suggestion or Concern form, filled out by the facility LSW, documented</p>	F 242			

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F 242	<p>Continued From page 16</p> <p>Resident #11's family was upset because the facility LSW "went over hospice with [Resident #11]. [Family] feels SSD was trying to talk [Resident #11] out of services." The resolution area of the form documented review with the Ombudsman regarding Resident #11's right to make her own decision regarding hospice, and documented that Resident #11's family did not feel she should make her own decision. The form did not document whether Resident #11 and her family were satisfied with the resolution of their concern.</p> <p>A hospice MSW note, dated 4/5/16, documented Resident #11 was counseled as to grief and anticipatory grief, as the facility had indicated an intent to cancel their contract with the hospice agency. The note documented Resident #11's family was considering moving her to another facility should the contract be canceled.</p> <p>A hospice MSW note, dated 4/25/16, documented the MSW was working with facility staff to ensure services and assistance for Resident #11 after the current contract between the facility and hospice expired in May 2016.</p> <p>A hospice MSW note, dated 5/9/16, documented the MSW had spoken with the facility Administrator and received permission for the hospice provider to continue to work with Resident #11, "as long as she would need service."</p> <p>A physician's order, dated 5/26/16, documented, "D/C hospice."</p> <p>A SSPN, dated 5/26/16 at 4:26 pm, documented the hospice agency was informed of the</p>	F 242			

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F 242	<p>Continued From page 17</p> <p>discontinuation of services, and a message was left Resident #11's family to that effect.</p> <p>A NN, dated 5/27/16 at 10:00 am, documented Resident #11 was notified of the discontinuation of hospice services. The note documented she did not want hospice services discontinued, and was provided with information as to how to change physicians. There was no documentation Resident #11's current physician was made aware of her preference to continue hospice, or of measures that were taken to re-institute hospice services.</p> <p>A NN, dated 5/27/16 at 11:46 am, documented the Administrator, DNS, and LSW had a conference call with Resident #11's family. The family requested a care conference with the facility, hospice agency, and the physician, due to wanting hospice services to continue. The note documented that the physician would not likely be willing to have such a meeting, and information was provided to the family as to how to change physicians that for Resident #11. The note documented if the family were to contact the physician, and the physician was willing to attend, and then the facility would attend the meeting. The note documented the family called back later and had arranged for the meeting to take place on 5/31/16.</p> <p>On 5/27/16 at 1:13 pm, a SSPN documented Resident #11's family was distrustful of facility staff, and was questioning the process by which Resident #11 was assessed to no longer need hospice services.</p> <p>A NN, documented Resident #11 passed away, and the physician and family were notified. The</p>	F 242		

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F 242	<p>Continued From page 18</p> <p>NN documented, "...daughter came here but [left] unable to get self under control over mother passing..." There was no documentation in the Resident #11's record that the hospice agency was notified of Resident #11's passing, or asked to provide support to Resident #11's daughter.</p> <p>A SSPN, dated 5/31/16, documented, "Resident's daughter had set up a meeting with IDT, [Physician] and Hospice for 1:00 pm on 5/31/16. [Physician] informed DNS he would not be in attendance. Hospice did not show up, [LSW] saw [Daughter] out front however she did not come into the building to talk about/cancel meeting with [LSW]."</p> <p>On 6/20/16 at 4:15 pm, a representative for Resident #11 reported that on 3/8/16, the family made arrangements to meet with a hospice agency to discuss the possibility of enrolling in hospice. The representative stated the meeting was arranged at the facility, so as to allow Resident #11 to participate in the discussion. The representative stated Resident #11 and her family wanted to meet privately with the hospice agency, as they had some concerns with the care in the facility. During the process of Resident #11 and her family meeting with hospice staff to make the final enrollment decision, the facility Administrator became angry, stated the paperwork completed thus far with hospice was not valid, and tore up the documents. The representative stated Resident #11 had participated in the discussion to the best of her ability, but was fatigued due to a recent heart attack and "breathing problems." The representative stated Resident #11 wanted to be excused once hospice had been explained, for family to finish the discussion and complete the admission paperwork. The representative stated</p>	F 242			

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F 242	<p>Continued From page 19</p> <p>that after Resident #11 was finally admitted to hospice services, the facility made multiple efforts to have hospice stopped, including "threats" to cancel the hospice contract as a whole, so as to force Resident #11 to discontinue hospice services or selecting a different hospice provider, and asking the physician to discontinue hospice services. The representative stated the facility requested hospice services be discontinued less than a week before Resident #11 passed away. The representative stated it was very difficult for Resident #11 and her family, as they felt, "they had to spend the last three months of her life fighting for her to get her hospice benefit."</p> <p>On 6/21/16 at 9:05 am, the Ombudsman stated she was aware of a conflict between Resident #11, her POA, and the facility regarding hospice services. The Ombudsman stated she was aware Resident #11's family had concerns that the facility had not wanted Resident #11 on hospice, and there was a time the order was discontinued, perhaps at the facility's request. The Ombudsman stated she believed Resident #11 was never "officially" taken off of hospice, despite the conflict.</p> <p>On 6/22/16 at 3:00 pm, the hospice admissions person who attempted the first meeting with Resident #11 and her family to discuss hospice services on 3/8/16, reported when she arrived at the facility to meet with Resident #11 and her family, no one was in either the facility business office or the social services office. The Admissions person stated she stepped into the Administrator's office to let her know hospice staff would be meeting with Resident #11 and her family, and there would be a service agreement for hospice and the facility to sign should</p>	F 242		

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F 242	<p>Continued From page 20</p> <p>Resident #11 decide to enroll in hospice. The Admissions person said the Administrator did not seem too concerned, so hospice proceeded to meet with Resident #11 and her family as planned. The Admissions person stated Resident #11 was initially part of the meeting, and wanted to enroll in hospice, but became fatigued and asked to be excused. The Admissions person stated while Resident #11 was being assisted to lay down, she went again to the business office to have the service agreement signed. The Admissions person stated the BOM appeared "confused" by the document, but signed it anyway. Shortly thereafter, the Admissions person reported she was summoned into the Administrator's office, where the Administrator was visibly upset and tore up the service agreement. The Admissions person then left the facility, and requested not to return.</p> <p>On 6/22/16 at 3:25 pm, the hospice LCSW stated that on 3/8/16, when she was informed the Administrator had torn up the original service agreement, she reached out to both the facility Administrator and the physician who had provided the initial referral to hospice as part of the resident's discharge from the hospital. The LCSW stated she was able to address the Administrator's concerns with the initial hospice visit and confirm with the physician that Resident #11 qualified medically for hospice services, and she and her family wanted hospice services. The LCSW stated Resident #11 enrolled with hospice on 3/8/16, but at the time the agency was told the contract would only be good until 5/8/16.</p> <p>On 6/21/16 at 3:50 pm, the hospice MSW reported she was aware the facility had concerns with hospice involvement for Resident #11, which</p>	F 242		

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F 242	<p>Continued From page 21</p> <p>she understood to be a concern that hospice would be billing fraudulently as the facility believed Resident #11 did not really need hospice services. The MSW stated there was a slight delay in Resident #11's enrollment in hospice, as the facility Administrator had become angry with the first hospice team who met with Resident #11 and her family, and that the team felt the most prudent action would be to leave the facility to research the situation before proceeding. The hospice MSW stated when she initially came to the facility, she met with both Resident #11 and her family, and that Resident #11 was aware of her diagnosis, prognosis, and the purpose of hospice services. The MSW stated Resident #11 wanted hospice services, and over time benefited from the services as her physical and emotional comfort needs were met. The MSW stated the facility communicated to the hospice agency frequently their intent to discontinue the hospice contract with them as a whole, which would mean Resident #11 would not be able to continue with services through their agency. The MSW stated this topic came up "every month," and so each month she talked with Resident #11 to prepare her to either change hospice agencies or discontinue services. The MSW stated as they approached each contract termination date, the facility Administrator extended the contract.</p> <p>During this same interview, the hospice MSW stated the hospice agency received a faxed physician's order from a facility physician in the days leading up to Resident #11's death which read simply, "D/C hospice." The MSW stated the fax did not include an assessment or rationale to explain why hospice had been discontinued. The MSW stated the facility was in the process of clarifying this order through communication with</p>	F 242		

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F 242	<p>Continued From page 22</p> <p>the hospice Medical Director and contact with Resident #11 and her family if, in fact, hospice services were no longer wanted or warranted for Resident #11, when she was notified via email that Resident #11 had died. The MSW stated the hospice agency was not notified at the time of Resident #11's death, so they could not be present with her and her family. The MSW stated, "I still don't know if we were officially involved at the time [Resident #11] died, but I have kept in contact with her family." The MSW stated, "Unfortunately, the politics of this whole situation have really complicated their grief."</p> <p>On 6/22/16 at 4:40 pm, the facility LSW confirmed the facility was aware Resident #11 returned to the facility with a referral for hospice. The LSW stated Resident #11 returned to the facility late in the day, so she was not able to act on the order until the following day. The LSW stated she had not yet had a chance to visit with Resident #11 about her desire for hospice when the hospice agency referred by the hospital, arrived at the facility. The LSW stated the facility felt the hospice agency should have met with herself and the Administrator before meeting with either Resident #11 or her family. The LSW was aware "some words were exchanged" between the facility and the hospice agency. The LSW stated ultimately, Resident #11 enrolled with and remained on hospice, but the length of the contract with the agency she had chosen was always under review. The LSW stated Resident #11 did well with hospice. The LSW stated hospice came to see Resident #11 often, and over time she was able to resume her normal socialization patterns, the quality of her interactions with peers improved, and her family seemed to visit more frequently than prior to</p>	F 242		

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F 242	<p>Continued From page 23</p> <p>hospice involvement. The LSW stated late one afternoon shortly before Resident #11 passed away the physician was in to see Resident #11, and had written an order to discontinue hospice. The LSW stated no explanation was offered for the sudden discontinuation, and that she "struggled" with the fact this step had been taken as she knew Resident #11 enjoyed interacting with her hospice providers, and the LSW felt she benefited from that service. The LSW stated when she was informed of the order, she only had a few minutes left in her work day, so she called and left messages for Resident #11's family and hospice, and faxed the discontinuation order to hospice. The LSW stated that since it was so close to the end of her workday, she did not have time to talk with Resident #11 about whether she was aware hospice services was being discontinued, or agreed with that decision. The LSW stated when Resident #11 was informed of this development the following day, she was "unhappy." The LSW reported Resident #11 stated she liked hospice and wanted them back, and was angry the physician had discontinued the service. The LSW stated she believed the DNS had hospice reinstated. The LSW stated Resident #11 passed away "a day or two later." The LSW stated the Administrator chose the course of action with Resident #11 and hospice, and as Resident #11's advocate she disagreed with the course, but did not say or do anything to alter or influence the action.</p> <p>On 6/23/16 at 8:35, the facility Administrator stated when the hospice Admissions person first arrived at the facility, she did not identify herself properly as being a representative of hospice. The Administrator stated when the BOM came to show her the service agreement which the BOM</p>	F 242			

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F 242	Continued From page 24 had signed, she considered it invalid and "wadded it up." The Administrator stated, "I feel I did the right thing. The resident has the right to be informed, and I would do it again." The Administrator stated after Resident #11 was enrolled in hospice, she remained on hospice without further incident, and had no concern that the contract could or would be canceled until after Resident #11 "no longer needed them." The Administrator stated there was some confusion a few days before Resident #11 died, but she was, "never taken off of hospice." The Administrator stated the confusion ensued when Resident #11's physician came to the facility to see another resident, who was also on hospice. The Administrator stated she asked the physician if he would review the other resident to see if that resident was appropriate to remain on hospice services, and as long as he was doing that suggested he review Resident #11's appropriateness for hospice as well. The Administrator stated she did not have any specific reason to ask the physician to review Resident #11's hospice, e.g., improvement in medical status, resident desire to discontinue hospice, etc. The Administrator stated, "It just seemed like a good idea." The Administrator stated the physician may have interpreted her request as a directive to discontinue hospice services for Resident #11, although that was not the intent of her request. The Administrator stated that same day, as soon as she saw the order to discontinue hospice, she went and talked to Resident #11, confirmed she wanted to continue hospice, and called the physician to make sure Resident #11 could continue with hospice services. The Administrator stated she did not document these conversations, and when asked by the surveyor, could not find an order in Resident #11's record to	F 242			

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F 242	Continued From page 25 continue hospice services. The Administrator stated it was a mistake not to communicate that information with the LSW, as she did not realize the LSW had already communicated the order with both Resident #11's family and the hospice agency.  Resident #11 was experienced psychosocial harm when:  *She experienced interference from the facility when she had arranged for an informational visit from, and was attempting to enroll in hospice services following a heart attack;  *The facility requested the physician review the appropriateness of hospice and an order to discontinue hospice was received without first consulting with Resident #11 or her representative, causing distress for both parties, in the days leading up to Resident #11's death, and;  *Hospice agency was not notified when Resident #11 passed away, and support was not obtained to aide the family in their immediate grief following the event.	F 242	F246  1. Rooms 201,203, 206 - beds have been moved so that they are 30" apart providing adequate personal living space.  2. All residents in semi-private rooms have the potential to be affected.  A complete audit of SNF has been completed to ensure that all semi private room beds provide adequate personal living space.  3. All rooms have been marked on the base board so that all beds remain in the proper location leaving adequate living space distance between them. Measurements will be reviewed and measured before the resident's quarterly care conference.  Environmental/Housekeeping and Nursing Staff have been in-serviced on the requirements of this regulation, the new marking system and requirements for monitoring on or before 07/22/2016.  4. Physical plant bed space audits will be completed Weekly X4; BI-monthly X 2, Monthly X3, Then as indicated by QAPI. All audit results will be reported to QAPI Committee for further monitoring and modification. Environmental Services Director or designee will audit and Administrator will ensure compliance.  5. Compliance on or before August 11, 2016.	
F 246 SS=E	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.	F 246		

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F 246	Continued From page 26  This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility failed to ensure adequate personal living space was available for 3 of 6 sampled semi-private resident rooms (rooms 201, 203, and 206). The deficient practice interfered with the residents' rights and preferences with the arrangements of their bedroom furniture and had the potential to adversely affect residents' sense of social well-being. Findings include:  During a group interview on 6/21/16 at 10:30 am, 5 of 7 residents who had a semi-private room stated they thought the beds were too close together.  The following spaces between beds were measured by the Maintenance Director on 6/23/16 beginning at 2:00 pm: * Semi-private Room 201, beds were measured 18 ½ inches apart * Semi-private Room 203, beds were measured 17 inches apart * Semi-private Room 206, beds were measured 20 inches apart  On 6/23/16 at 4:30 pm, the Administrator stated she did not realize the residents felt that way and it would be fixed.	F 246		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE  A resident has the right to receive notice before the resident's room or roommate in the facility is changed.	F 247	<b>F247</b>  1. Resident #1- was interviewed on 07/19/2016 and stated "This room is just fine. " She reports being satisfied in the room she is in and does not want to move at this time. Documentation was completed as to the discussion and resident statement. 2. Residents who have had, or need a room change have the potential to be affected by this practice. Administrative and licensed staff have been in-serviced on a residents right to receive notice prior to a room change 08/11/2016. 3. Residents needing a room change will be consulted and given advanced notice before a room move. Discussion and outcome will be documented in the Resident's record. 4. Audits will be completed weekly x4 then monthly x2 to ensure documentation supports that Resident/POA have been given advanced notice of room move. All audit results will be reported to QAPI Committee for further monitoring and modification. 5. Compliance date will be by 08/11/2016.	

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F 247	Continued From page 27  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure advanced notice was given before a resident was moved to a different room. This was true for 1 of 11 (#1) sampled residents and had the potential for psychosocial harm if the resident experienced increased anxiety, agitation, and/or fear. Findings include:  Resident #1 was admitted to the facility on 12/11/15, with diagnoses which included pain, osteoarthritis of one hip and both knees, weakness, depression, and chronic kidney disease Stage 3.  Resident #1's Quarterly MDS assessment, dated 5/27/16, documented Resident #1 was cognitively intact.  On 3/10/16 Resident #1's NN documented she was not happy with her current roommate but had declined the option to move rooms.  On 3/22/16 Resident #1's Social service note documented Resident #1 wanted to go home and did not get along with her roommate, but did not want to be moved out of her room.  On 4/13/16. Resident #1's NN documented the nurse discussed with the son that Resident #1 was moved to a different room to be closer to the nurses' station. The record did not contain documentation the move was discussed with Resident #1.	F 247			

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F 247	Continued From page 28 On 4/15/16 Resident #1's NN documented she had refused cares all morning, wanted to be left alone and would not look at the CNA.	F 247			
F 250 SS=G	On 6/23/16 at 3:40 pm, the DNS stated she could not find documentation that the room change was discussed with Resident #1. 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure a resident was allowed to make decisions about how to meet her physical and emotional needs at the end of life. This was true for 1 of 7 residents (Resident #11) sampled for social services. Resident #11 was harmed when an order was sent to a hospice agency discontinuing services without her knowledge or consent, three days before she passed away. Findings included:  Resident #11 was re-admitted to the facility on 3/7/16 following a hospitalization for a heart attack and pulmonary edema. Resident #11's readmission orders included an order for a hospice consultation. Resident #11 enrolled with hospice on 3/8/16.  Resident #11's hospice MSW notes documented	F 250	F250  1. Resident #11 has passed away.  2. Residents at end of life have the potential to be affected by this practice.  3. System change: When a resident is at end of life, Social Service Director will have discussion with resident /responsible party to allow them to make decisions about how to meet their physical and emotional needs, including Hospice use or discontinuation of use. Social Services will document conversation.  Education: Licensed staff and Interdisciplinary Team members have been in serviced on residents are allowed to make decisions about how to meet their physical and emotional needs at the end of life, including hospice and the rights of a hospice resident, notification of physician, family and hospice agency.  4. Individual audits will be completed as a resident signs on for hospice X 1 year. Audit results will be reported to the QAPI committee for further monitoring and modification. SD or designee will audit. All audits will be reported to QAPI for additional monitoring and modification.  5. Completion on or before August 11, 2016		

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STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/24/2016
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867		
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F 250	<p>Continued From page 29</p> <p>on 4/5/16, 4/14/16, and 4/25/16, that Resident #11 was receptive to hospice services, wanted to continue the services, and benefited from the emotional support from the hospice team. The MSW notes for these dates documented Resident #11 was experiencing increased distress and anxiousness as the facility was planning to cancel the contract with her hospice provider in May 2016, and she would either have to select a different hospice agency, or discontinue hospice services.</p> <p>There were no SSPNs in Resident #11's record between 3/9/16 and 5/8/16.</p> <p>On 5/9/16 at 2:00 pm, Resident #11's hospice MSW notes documented the MSW had spoken with the facility Administrator, and the Administrator had agreed to, "allow [hospice] services to stay in place...as long as [Resident #11] would need service."</p> <p>On 5/9/16 at 4:08 pm, the facility LSW documented the Resident #11 had engaged in a social activity before a hospice visit that day, and participated in a painting class afterwards.</p> <p>The next SSPN was documented on 5/26/16.</p> <p>On 5/26/16, a physician's order form documented, "D/C hospice."</p> <p>On 5/26/16 at 4:26 PM, Resident #11's SSPNs documented the LSW informed the hospice agency that their services had been discontinued, and left a message for Resident #11's family.</p> <p>On 5/27/16 at 10:00 am, Resident #11's NNs documented she was asked how she felt about</p>	F 250			

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F 250	<p>Continued From page 30</p> <p>the hospice discharge. Resident #11 stated she did not want them discharged and liked having them come. Resident #11 stated her physician was a "quack" for discharging her from hospice.</p> <p>On 5/27/16 at 11:46 am, Resident #11's NNs documented her family was upset with the discontinuation of hospice services. The NN documented Resident #11's family wanted a meeting with the physician, hospice, and facility staff to discuss this further. The NN documented the facility would not arrange such a meeting, but would attend if Resident #11's family made the arrangements. The note documented Resident #11's family was able to arrange the care conference for 5/31/16.</p> <p>On 5/27/16 at 3:13 pm, Resident #11's SSPNs documented Resident #11's family was upset with the discontinuation of hospice services without documented rationale, and had lost trust with facility staff. Documentation that the LSW spoke with Resident #11 regarding the discontinuation of hospice, or how the discontinuation of those services impacted her, was not found in Resident #11's record.</p> <p>On 5/29/16 at 12:07 am, Resident #11's NN documented she had passed away. The note documented, "...daughter came here but [left] unable to get self under control over mother passing..." There was no documentation of the hospice agency's involvement at the time of Resident #11's death.</p> <p>On 5/31/16 at 1:17 pm, Resident #11's SSPNs documented, "...daughter had set up a meeting with IDT, [Physician], and Hospice...Hospice did not show up...saw [Daughter] out in front however</p>	F 250			

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F 250	<p>Continued From page 31 she did not come into the building to talk about/cancel meeting with [LSW]."</p> <p>On 6/22/16 at 4:40 pm, the LSW stated:</p> <p>*There was a barrier to Resident #11 enrolling in hospice when she initially met with hospice staff on 3/8/16, as the facility felt hospice should have first met with the Administrator and LSW before meeting with Resident #11. The LSW stated this should have been the case because the facility was concerned Resident #11's choice to involve hospice would impact the facility's reimbursement from Medicare.</p> <p>*The Administrator eventually made the decision to "allow" Resident #11 to enroll in hospice with the provider of her choice, after which Resident #11 enrolled with hospice.</p> <p>*After Resident #11 enrolled in hospice, the Administrator initially made the decision for the facility to stop working with the agency Resident #11 chose. As the termination date for the contract approached, the Administrator agreed to let Resident #11 continue services with that agency.</p> <p>*Once Resident #11 enrolled with hospice, she was able to resume her socialization patterns, the quality of those interactions improved, and her family visited more often.</p> <p>*When the LSW was informed of the physician's order to discontinue hospice, she "struggled" with the decision, but did not say anything to the physician. She did not talk to Resident #11 about the impact of discontinuing hospice until after she had faxed the order to hospice and called</p>	F 250			

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F 250	<p>Continued From page 32</p> <p>Resident #11's family to inform them hospice had been discontinued. The LSW stated this was because the order came in at the end of her work day, and she needed to decide whether to talk to Resident #11 or get the order to hospice before she went home. The LSW stated at the time, she made the decision not to talk to Resident #11, but chose to fax the discontinuation order to hospice.</p> <p>*Resident #11 was "very unhappy" when she found out the next day that hospice services were discontinued, and insisted something be done to reinstate the service.</p> <p>*The LSW had many concerns about how the facility handled Resident #11's course with hospice, but did not advocate for Resident #11 when concerned because, "The Administrator chose the actions and course of action. I would not have done it that way. It was incorrect."</p> <p>Resident #11 was harmed when the facility failed to recognize the importance of hospice services to her as she neared the end of her life. The facility failed to advocate for Resident #11 to assure her hospice services would continue without interruption, causing her ongoing distress. Resident #11 was further distressed when her physician discontinued hospice services with no rationale three days before she died, and the hospice was notified of the discontinuation prior to Resident #11 being assessed for the psychosocial impact of the discontinuation. There was no evidence Resident #11's physician or the hospice agency were notified of Resident #11's wishes to continue services. The hospice agency was not notified at the time of Resident #11's death, or that her family was overcome with grief at her passing.</p>	F 250		

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F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</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 residents care plans were followed regarding transfers for 1 of 10 (#1) sampled residents residing in the facility. The deficient practice created the potential for harm if the resident was injured when not provided enough support during transfers. Findings included:</p> <p>Resident #1 was admitted to the facility on 12/11/15, with diagnoses which included pain, osteoarthritis of one hip and both knees, weakness, and CKD disease Stage 3.</p> <p>Resident #1's Quarterly MDS assessment, dated 5/27/16, documented Resident #1 was cognitively intact. The MDS documented Resident #1 required extensive assistance of two or more staff members with all transfer, toilet use, and bathing. Resident #1 had one sided upper extremity impairment and both sided lower extremity impairment.</p> <p>Resident #1's care plan for ADL deficits, dated 3/21/16, documented she had an ADL self-care performance deficit related to weakness, pain, limited mobility and required 2 staff assist for all cares.</p>	F 282	<p>F282</p> <ol style="list-style-type: none"> <li>1. Resident #1- Mobility transfer assistance has been reevaluated Per care plan; "transfer between surfaces and she cannot pull self to stand. Two staff assist, total lift, and high-back sling." Care Plan and Kardex have been reviewed to ensure that information for safe transfer is present. CNA providing care has been re-educated on review of KARDEX prior to providing cares.</li> <li>2. All residents requiring transfer assistance have the potential to be affected by this practice.</li> <li>3. Care Plan team will review with the resident/family mobility transfer needs of the resident to ensure that the resident is happy and comfortable with the current process. Kardex will be updated at that time and staff informed of changes to care needs.  Nursing staff have been re-educated on requirement of use of the Kardex system prior to providing care for the resident on 07/26/2016.</li> <li>4. Residents requiring a 2 person transfer will be monitored by DNS and/or designee. Audits will be completed Weekly X 4, Bi weekly X 2 months, Monthly X 3 months.  Audit results will be reported to QAPI for further monitoring and modification.</li> <li>5. Compliance on or before August 11 2016.</li> </ol>	

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F 282	Continued From page 34 Interventions included: * 2 staff assist required for dressing * 2 staff assist required for transfers between surfaces * 2 staff assist required for bathing * 2 staff assist required for all bed mobility  On 6/21/16 at 8:32 am Resident #1 pressed the call light and requested help to get dressed and out of bed for the day. CNA #1 at 8:32 am, dressed Resident #1 and transferred her from her bed to her wheelchair. There was not a second person in the room to assist.  On 6/23/16 at 3:45 pm the DNS confirmed Resident #1 required 2 staff to assist her with all cares, as stated in her care plan.	F 282	F309 1. Resident #11 passed away 05/28/2016.  Resident #3 was educated on alternative pain modalities. Knees were injected 06/28/2016. Resident was re-educated on non pharmacological interventions and resident rights on discontinuation of pain medications. Pain assessment completed with no changes in pain level. Care Plan updated.  Resident #1 was educated on alternative pain modalities and resident rights in discontinuation of pain medications. Pain assessment completed with no changes in pain level.  Resident #2 Dialysis Center was contacted and care has been coordinated includign the use of a dialysis communication form .  Resident #10 Antipsychotic medication has been reviewed for clear indications for use and behavioral monitoring placed. Care plan has been updated to reflect non pharmacy interventions and behavioral monitoring.  Resident #6 Care plan has been modified to reflect interventions to meet the residents dementia care needs.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of Incident Reports and Suggestion Concern forms, and record review, it was determined the facility failed to ensure care and services necessary for residents to achieve their highest practicable physical, emotional, and psychosocial wellbeing. This was true for 6 of 11 sampled residents	F 309	2. All residents have the potential to be affected by these practices.  3. Nurses re-educated on physician notification of acute episodes. Residents will be informed of physicians decisions. If resident disagrees with MD decision, social services, family and the ombudsman will be included as indicated.  4. Audit for Physician notification of resident status change, Narcotic pain med usage and discontinuance, Use of Dialysis communication form , Indications for antipsychotic medicaiton use, and interventios for Behavior and Dementia care Interventions will be Audited by DNS and/or designee weekly X 4, Bi-weekly X2, monthly X3.	

Audit results will be reported to QAPI Committee for further monitoring and modification.

5. Compliance on or before 08/11/2016.

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F 309	<p>Continued From page 35 (#1,#2, #3, #6, #10, and #11). a) Resident #11 was harmed when the facility failed to inform the physician for four hours after an acute onset of symptoms, requiring hospitalization and resulting in her being placed on palliative care. Resident #11 was at further risk of harm from a lack of communication and coordination with hospice. b) Resident #3 was harmed when his narcotic pain patch was discontinued and he experienced debilitating prolonged pain and he was not included in decisions made about his pain management needs and goals. c) Resident #1 had the potential for harm when her narcotic pain medication was discontinued and she experienced increased pain. d) Resident #2 had the potential for harm when the facility did not coordinate care with the dialysis unit. e) Resident #10 was placed at risk of harm when he was administered antipsychotic medication without clear indication for use and without effective behavioral monitoring systems in place. f) Resident #6 had the potential for harm when the facility failed to develop a dementia care plan consistent with recognized standards of practice. Findings include:</p> <p>1. Resident #11 was initially admitted to the facility on 2/1/12 following a stroke, with additional diagnoses including hypertension and type 2 diabetes.</p> <p>On 12/4/13, Resident #11's care plan documented a focus area of altered thought process related to her stroke, involving forgetfulness, impulsivity, impaired safety awareness, and poor judgement.</p> <p>a. Resident #11's Annual MDS assessment, dated 2/8/16, documented she was able to</p>	F 309			

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F 309	<p>Continued From page 36 answer orientation questions correctly.</p> <p>On 3/4/16 at 4:00 am, her facility incident report documented Resident #11 had a fall from bed following an acute change in her medical status, due to leaning forward and to the right to cough.</p> <p>On 3/4/16 at 7:15 am, Resident #11's NN documented she had difficulty breathing in the night, with decreased oxygen saturations in the nighttime which continued in the morning. The NN documented her oxygen saturations at 83%, on 5 liters of oxygen. The note documented the physician was notified at that time, and a new order for a chest x-ray was obtained.</p> <p>On 3/4/16 at 7:25 am, Resident #11's NN documented the facility called her family with information that she had fallen from bed in the night, and was being sent out for a chest x-ray.</p> <p>On 3/4/16 at 9:53 am, Resident #11's SSPNs documented she had returned from the hospital and did not feel well. The note documented she had refused returning to the hospital twice before the facility reviewed the results of the chest x-ray with her. After Resident #11 was made aware of the results of the x-ray taken that morning, she agreed to go to the hospital for evaluation if her physician felt it was necessary.</p> <p>On 3/5/16, a facility Suggestion or Concern form documented Resident #11's family was concerned she was not taken to the hospital, "soon enough when she was having heart, chest pains." The "Investigation" into the family's concern was documented on 5/5/16, the "Resolution" on 5/6/16, and the "Follow-up" on 5/9/16. The form documented Resident #11 was</p>	F 309		

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F 309	<p>Continued From page 37</p> <p>"not incompetent" and had refused to go to the hospital, and that she had a DNR in place.</p> <p>On 3/7/16, the hospital H&amp;P stated Resident #11 had previously been hospitalized from 2/25/16 through 2/27/16 for similar symptoms, and was noted with suggestive EKG changes for the potential for a heart attack at that time. The H&amp;P documented Resident #11 was sent to the ER at 4:00 pm on 3/4/16, due to continued reports of chest pain and shortness of breath. Upon arrival at the ER, Resident #11's blood pressure was 85/60 and oxygen saturations were documented at 85%. The H&amp;P documented Resident #11 was found to have had a heart attack with the complication of pulmonary edema, with the onset of symptoms at 7:00 am or earlier. The H&amp;P documented discussions were held with Resident #11's family at that time, and due to the additional time delay, the decision was made to keep her in the hospital on comfort measures.</p> <p>On 6/22/16 at 4:40 pm, the LSW stated that on 3/4/16, she was informed when she arrived at work at approximately 8:00 am that Resident #11 was not feeling well and had refused to go to the hospital. The LSW stated she and the DNS reapproached her to discuss risks and benefits of her decision, and she agreed to go to the hospital. She could not be certain of the timeframe.</p> <p>On 6/23/16 at 8:35 am, the DNS stated that on 3/4/16 at approximately 3:00 am, Resident #11 awoke with shortness of breath, decreased oxygen saturations, and was coughing up orange and yellow sputum. The DNS stated the nurse on duty offered several times to send her to the ER, but she refused to go. The DNS stated Resident</p>	F 309			

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F 309	<p>Continued From page 38</p> <p>#11 fell from bed at 4:00 am. The DNS stated that though the onset of symptoms was 3:00 am, the physician was notified at 7:00 am. The DNS stated the facility considered Resident #11 to be able to speak for herself, so did not feel the need to notify the physician when Resident #11 was refusing to go to the hospital. The DNS did not know if there were other assessments or treatment options the physician would have ordered, aside from evaluation at the ER, if such notification had been made. The DNS was unable to explain how Resident #11 was assessed for decision making capacity at the time of her refusals. Resident #11 had impaired judgement at baseline, low oxygen saturations, and illness at the time of the discussions.</p> <p>Resident #11 was harmed when the facility did not notify the physician for four hours after the onset of acute symptoms, including shortness of breath with decreased oxygen saturation levels and a fall. When the physician was notified, Resident #11 agreed to have a chest x-ray. When the chest x-ray results were known, Resident #11 agreed to go to the hospital for evaluation. She was found to have suffered a heart attack several hours earlier, which had worsened over the course of the day. Resident #11 and her family opted for palliative care, in part due to the time delay in diagnosis and worsening of the symptoms over the course of the hours during which treatment was delayed.</p> <p>b. Resident #11 was re-admitted to the facility on 3/7/16 following her heart attack, with an order for a hospice consultation. Resident #11 was admitted to hospice services on 3/8/16.</p> <p>Resident #11's care plan at the time of her death</p>	F 309			

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F 309	<p>Continued From page 39</p> <p>on 5/29/16, documented a focus area of a terminal diagnosis and the involvement of hospice services. The care plan did not include how cares and services would be coordinated between the facility and the hospice agency, which hospice agency was working with her, or when or how the hospice agency was to be contacted.</p> <p>On 5/17/16, a facility Suggestion or Concern form documented Resident #11 was sent to the hospital for evaluation of a stomach ache, but her family was not notified. The Resolution area of the form documented the facility nurse notified the hospice agency, but did not notify Resident #11's family as it was assumed the hospice agency would make that notification.</p> <p>On 5/29/16 at 12:07 am, Resident #11's NN documented Resident #11 passed away. The note documented her family "came here but [left] unable to get self under control over [Resident #11] passing..." The NN did not include documentation the hospice agency was contacted regarding Resident #11's passing or her family's response to her death.</p> <p>On 6/23/16 at 8:35 am, the DNS and Administrator stated they had no further documentation to offer to show the coordination between the facility and the hospice agency for Resident #11.</p> <p>2. Resident #3 was admitted to the facility with multiple diagnoses including thoracic and lumbar compression fractures, low back pain, osteoarthritis, chronic pain, and degenerative disk disease.</p>	F 309			

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F 309	<p>Continued From page 40</p> <p>The Annual MDS assessment, dated 3/19/16, indicated Resident #3 was cognitively intact; received scheduled pain medications and non-medication interventions for pain; and denied the presence of pain during a pain assessment interview.</p> <p>Resident #3's pain care plan, revised on 3/31/16, documented Resident #3 had chronic pain/discomfort related to degenerative disk disease, thoracic and lumbar compression fractures, osteoporosis, and [chronic] low back pain. A list of Resident #3's strengths were identified under interventions and included Resident #3 was able to call for assistance when in pain; could reposition himself; ask for medication; and verbalize what increased and/or alleviated the pain. Interventions included warm blankets, repositioning, 1:1 visits, reading, watching television, reminiscing about hunting and fishing, and listening to music. The interventions also included assessing Resident #3's pain using the numeric pain scale. The numeric pain scale identified pain on a scale of 1 to 10, with 10 being the worst pain.</p> <p>A Physician Progress note, dated 12/30/15, documented Resident #3 verbalized complaints related to his diffuse chronic arthritic pain in his hands, shoulders, hip, knees, thoracic/lumbar spine. Resident #3 required opioid therapy for chronic pain and the Fentanyl patch appeared to work well at reducing the chronic pain to a bearable level without adverse side effects.</p> <p>Physician Orders, dated 1/22/16, included: * Ultram 100 mg tablet by mouth two times a day for severe pain * Tylenol 650 mg tablet by mouth three times a</p>	F 309			

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F 309	<p>Continued From page 41 day for severe pain * Give Ultram and Tylenol together * Evaluate the resident's pain level</p> <p>A Physician Progress note, dated 1/29/16, documented Resident #3 continued to complain of chronic pain; however, the pain was reduced to a level of 3 on the pain scale. Additionally, the physician documented, "Specifically, the Duragesic [Fentanyl patch] appeared to be controlling his pain adequately without side effects."</p> <p>A Physician Progress note, dated 2/26/16, documented Resident #3 was "completely focused" on his arthritic pain, and stated he was in pain on a daily basis; however, the pain medication was helping to reduce it to a 3 to 4. The note stated, "I informed him that he is on a narcotic pain medication and that I will not increase it due to safety issues...I believe the risks outweigh any benefits." The note did identify the specific safety concerns and risks identified by the physician. Documentation that Resident #3 was given the opportunity to participate in the decision making process related to his individual pain management plan, needs, and goals, was not included in the note.</p> <p>A Physician Progress note, dated 3/25/16, documented, "Continued to focus on his [Resident #3] chronic pain in his back, hip, and knees. He is on the lowest dose of fentanyl currently and I clearly discussed with him my reasoning of not increasing it due to increasing his risk for falls and other side effects. I feel he is on the lowest dose of narcotic pain medication possible to control his severe arthritic pain. Nursing reports no untoward side effects to the</p>	F 309			

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F 309	<p>Continued From page 42</p> <p>medication and it does offer him pain relief." The note did not include how it was determined Resident #3 would be at increased risk for falls or describe the other potential side effects. Documentation that Resident #3 was given the opportunity to participate in the decision making process related to his individual pain management plan, needs, and goals, was not included in the note.</p> <p>Fall Incident and Accident reports reviewed from 11/15/15 to 6/23/16, did not include documentation that Resident #3 had fallen.</p> <p>Resident #3's Fall Risk Assessments documented: * 11/13/15 - low risk for falls; * 1/11/16 - medium risk for falls; and * 3/28/16 - low risk for falls.</p> <p>Resident #3's Pain Medication Administration Record for April 2016 documented Resident #3 experienced pain ranging from 1/10 - 10/10 pain for 50 of 90 assessments; no pain for 34 of 90 assessments, and there was no documented assessment for 6 of 90 assessment time frames.</p> <p>Physician Orders and the MAR for April 2016 included:  * Fentanyl patch 12 mcg apply transdermal every 72 hours related to collapsed vertebra and fatigue fracture of the thoracolumbar region * Ultram 100 mg tablet by mouth two times a day for severe pain * Tylenol 650 mg tablet by mouth three times a day for severe pain * Give Tylenol with Ultram. * Evaluate pain level using PAINAD due to</p>	F 309			

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F 309	<p>Continued From page 43 cognitive deficits.</p> <p>An MD/Nursing Communications form, dated 4/7/16, documented Resident #3 had routinely asked for pain medication in the middle of the afternoon and at 11:30 PM. Nursing staff requested an, as needed, order for Tylenol 650 mg to be given at the identified times, in addition to the scheduled Tylenol Resident #3 was already receiving. On 4/8/16, the form included a handwritten "Yes," signed by the physician.</p> <p>A Nursing note, dated 4/13/16, documented Resident #3 was kicked in the back 4-5 times by another resident and was not injured.</p> <p>A Nursing note, dated 4/16/16, documented Resident #3 complained of back pain after being kicked by another resident on 4/13/16 and stated, Resident #3 thought the other resident injured his spine and back and asked, "What if I have a bad disc?" The note stated, "The resident was able to move his feet but did not feel he should propel his wheelchair any more-so he does not injure anything. He wants an x-ray of his back on Monday to ensure there are no fractures. He has been very anxious about the incident and will talk to whoever will listen." Resident #3 received as needed pain medication and accepted ice and heat to the area with positive results.</p> <p>A Nurse note, dated 4/19/16, documented Resident #3 was sent to a local medical center for x-rays of his thoracic and lumbar spine.</p> <p>Diagnostic x-ray reports, dated 4/19/16, documented Resident #3 had an old compression fractures at T12 and L3. The compression fracture at T12 is unchanged from previous x-ray.</p>	F 309		

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F 309	<p>Continued From page 44</p> <p>The compression fracture at L3 had interval progression when compared to prior study. Multi-level degenerative changes were identified through out the thoracic spine, with disc space narrowing and marginal osteophytes at multiple levels. No acute compression fractures were identified.</p> <p>A Physician Progress note, dated 4/30/16, documented, Resident #3 continued to have primary complaint of chronic musculoskeletal pain. The note stated, "I informed him of the new CDC guidelines and the fact we will wean him off narcotics. We will begin weaning [the Fentanyl patch] off with the new CDC guidelines. We will rely on NSAID's, Tylenol, topical analgesics, and Tramadol." Documentation that Resident #3 participated in the pain management plan to discontinue use of Fentanyl patch was not included in the note. Consideration of the potential negative impact discontinuation of the Fentanyl patch could have on Resident #3's quality of life, was not documented. Resident #3 had used Fentanyl patches at the lowest dose to manage his pain since 8/20/14. The potential risks and benefits of Resident #3's continued use the Fentanyl patch were not documented, nor discussed with Resident #3.</p> <p>Resident #3's Pain Medication Administration Record from 5/1/16 through 5/31/16 documented Resident #3 experienced pain ranging from 1 - 8 on the pain scale, for 61 of 93 assessments and reported no pain for 32 of 93 assessments.</p> <p>A Physician Order, dated 5/10/16, documented:</p> <p>* Fentanyl 12 mcg apply patch every four days times eight days and then discontinue.</p>	F 309			

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F 309	<p>Continued From page 45</p> <p>* Ultram 50 mg tablet give one tablet twice a day as needed for pain.</p> <p>The Medication Administration Record, dated 5/21/16, at 6:46 PM, documented removal of Resident #3's last Fentanyl patch.</p> <p>A Nurse progress note, dated 5/22/16, documented, "The resident ate two meals in his room yesterday related to increased pain in his back. He says it is getting more difficult to self-propel in his wheelchair. His shoulders, back, and knees are getting more stiff and painful. Will continue to assess."</p> <p>An MD/Nursing communication form, dated 5/23/16, documented nursing staff notified the physician of Resident #3's increased pain. A new order was received to apply cold spot/Biofreeze to painful joints and back twice a day for increased pain.</p> <p>A Nurses note, dated 5/26/16, documented, "Resident #3 is in so much pain he 'can't do it no more.' Stated he could not even use his wheelchair anymore due to increasing pain." The note stated Resident #3 appeared to be stiff and unable to move due to pain.</p> <p>A Physician Progress note, dated 5/27/16, documented, "The patient speaks of nothing other than his pain in his back, hip, knees, shoulders, and upper extremities. I had a lengthy discussion with him regarding the CDC guidelines regarding pain medication." The physician documented Resident #3 would continue with current pain medications, Ultram and tylenol, and Lyrica would be added for pain management." Documentation that Resident #3's increased pain</p>	F 309			

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F 309	<p>Continued From page 46</p> <p>was evaluated by the physician after the Fentanyl patch was discontinued on 5/21/16, was not included in the note.</p> <p>Resident #3's record did not include documentation that the risks and benefits of receiving Lyrica were discussed with Resident #3 and he had participated in the decision to add the medication to his pain management regimen.</p> <p>A Physician Order, dated 5/27/16, documented:</p> <ul style="list-style-type: none"> <li>* Lyrica 50 mg give one capsule by mouth two times a day for pain.</li> <li>* Tramadol 50 mg give one to two tablets three times a day as needed for pain.</li> </ul> <p>Nurses notes, dated 5/28/16 and 5/29/16, documented Resident #3 indicated the Lyrica and Cold Spot had help to decrease his pain.</p> <p>Nurse notes dated 5/30/16, documented:</p> <ul style="list-style-type: none"> <li>* 4:05 PM.- "Resident #3 was bent over in his wheelchair and said his lower back was very painful." A hot pack was applied to Resident #3's lower back.</li> <li>* 4:20 PM - Resident #3's family member was notified and asked the nurse if Resident #3 could be transferred to the emergency room if the pain worsened. The family member was informed that if Resident #3 wanted to go to the emergency room the facility would take him. The note did not state facility staff had discussed this option with Resident #3.</li> <li>* 4:50 PM - Resident #3 was observed "sitting</li> </ul>	F 309		

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F 309	<p>Continued From page 47</p> <p>more upright" in his wheelchair and reported the pain was still present and rated it 4/10. Resident #3's pain level was not assessed prior to the application of the hot pack; therefore, the effectiveness of the intervention could not be determined.</p> <p>Nurses' notes reviewed from 5/31/16 through 6/21/16 did not include:</p> <ul style="list-style-type: none"> <li>* Continued evaluation(s) related to signs or symptoms of pain exhibited by Resident #3</li> <li>* Whether, and how, the changes in Resident #3's pain management interventions impacted Resident #3's ability to function and participate in routine care and activities</li> <li>* The effectiveness of the interventions for controlling Resident #3's pain</li> </ul> <p>Resident #3's Pain Medication Administration Record, for 6/1/16 through 6/22/16, documented Resident #3 experienced pain ranging from 2/10 - 9/10 for 43 of 66 assessments. In addition to scheduled pain medication, Resident #3 also received 13 doses of PRN medication related to increased pain. Assessments of Resident #3's pain level were not documented prior to administration of the PRN medication or after administration.</p> <p>On 6/20/16, from 1:50 PM to 2:15 PM, Resident #3 attempted to propel himself in his wheelchair several times without success. Staff offered him assistance and each time he politely declined. At 2:15 PM, RN #4 observed Resident #3 struggling with his wheelchair and when she asked him if he was hurting and needed something for pain, he</p>	F 309			

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F 309	<p>Continued From page 48</p> <p>responded, "Yes." Resident #3 was taken back to his room and verbalized the pain was 7/10 and was in his lower back. When RN #4 asked him if he had pain in his knees, Resident #3 responded, "Yes," and rated the pain 7/10. RN #4 applied topical analgesic gel to Resident #3's spine/back and bilateral knees. Resident #3 requested the gel be applied to his right elbow. After RN #4 applied the gel to his right elbow he asked if there was any of it left for his left elbow. RN #4 informed him she had used the last of it on his right elbow. RN# 4 was not observed to obtain more analgesic gel for Resident #3's right elbow.</p> <p>A Nurse note, dated 6/22/16 at 9:10 am, documented, "Resident #3 had uncontrolled pain for the last two days. We are using "ALL" prescribed medications, plus analgesic gels. He continues to verbally say he is in 10/10 pain. May I schedule him to see a pain specialist?"</p> <p>On 6/22/16, at 10:55 am, Resident #3 was laying in bed and CNA #2 stated he had a "rough" night and did not sleep well related to terrible pain in his legs. CNA #2 stated Resident #3 was very stiff in his joints and he had struggled with routine activity that morning. CNA #2 stated it was not routine for Resident #3 to lay back down once he got up in the morning.</p> <p>On 6/22/16, at 11:00 AM, when RN #1 was asked what had been done to address Resident #3's increased pain. The RN shook her head and stated "The resident started having increased pain when his physician decided to discontinue the resident's Fentanyl patch." When asked if Resident #3 was part of the decision making process, RN #1 stated she did not think so. RN #1 stated she and the Unit Manager had</p>	F 309			

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F 309	<p>Continued From page 49</p> <p>expressed their concerns to the physician several times after the patch was discontinued. RN #1 stated Resident #3 had verbalized increased pain in his joints, knees, shoulder, and legs; the CNAs reported he struggled with routine activities; and he was observed to have increased stiffness in his joints. RN #1 stated she and the Unit Manager had informed the physician Resident #3's pain was not controlled and requested the Fentanyl patch be restarted. RN #1 stated the physician was unwilling to discuss the use of the Fentanyl patch and would not restart it.</p> <p>On 6/22/16, at 11:15 AM, when asked about the reason Resident #3's physician had discontinued the Fentanyl patch, the DNS stated Resident #3's physician informed the facility at the last QA meeting he would be discontinuing narcotic pain medications for all of his patients. The DNS was asked if Resident #3 was involved in the decision to discontinue the Fentanyl patch. The DNS stated he was not, nor were the other residents. The DNS stated the IDT was not involved in the decisions. The DNS stated the physician made the decisions independently based on his interpretation of the new CDC guidelines.</p> <p>On 6/22/16, at 4:40 PM, Resident #3 was laying in bed and CNA #3 stated he was having "a lot" of pain and would not be getting up for dinner. CNA #3 stated Resident #3 attempted to assist staff with routine activities, but due to increased pain he was unable to provide much assistance.</p> <p>On 6/23/16, at 12:25 PM, when Resident #3 was asked if he had recently experience increased pain, he stated he was having more pain in his back, knees, joints, shoulders, and wrists. When asked if he felt better today than yesterday, he</p>	F 309			

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F 309	Continued From page 50 stated, "I was in so much pain yesterday that if I could have killed myself I would have." When asked if he felt the Fentanyl patch provided him with more sustained and continuous pain control, he stated it did and "you have to use what works."  On 6/24/16, at 11:00 AM, the physician was asked about who participated in decision making process to discontinue Resident #3's Fentanyl patch. The physician stated, "I made the decision solely on my own and did not feel I needed to discuss it with the resident and/or nursing staff." When asked if a dialogue had occurred with Resident #3 and/or hisfamily, the physician stated, "No, Resident #3 was not given a choice. I informed the resident I would be weaning him off and discontinuing the pain patch." When asked if the nursing staff had been in communication with him related to Resident #3's increased pain after the patch was discontinued, the physician stated, "Nursing staff notified me and challenged my decision to discontinuing the patch. I told the nursing staff I would absolutely not consider restarting the patch as it was not recommended for treating chronic MSK pain." When asked how it was determined the risks were greater than the benefits for Resident #3, who was on the lowest dose of Fentanyl patch and had been receiving the medication since 8/2014, the physician stated, "He is on the lowest dose of the Fentanyl patch? I guess I did not realize that. The CDC guidelines, BEERS criteria, and the fact the resident had not had a trial on non-narcotic pain medication had a major influence on my decision to discontinue the patch." When asked if he would consider restarting the Fentanyl patch for Resident #3, initially the physician stated, "Of course I would if I felt the resident was not experiencing adequate pain control with the	F 309			

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F 309	<p>Continued From page 51</p> <p>current medications." The physician then stated, "I would not consider restarting the patch; however, there is always a plan B." The physician stated he had considered giving Resident #3 injections in his shoulder and knees and/or referring him to a Pain Management Physician in the community. The physician stated the waiting list for the Pain Management physicians was approximately 6-8 months and they did not take Medicare.</p> <p>Resident #3 was harmed when:</p> <ul style="list-style-type: none"> <li>* He experienced debilitating pain after the Fentanyl patch was discontinued, which diminished his w/c mobility, ability to eat and sleep, complete functions of everyday life, and enjoy leisure activities, to point he felt he would rather end his existence than live with the pain.</li> <li>* He was not provided with the risks and benefits of continuing the use of Fentanyl patches to manage his pain, and was not allowed to participate in decisions regarding his pain management regimen.</li> </ul> <p>3. Resident #1 was admitted to the facility on 12/11/15, with diagnoses which included pain, Osteoarthritis of one hip and both knees, weakness, and Chronic Kidney disease Stage 3.</p> <p>Resident #1's Admit MDS assessment, dated 12/18/15, documented Resident #1 had a moderate cognitive impairment. The MDS assessment further documented Resident #1 used medications as needed, and had no scheduled pain medications. Resident #1 reported occasional pain during a pain assessment interview. The MDS documented</p>	F 309			

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F 309	<p>Continued From page 52</p> <p>Resident #1 was occasionally incontinent of bowel and frequently incontinent of bladder. Resident #1 had no upper or lower extremity impairments.</p> <p>Resident #1's Quarterly MDS assessment, dated 5/27/16, documented Resident #1 was cognitively intact. The MDS documented the same findings in regards to pain as in the 12/18/15. The MDS documented that Resident #1 was always incontinent of bowel and bladder. The assessment stated Resident #1 had one sided upper extremity impairment and both sided lower extremity impairment.</p> <p>Resident #1's pain plan of care, dated 5/31/16, documented Resident #1 had pain medication therapy related to unilateral primary osteoarthritis of the hip and bilateral primary osteoarthritis of the knees. Interventions included:</p> <ul style="list-style-type: none"> <li>* Staff were to report any changes in usual activity related to c/o pain.</li> <li>* Staff were to observe and record changes in Resident #1's usual routine, changes in sleeping patterns, decreased functional abilities, decreased ROM ability, and withdrawal or resistance to care.</li> <li>* Staff were to attempt non-pharmacological intervention of offering a warm blanket or repositioning for comfort.</li> <li>* Staff were to use PAINAD to rate pain.</li> </ul> <p>Resident #1's current Physician Orders, dated 6/6/16, included:</p>	F 309			

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F 309	<p>Continued From page 53</p> <p>* Tylenol 650 mg every 4 hours PRN for pain beginning on 12/11/15</p> <p>* Ultram 50 mg every 6 hours PRN for pain beginning on 5/13/16</p> <p>Resident #1's discontinued Physician's Orders from 12/11/15 through 5/31/16 included, Norco 7.5-325 mg to be given every 6 hours. The order was gradually decreased to every 8 hours for pain. The Norco dose was changed 4/29/16 to 5-325 mg every 12 hours and then the Norco was discontinued completely 5/13/16.</p> <p>Resident #1's April 2016 MAR documented Resident #1 was given Norco 31 times and Tylenol 5 times.</p> <p>Resident #1's May 2016 MAR documented that she was given Norco 10 times until it was discontinued on the 5/12/16. After 5/12/16 Tramadol was given 23 times and Tylenol was given 8 times.</p> <p>Resident #1's June 2016 MAR (from 6/1/16 through 6/22/16) documented that Resident #1 was given Tramadol 35 times and Tylenol 6 times.</p> <p>On 3/23/16 a NN documented Resident #1 had pain for which she received PRN medications.</p> <p>On 4/7/16 Resident #1's NN documented she complained of pain, could hardly move and did not want to get out of bed.</p> <p>On 4/13/16 Resident #1's NN documented Resident #1 was unable to lift her legs due to pain.</p>	F 309			

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F 309	<p>Continued From page 54</p> <p>On 4/16/16 Resident #1's NN documented she complained of pain in her shoulder and back.</p> <p>On 4/30/16 Resident #1's MD note documented Resident #1 continued to experience arthritis pain of the upper extremity and lower extremities. The note stated Resident #1 had been receiving Norco but with the new CDC guidelines the MD recommended discontinuing the medication and changed Resident #1's pain medications to Tramadol and Tylenol.</p> <p>On 5/20/16 Resident #1's social service note documented Resident #1's pain to her shoulders and knees were her biggest hindrance.</p> <p>On 6/2/16 Resident #1's Care Plan Note documented that Resident #1 stated that she did not want to use a sit-to-stand device for toileting as it jarred her too much. The note stated staff offered her a bed pan and she had declined and stated she would like to use her attends to avoid the jarring.</p> <p>On 6/5/16 Resident #1's NN documented she did not want to get out of bed.</p> <p>On 6/7/16 Resident #1's NN documented she did not want to get out of bed for meals.</p> <p>On 6/15/16 Resident #1's NN documented she had complained of pain in her left wrist.</p> <p>On 6/23/16 at 10:25 am, Resident #1 stated she experienced pain the majority of time and she said the nursing staff were aware of it. She stated she liked to stay in bed as much as possible because it hurt less. Resident #1 stated she did not like to do activities, in part, due to the pain.</p>	F 309		

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F-309	<p>Continued From page 55</p> <p>On 6/23/16 at 3:15 pm the DNS, stated Resident #1 had bone on bone areas due to her Osteoarthritis and she complained of pain often.</p> <p>4. Resident #2 was admitted to the facility on 10/24/15 with diagnoses which included End Stage Renal Disease with dialysis, and Type II diabetes with hypoglycemia events.</p> <p>Resident #2's recapitulated May 2016 Physician's Orders and the MAR for 5/4/16 through 6/21/16 stated staff were to monitor twice a day for:</p> <ul style="list-style-type: none"> <li>* Bruit at the dialysis site</li> <li>* Bleeding at the dialysis site</li> <li>* Monitor for s/s of infection at the dialysis site</li> <li>* Report as indicated every morning and at bedtime to the MD and dialysis unit.</li> </ul> <p>Resident #2's May 2016 Physician Orders, and MAR for 5/4/16 through 6/21/16 did not include:</p> <ul style="list-style-type: none"> <li>* Resident #2's dialysis schedule</li> <li>* Location of the dialysis port</li> <li>* When to remove bandage after dialysis</li> <li>* A pre-dialysis and post-dialysis check list</li> <li>* Clear indication of where and when Resident #2 was to be given morning medications on days he received dialysis</li> </ul> <p>Resident #2's Hemodialysis Care Plan, dated 3/15/16, identified the access site as an AV fistula in the left forearm. Interventions included:</p> <ul style="list-style-type: none"> <li>* Monitor and document for signs of peripheral edema</li> <li>* Monitor for s/s of renal insufficiency</li> <li>* Monitor for s/s of infection to the access site</li> </ul>	F 309		

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F 309	<p>Continued From page 56</p> <p>* Do not use the left arm for blood draws or blood pressure</p> <p>* Nursing staff were to obtain vital signs daily in the PM, and Resident #2 was to be weighed at the dialysis unit M, W, &amp; F, and weighed on bath days 2 times a week in the facility. The staff were to report significant changes to the nurse immediately.</p> <p>On 5/4/16, the CP was updated to include: the staffs was to monitor and document on the MARS the status of the dialysis fistula for bruit, bleeding, s/s of infection or redness and were to report findings to the MD and dialysis unit BID.</p> <p>Resident #2's Hemodialysis Care Plan did not include the need for communication records before and after dialysis. The CP did not include when staff were to give Resident #2 his morning medications on days he received dialysis.</p> <p>Resident #2's MAR from 5/4/16 through 6/21/16 was inconsistent with the facility's "Chart Codes". The MAR documented staff were to monitor the dialysis fistula insertion site BID for bruit presence, bleeding, s/s of infection/drainage, and to report to the MD and dialysis unit as indicated. The "Chart Codes/Follow Up Codes" section of the MAR did not include "yes", "0", "+", "ok" and "x". However, those codes were used by staff to document if the above actions related to the fistula were completed.</p> <p>For example, the Month of June included:</p> <p>* 21 days which documented "Yes". * 2 days which documented "0". * 7 days which documented "+". * 1 day which documented "ok".</p>	F 309		

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F 309	<p>Continued From page 57 * 1 day which documented "x".</p> <p>It also included:</p> <p>In addition, there was 1 day in which the documentation was left blank for the evening shift.</p> <p>Resident #2's NN, dated January through June 22, 2016, did not clearly document if Resident #2 received his morning medications at the dialysis unit or at the facility before he left. For example, in the month of June, NN eAdmin Record for 6/1/16, 6/8/16, and 6/20/16 documented "dialysis" for the following meds:</p> <ul style="list-style-type: none"> <li>* Celexa - to be given at 8:00 am</li> <li>* Coreg - to be given in the am and pm</li> <li>* Colace - to be given in the am and pm</li> <li>* Aricept - to be given in the am</li> <li>* Asprin - to be given in the am</li> <li>* Lantus - to be given in the am</li> <li>* Nephro-Vite - to be given in the am</li> <li>* Eliquis - to be given in the am and pm</li> <li>* Lisinopril- to be given in the am</li> <li>* Prilosec - to be given in the am</li> <li>* Norco - to be given in the am and pm</li> <li>* Omega-3 Krill oil - to be given in the am</li> </ul> <p>On the June MAR for 6/1/16, 6/8/16, and 6/20/16, the medications listed above were documented as administered in the facility. However, Resident #2 received dialysis from 6:00 am to 12:00 pm on those dates.</p> <p>On 6/22/16 at 10:46 am, the DNS was asked to provide all documented communications between facility and the dialysis unit regarding Resident #2 from October 2015 through June 21, 2016. Seven</p>	F 309			

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F 309	<p>Continued From page 58</p> <p>notes from the dialysis unit were supplied dated, 5/4/16, 5/9/16, 5/12/16, 5/16/16, 5/20/19, 6/6/16, and 6/9/16. The DNS stated the facility would have to contact the dialysis unit for any other notes.</p> <p>On 6/22/16 at 11:07 am, the DNS stated the facility sent the dialysis unit a communication sheet only if there was a change in Resident #2's status due to Resident #2's frequent dialysis schedule. The DNS stated the Administrator had the contract for Resident #2 and the dialysis unit. The DNS stated the facility did not have a policy and procedure for Hemodialysis.</p> <p>On 6/22/16 at 2:34 pm, the Administrator stated the facility did not currently have a copy of the dialysis contract in the facility and that it was over at the dialysis unit. The Administrator stated the contract was not signed by the administrator at the current time.</p> <p>Resident #2's records did not contain documentation of the coordination of care between the facility and the dialysis unit. The care plan did not include when to remove bandage after dialysis and a pre-dialysis or post-dialysis check list. Resident #2 records did not contain clear indication of where and when Resident #2 was to be given his morning medications on days he received dialysis.</p> <p>5. Resident #10 was admitted to the facility on 6/30/15, with diagnoses which included dementia with behaviors, violent behaviors, delusional disorder, and fall history.</p> <p>Resident #10's Quarterly MDS assessment, dated 4/11/16, documented Resident #10 had a</p>	F 309			

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F 309	<p>Continued From page 59 severe cognitive impairment.</p> <p>Resident #10's Behavioral Symptoms Care Plan, dated 4/13/16, documented he had dementia with behavioral disturbances, delusional disorder, and violent behaviors. Interventions included:</p> <ul style="list-style-type: none"> <li>*Staff were to intervene as necessary to protect the rights and safety of others, they were to try and divert Resident #10's attention and remove him the situation as needed.</li> <li>* Staff were to try and discuss Resident #10's behavior with him and explain to him why his behavior is inappropriate.</li> <li>* Staff were to praise Resident #10 when he had good behavior.</li> </ul> <p>Non-pharmacological approaches, identified on the Care Plan for Resident #10's behaviors, included:</p> <ul style="list-style-type: none"> <li>* Staff were to put Resident #10 in a recliner with a massage.</li> <li>* Staff were to allow Resident #10 to visit his wife.</li> <li>* Staff were to give Resident #10 a snack or beverages (cookies are his favorite).</li> <li>* If Resident #10 exhibited the behavior of wandering into the nurse's station, staff were to remind him that only staff were allowed in the nurse's station and to redirect him to the dayroom. Staff were instructed to not give him a cookie or candy when he went into the nurse's station. They were to remind him his diabetes was not well controlled and that sugar was not</li> </ul>	F 309			

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F 309	<p>Continued From page 60 good for him.</p> <p>Incident Reports dated 4/12/16, 2/22/16, 2/19/16, 2/2/16, and 1/22/16, all document Resident #10 was an instigator in multiple resident to resident altercation. The interventions the nursing staff tried was not included in the documentation for 4 of the 5 altercations. The intervention documented was on 2/2/16 in a social service note. The note documented that one-on-one time with Resident #10 was given, in which the LSW reviewed respecting resident's rights and inappropriate language.</p> <p>On 6/23/16 at 11:30 am, the LSW stated they had attempted one-on-one interventions and when staff gave him a snack it seemed to help.</p> <p>On 6/24/16 at 8:30 am, RN #1 stated cookies and candy previously at the nurse's station and Resident #10 came into the station to get them. Resident #10 was coming into the nurse's station too much and his wife did not want the him to have so many cookies. They stopped giving cookies to Resident #10 at the nurse's station. The staff were trying to redirect the Resident #10 to the dayroom to get cookies or candy..The staff did use cookies to distract him when he would try to go outside, and no one was able to go with him, or go down to the Assisted Living Facility. RN #1 stated they tried to talk to Resident #10 and would move him to a different location, if he had kicked or hit anyone. RN #1 did agree the way the care plan was currently written it could be misinterpreted. That is, cookies and candy were not given to Resident #10 at the nurse's station to punish him, and if he did something inappropriate he would get a cookie to distract him.</p>	F 309			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 61 6. Resident #6 was admitted to the facility on 6/29/15 with a diagnosis of Parkinson's disease.  On 2/26/16, Resident #6 was started on Zyprexa 5 mg daily for a diagnosis of Dementia with Lewy Bodies.  The Lewy Body Dementia Association (lbda.org) defined Lewy Body Dementia as a degenerative dementia. The "Caregiving Topics" area of the website documented, "...Do not reality orient...trying to convince them of the truth is generally fruitless and can be frustrating or even frightening..."  On 12/21/15, Resident #6's care plan documented a focus area for impaired thought process related to dementia. The goals were documented as, "Resident will maintain current level of cognitive function..." and, "Resident will remain oriented to person, place, situation, and time..." The interventions included, "Cue, reorient and supervise as needed."	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315	F 315  1. Resident #4- Has been re-evaluated to determine a voiding pattern and then development of a toileting plan based on outcome of assessment will be completed on 7/21/16. Care plan will be updated with interventions to promote improvement or maintenance of current function.		

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F 315	<p>Continued From page 62</p> <p>infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, the facility failed to ensure residents who were incontinent of urine were consistently and comprehensively assessed to determine if a toilet training program would be beneficial. In addition, the facility failed to develop and implement toileting care directives to restore as much normal bladder function as possible. This was true for 2 of 10 sampled residents (#4 and #6) reviewed for bladder control. This created the potential for residents with the ability to improve their bladder control to not receive services necessary to do so. Findings include:</p> <p>The facility's Policy and Procedure for identifying and determining toileting programs documented:</p> <p>* The type of incontinence should be identified based on information obtained and evaluated through the use of the Bladder Incontinence Data Collection Tool, Bladder Assessment...</p> <p>* A proper toileting program should be implemented based on the type of incontinence and information obtained through evaluation.</p> <p>* Toileting programs include:</p> <p>a. Scheduled - performing the activity at a specific routine time clearly communicated to the resident (as appropriate) and to caregivers.</p> <p>b. Toileting - voiding in the bathroom, commode or into another appropriate receptacle (bed pan or</p>	F 315	<p>Resident #6- Has been re-evaluated to determine a voiding pattern and then development of a toileting plan based on outcome of assessment will be completed on 7/21/16.</p> <p>Care plan will be updated with interventions to promote improvement or maintenance of current function.</p> <p>2. Residents that are admitted continent or with toileting issues have the potential to be affected by this practice.</p> <p>3. SYSTEM: All residents will have a 72 hour Bowel and Bladder assessment completed on admission followed by a Bladder incontinent assessment tool and then a Bladder assessment to help develop a toileting program for them. DNS and/or designee to monitor.</p> <p>EDUCATION: Licensed Nurses have been in-serviced on this process change on or before 07/26/2016.</p> <p>4. Audits will be completed weekly x 4, Monthly x 2, and then Quarterly x 3. Audit results will be reported to QAPI Committee for further monitoring and modification.</p> <p>5. Compliance on or before 08/11/2016.</p>	

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F 315	<p>Continued From page 63 urinal).</p> <p>c. Program,- a specific approach that is organized, planned, documented, monitored, and evaluated.</p> <p>1. Resident #7 was admitted to the facility with multiple diagnoses including expressive aphasia Alzheimer's Disease.</p> <p>Resident #7's Admission MDS assessment, dated 9/4/15, Quarterly MDS assessment, dated 11/30/15, and Quarterly MDS assessment, dated 2/9/16, documented Resident #7 was frequently incontinent of bladder and a trial toileting program had not been attempted.</p> <p>Resident #7's Toileting care plan, dated 5/17/16, documented the following interventions: * Resident #7 often takes himself to the bathroom independently; staff to assist with incontinence care... * Check Resident #7 every two hours and as needed.</p> <p>Resident #7's record reviewed from 9/14/15 through 6/20/16, did not document a bladder assessment was completed for Resident #7 upon Admission and/or during the Quarterly assessment periods.</p> <p>On 6/24/16 at 10:50 am, the DNS stated Resident #7 was assessed quarterly in an effort to establish his bladder patterns and determine if he would benefit from a toileting program. The DNS was asked to provide documentation of these assessments since 9/14/15, but could not locate the assessments. When asked if the facility had considered a toileting program for Resident #7, the DNS stated she did not think so. She stated</p>	F 315			

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F 315	<p>Continued From page 64</p> <p>the determination to not complete one must have been made by the nurse completing the assessments.</p> <p>2. Resident #6 was admitted to the facility on 6/29/15 with diagnoses which included Parkinson's disease.</p> <p>On 7/2/15, Resident #2's ADL care plan documented she required assistance of one person to use the toilet as needed, and if the resident became incontinent she required assistance with hygiene and to change her brief.</p> <p>On 7/6/15, Resident #6's Bladder Incontinence Data Collection Tool documented the resident had previously been incontinent, but was currently incontinent less than daily, and characterized her incontinence as urge incontinence.</p> <p>Resident #6's Quarterly MDS assessment dated 3/12/16 and Annual MDS assessment dated 6/1/16 documented she was frequently incontinent of bladder with no toileting program in place. The 3/12/16 MDS documented Resident required extensive assistance of one person to use the toilet. The 6/1/16 MDS documented she required extensive assistance from two people.</p> <p>On 6/23/16 at 2:30 pm, the DNS stated Resident #6's bladder patterns were reviewed quarterly via the MDS, but could not find bladder assessments since 7/6/15. The DNS stated Resident # 6 had urge incontinence, but would tell the staff when she needed to use the restroom. The DNS was unable to explain how the facility had determined Resident #6's individualized bladder pattern, but stated Resident #6 routinely waited more than 2 hours before asking for assistance to the toilet.</p>	F 315			

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F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, it was determined the facility failed to ensure side rails were assessed to determine if they were safe for resident use; that residents who were at risk for falls received the necessary supervision and assistance to prevent falls and that residents remained free from potential accident hazards. This was true for 7 of 11 sampled residents (#1, #2, #3, #4, #5, #6, and #10). These deficient practices resulted in the potential for harm when a) Resident #1, #2, #3, #4, #5, #6 and #10 are at increased risk of entrapment when bed/side rail safety assessments were not completed; b) Resident #1 experienced multiple falls without evidence of increased supervision; c) Resident #4 experienced 27 falls and interventions were not revised to prevent falls; d) Resident #5 experienced multiple falls and interventions were not revised to prevent falls; and, e) Resident #10 was at risk of experiencing a burn from a grate in front of the fireplace in the dayroom. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 12/11/15 with multiple diagnoses which included</p>	F 323	<p><b>F323 E</b></p> <ol style="list-style-type: none"> <li>Resident #1, #2, #3, #4, #5, #6, and # 10 have had physical device and restraint safety assessments completed to determine if the devices were safe for resident use and did not pose an entrapment risk. Residents needing supervision and assistance have been reassessed and interventions updated to prevent falls.</li> </ol> <p>A permanently affixed grate has been attached to the dayroom and chapel fireplaces.</p> <ol style="list-style-type: none"> <li>Residents using mobility bars, having frequent falls or near the fireplace has the potential to be affected by these practices.</li> <li>System Change: Residents using mobility bars will have the physical device and restraint assessment completed including a statement documented regarding safety and risk for entrapment. Orders for mobility bars will be obtained as needed.</li> </ol> <p>Residents identified as needing assistance to prevent falls, will be addressed at Clinical follow up and Care plan updated at that time.</p> <p>A permanent fireplace screen has been added to the dayroom and chapel fireplaces. Education: All staff has been educated on the changes to this procedure, documentation requirements and new equipment placement on 07/26/2016.</p>

- DNS, SD or designee will complete audits.
- Mobility bar, fall supervision, fall interventions and fireplace screen audits will be completed weekly x 4 weeks, biweekly x 2 weeks, monthly x 2 months. Audit results will be reported to QAPI for further monitoring and modification.

5. Compliance date will be on or before 08/11/2016.

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F 323	<p>Continued From page 66 weakness, osteoarthritis and pain.</p> <p>Resident #1's Quarterly MDS assessment, dated 5/27/16, documented she did not use side rails.</p> <p>Resident #1's June 2016 Physician Order Summary Report, did not include an order for the use of side rails.</p> <p>Resident #1's care plan for ADL deficits for bed mobility included the use of side rails as an intervention on 3/9/16. The potential for pressure ulcers care plan also included side rails as an intervention on 12/11/15.</p> <p>Resident #1's OT assessment, dated 12/12/15, included the use of 1/2 side rails for bed mobility. The assessment did not include a side rail safety assessment for the risk for entrapment.</p> <p>Resident #1's June Physical Device and Restraint Review, documented that the side rails were used as bilateral mobility bars and did not impair Resident #1's ability to move. The review did not include a safety assessment, to assess the risk for entrapment.</p> <p>Bilateral quarter side rails were observed in the raised position on Resident #1's bed on 6/20/16 at 11:20 am while she was in the bed. The side rails were also observed in the raised position on 6/20/16 at 1:47 pm, 2:10 pm, 2:30 pm, and 2:59 pm, on 6/21/16 at 8:17 am, 8:57 am and 2:50 pm, on 6/23/16 at 10:25 am, and on 6/24/16 at 9:15 am and 10:26 am.</p> <p>On 6/24/16 at 9:20 am, RN #2 stated the side rails were called mobility bars and were used for mobility purposes.</p>	F 323			

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F 323	<p>Continued From page 67</p> <p>On 6/24/16 at 9:24 am the DNS stated the OT or PT evaluations residents received might include the side rail safety assessment. Resident #1's records did not contain and the facility could not provide a side rail safety assessment, to assess the risk for entrapment.</p> <p>2. Resident #2 was admitted to the facility on 10/24/15, with diagnoses which included Diabetes Type II, and Diabetic Hypoglycemia.</p> <p>On Resident #2's Quarterly MDS assessment, dated 5/26/16, documented he did not use side rails.</p> <p>Resident #2's June 2016 Physician Order Summary Report, did not include and order for the use of side rails.</p> <p>Resident #2's care plan for, ADL deficits for bed mobility, included the use of side rails as an intervention on 11/11/15. The potential for pressure ulcers care plan also included bed rails as an intervention on 1/12/16.</p> <p>Resident #2's June Physical Device and Restraint Assessment documented that the rails were used as bilateral mobility bars and did not impair Resident #2 ability to move. The review did not include a safety assessment, to assess the risk for entrapment.</p> <p>On 11/30/15, Resident #2's OT assessment did not reference the use of 1/2 side rails for bed mobility. The assessment did not include a safety assessment, to include, the risk for entrapment.</p> <p>On 6/24/16 at 9:20 am, RN #2 stated the side</p>	F 323			

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F 323	<p>Continued From page 68</p> <p>rails were called mobility bars and were used for mobility purposes.</p> <p>On 6/24/16 at 9:24 am the DNS stated the OT or PT evaluations residents received might include the side rail safety assessment. Resident #1's records did not contain and the facility could not provide a side rail safety assessment, to assess the risk for entrapment.</p> <p>3. Resident #3 was admitted to the facility on 7/8/13, with diagnoses which included dementia, collapsed vertebra, and lower back pain.</p> <p>Resident #3's Quarterly MDS assessment, dated 6/3/16, documented he did not use side rails.</p> <p>Resident #3's June 2016 Physician Order Summary Report, did not include an order for the use of side rails.</p> <p>Resident #3's care plan for ADL deficits for bed mobility included the use of side rails as an intervention on 3/28/16. The potential for pressure ulcers care plan also included side rails as an intervention on 6/8/16.</p> <p>Resident #3's June Kardex, documented staff were to assess him for safety while he was in bed. The June Kardex documentation did not contain a side rail safety assessment.</p> <p>On 3/10/16, Resident #3's PT assessment did not reference the use of 1/2 side rails for bed mobility. The assessment did not include a safety assessment, to include, the risk for entrapment.</p> <p>On 6/24/16 at 9:20 am, RN #2 stated the side rails were called mobility bars and were used for</p>	F 323			

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F 323	<p>Continued From page 69 mobility purposes.</p> <p>On 6/24/16 at 9:24 am the DNS stated the OT or PT evaluations residents received might include the side rail safety assessment. Resident #1's records did not contain a side rail safety assessment, to assess the risk for entrapment.</p> <p>4. Resident #4 was admitted to the facility on 7/13/11, with diagnoses which included osteoarthritis.</p> <p>Resident #4's Quarterly MDS assessment, dated 4/4/16, documented he did not use side rails.</p> <p>Resident #4's June 2016 Physician Order Summary Report, did not include an order for the use of side rails.</p> <p>Resident #4's care plan for ADL deficits, for bed mobility, included the use of side rails as an intervention on 4/6/16.</p> <p>Resident #4's June Kardex documented staff were to assess Resident #4's safety while he was in bed. The June Kardex documentation did not contain a side rail safety assessment.</p> <p>Resident #4's OT assessment, dated 1/21/15, did not reference the use of 1/2 side rails for bed mobility or include a side rail safety assessment for the risk for entrapment.</p> <p>On 6/24/16 at 9:20 am, RN #2 stated the side rails were called mobility bars and were used for mobility purposes.</p> <p>On 6/24/16 at 9:24 am the DNS stated the OT or PT evaluations residents received might include</p>	F 323			

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F 323	<p>Continued From page 70</p> <p>the side rail safety assessment. Resident #1's records did not contain a side rail safety assessment, to assess the risk for entrapment.</p> <p>5. Similar finding were found for Resident #5, Resident #6, and Resident #10.</p> <p>6. Resident #1 was admitted to the facility on 12/11/15, with multiple diagnoses which included weakness, osteoarthritis, and pain.</p> <p>Resident #1's Quarterly MDS assessment, dated 5/27/16, documented Resident #1 was cognitively intact and required extensive assistance of two staff for all transfers and toileting use. The MDS assessment documented Resident #1 did not ambulate at the time of this MDS assessment. The assessment stated Resident #1 had 2 or more falls with no injury prior to the assessment.</p> <p>Resident #1's care plan for falls, dated 12/29/15, documented Resident #1 was at risk for falls related to weakness, pain and cognitive deficits. Interventions included staff were to encourage Resident #1 to participate in activities for strength, and improved mobility, and staff were to monitor for significant changes on mobility, sitting balance, and lower extremity joint function.</p> <p>A 4/4/16 Incident Report documented, Resident #1 was found on the floor in her room at 6:05 pm. Staff determined that Resident #1 had been attempting to get into her bed and increased pain and decreased mobility affected her ability to get into bed. The plan to resolve the situation was for staff to leave Resident #1's door open when not doing cares, staff to attempt to assist Resident #1 to bed quickly after meals, Resident #1 moved closer to the nurses' station, and Resident #1 to</p>	F 323			

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F 323	<p>Continued From page 71</p> <p>remain in the dayroom with an activity after meals until staff could assist her to bed.</p> <p>On 4/12/16 a Fall Investigation Report documented, Resident #1 was found on the floor next to her bed with her attends pulled off and on the floor above her head. Resident #1 stated she had not been taken to the bathroom all night and had been trying to get up and get dressed to go eat. The plan to resolve the situation was for staff to leave Resident #1's door open when staff were not doing cares and to move her closer to the nurses' station.</p> <p>On 4/13/16 at 11:17 am, a NN documented Resident #1 was moved to a room closer to the nurses' station for safety purposes.</p> <p>On 4/13/16 at 4:44 pm, a NN documented Resident #1 had slid down in her chair and had both legs on the bed, and her pants were hanging part way off. The nursing staff was able to get her back in her chair and moved her out of her room as staff did not trust Resident #1 in her room by herself.</p> <p>NN dated 4/15/16, 5/12/16, 6/5/16, 6/7/16 documented Resident #1 wanted to remain in bed and be left alone during meals and after meals. There was no documentation in NN or elsewhere that care plan interventions were implemented.</p> <p>On 6/20/16 from 1:47 pm to 3:00 pm, Resident #1 was lying down in bed alone in her room.</p> <p>On 6/22/16 at 4:15 pm, the DNS stated when someone had multiple falls in a short period of time, 15 minutes checks may be implemented. She said the facility usually implemented the 15</p>	F 323		

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F 323	<p>Continued From page 72</p> <p>minutes checks after 2-3 falls. The 15 minutes checks were not implemented after Resident #1's 2 falls in April. The DNS stated in Resident #1's case the staff were to encourage Resident #1 to remain out of her room.</p> <p>7. Resident #10 was admitted to the facility on 6/30/15, with diagnoses which included dementia with behaviors.</p> <p>Resident #10's Quarterly MDS assessment, dated 4/11/16, documented Resident #10 had a severe cognitive impairment.</p> <p>On 6/21/16 at 11:30 am, Resident #10 was in the dayroom and wheeled his w/c between the two couches in front of the fireplace. When he got closer to the fireplace he reached up with his right arm and grabbed the fireplace mantle. Resident #10 used the mantle to propel himself across the length of the fireplace. While he pulled himself up to the fireplace, his right knee touched the left side of the metal screen that was set on the floor in front of the fireplace. The metal screen had hinges on two sides that had the ability to rotate both ways. Resident #10's knee pushed the left side of the screen until it touched the front of the glass insert on the fireplace. He stayed in front of the fireplace for a couple minutes and then left. After Resident #10 left, the screen was still touching the fireplace glass surface.</p> <p>On 6/21/16 at 11:40 am, the Maintenance Director was asked to please come check the ambient temperature of the metal screen. The temperature was checked and the reading was 153 degrees on the left side of the metal screen. The Maintenance Director stated "hot" but said it "could be reading temp from the fire". He moved</p>	F 323		

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F 323	<p>Continued From page 73</p> <p>the screen away from the fireplace surface and stated "but it was hot when I touched it. Too hot." After he checked the ambient temperature he left the area. The fireplace was left unsupervised.</p> <p>On 6/21/16 at 11:42 am Resident #10 came up in his w/c and wheeled around one of the couches and reached up with his right arm and grabbed the mantle again. Resident #10 propelled himself across the mantle and his right knee came within 1 and 1/2 to 2 inches of the metal screen. Resident #10 stated "This is a hot place right here." Resident #10 left the area again.</p> <p>On 6/21/16 at 12:00 pm, the Maintenance Director again checked the ambient temperature and the screen was 105 degrees. The Maintenance Director stated the plan was to weld metal pieces to the screen, which would prevent the screen from collapsing into the fire again. He stated he would shut the fireplace off and lock the control in his office.</p> <p>On 6/21/16 at 5:00 pm the Administrator stated the Maintenance Director should not have left until the danger had been removed. She stated both fireplaces were turned off and the screens were at the welders to prevent further incidents.</p> <p>8. Resident #4 was admitted to the facility with multiple diagnoses including edema, anxiety, incontinence and osteoarthritis.</p> <p>Resident #4's 4/4/16 MDS assessment documented: severe cognitive impairment; extensive assist of one person for transfers, ambulation, and toileting; not steady and needed physical assistance to stabilize when moving from a seated to standing position, while walking, and</p>	F 323			

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F 323	<p>Continued From page 74 for surface-to-surface transfers. The MDS assessment documented Resident #4 had 2 or more falls within the past quarter.</p> <p>Resident #4's Fall Care plan documented the following:</p> <p>* On 3/2/15, interventions include: Ensure resident is wearing appropriate footwear (black shoes) when ambulating or propelling wheelchair. Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function. Provide restorative nursing program maintain improved strength and balance.</p> <p>* On 3/27/16 and revised on 6/21/16, interventions included: Divert and distract the resident with a movie, coloring book and crayons, and keep in line of site. Offer to transfer him to the couch or an easy chair after meals.</p> <p>* On 4/6/16 and revised on 5/4/16, interventions included: Monitor 15 minutes for high fall risk, safety, and elopement.</p> <p>* On 5/23/16, interventions included: Ensure and provide a safe environment, tie a stuffed animal to the end of the call light to make it easier for the resident to find it.</p> <p>The facility's Incident and Accident reports were reviewed for the past six months and documented from 2/29/16 through 6/21/16, Resident #4 experienced 25 falls. For 20 of 25 falls Resident #4 was found on the floor in his room; falls ranged from 3:45 am to 9:15 pm and poor safety awareness was consistently identified as a contributing factor or the root cause of the</p>	F 323		

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F 323	<p>Continued From page 75</p> <p>falls. Interventions were not consistently implemented, nor were they reviewed and revised to include increased supervision.</p> <p>On 6/24/16, at 11:00 am, the DNS stated Resident #4, "just all of a sudden stopped walking" and she had no idea why. The DNS stated Resident #4 had become weaker, had a decline in mobility, had poor safety awareness, and had poor impulse control. The DNS stated Resident #4's falls were discussed during stand-up meetings and with the executive committee, and fall committee. When asked why Resident #4 did not have continuous increased supervision related to the time frame and number of falls he had experienced, the DNS could not provide an explanation. The DNS stated the facility needed to consider additional staffing for residents requiring increased supervision.</p> <p>9. Resident #5 was admitted to the facility on 11/6/14 with diagnoses which included encephalopathy and blindness in his right eye.</p> <p>Resident # 5's 10/8/15 Annual MDS assessment documented he required extensive assistance of one person for transfers and ambulation; was not steady and needed physical assistance to stabilize when moving from a seated to standing position, while walking, and for surface-to-surface transfers. The MDS assessment documented Resident #5 had 2 or more falls within the past quarter.</p> <p>On 11/6/14, Resident #5's care plan documented he was at risk for falls due to weakness, medication side effects, and encephalopathy. The care plan documented Resident #5 had a history of falls, poor safety awareness, an unsteady gait,</p>	F 323		

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F 323	<p>Continued From page 76 and was impulsive. Interventions included:</p> <p>*11/9/14, educate Resident #5 and his family as to the causes of his falls, and encourage him to ask for assistance versus reaching to the floor for items;</p> <p>*11/18/14, encourage activities promoting exercise, strengthening, and physical activity;</p> <p>*11/21/14, monitor for significant changes in mobility and balance;</p> <p>*11/25/14, remind Resident #5 not to bend over to pick up dropped items and assist him to get up and out of his room as soon as he indicates he is ready;</p> <p>3/5/15, monitor Resident #5 every 15 minutes and make sure his headphones were in reach;</p> <p>*7/22/15, offer Resident #5 to lay down between 3:00 and 3:30 pm, mobility bar on the wall next to his chair and in the bathroom, and remind him to use his call light for all transfers.</p> <p>On 12/3/15 at 10:00 am, a facility Incident Record documented Resident #5 was found on his knees in front of his toilet. A FSI form for the incident documented the corrective action was to continue all fall interventions, with 15 minute checks being effective multiple times per day as Resident #5 was "caught doing transfers." The FSI documented Resident #5 was much weaker since his last UTI. The Incident Record documented the facility's conclusions as, "Resident continues not to follow safety precautions...has had repeat UTIs. The UTIs have made him weaker. He has had no falls [for] 30 days. Administration met. No</p>	F 323			

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F 323	<p>Continued From page 77 additional interventions were identified."</p> <p>On 12/4/15 at 3:04 pm, an Incident Record documented Resident #5 was found on his knees between his wheelchair, chair, and bed. A FSI form for the incident documented he was attempting to self-transfer, and had increased weakness since his recent UTI. The FSI documented Resident #5 had fallen 30 times in the past year. The documented corrective action was to continue all preventive/protective interventions. The Incident Record documented the facility's conclusions as, "...Current interventions keep him as safe as possible. 15 minute checks often find him transferring himself and prevent additional incidents...Resident has become weaker in the past several weeks. He has a return UTI. No incidents [for] 1 month."</p> <p>On 12/7/15 at 6:59 am, an Incident Record documented Resident #5 fell while trying to obtain condiments for his coffee. The FSI documented Resident #5 did not ask for assistance, and the corrective action was to continue all care plan interventions. The Incident Record documented the facility's conclusions as, "...Resident will not even request assistance when staff is in close proximity...continue all current interventions...Resident has had no falls [for] 30 days [related to] weakness..."</p> <p>On 1/28/16 at 11:10 am, an Incident Report documented Resident #5 was found on his knees in front of his wheelchair. The FSI documented Resident #5, "has had multiple incidents of this type...poor safety awareness. Has had a slow generalized decline." The FSI documented a new intervention of discouraging Resident #5 from sitting in the chair at his bedside. The Incident</p>	F 323			

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F 323	Continued From page 78 Report documented the facility's conclusions as, "...Resident returned to a double occupancy room where he has a favorite chair. He attempted to transfer self to his chair and ended on the floor...No additional interventions identified..."  On 6/23/16 at 3:00 pm, the DNS stated Resident #5 had numerous UTIs, including a "significant" one which resulted in his hospitalization. The DNS stated the resident had become weaker and his mobility had declined through this process. The DNS stated the facility felt there was nothing to be done to prevent Resident #5 from falling, as he was on 15 minute checks and continued to fall. The DNS could not provide documentation the 15 minute checks were completed. Resident #5 was not provided increased supervision when he experienced multiple falls related to UTIs and increased weakness.	F 323	F 328-  1. Resident #2- has been reevaluated for delivery of Oxygen and oxygen saturation testing. Oxygen and saturation testing continues per physician orders. Oxygen saturation level checks have been re input to the treatment sheet for documentation.  2. Residents that require oxygen therapy and saturation testing have the potential to be affected by this practice.  3. SYSTEM CHANGE: Residents who are on oxygen with orders for oxygen saturation level testing will be completed and documented as physician ordered. The Physician will be notified of oxygen saturation levels below ordered parameters.  EDUCATION: Licensed Nurses have been re- educated to clarify expectations for residents on oxygen therapy requiring testing, on or before 07/26/2016.  4. Audits to ensure compliance with Oxygen testing documentation will be completed weekly X4, monthly X2 and Quarterly X3. Audit findings will be reported to QAPI Committee for further monitoring and modification.  5. Compliance on or before August 11 2016	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 328		

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F 328	<p>Continued From page 79</p> <p>interview, it was determined the facility failed to ensure residents received appropriate respiratory care as ordered by a physician. This was true for 1 of 1 (#2) resident reviewed for oxygen therapy. This deficient practice created the potential for more than minimal harm due to staff not following physician orders related to oxygen therapy. Findings include:</p> <p>Resident #2 was admitted to the facility on 10/24/15 with multiple diagnoses, including CKD end stage, A-fib, chronic pulmonary edema, and atherosclerosis (hardening of the arteries).</p> <p>Resident #2's, May 2016 physician recapitulation orders, documented he was on O2 at 2 LPM per NC and to keep his O2 saturation level above 90% related to bacterial pneumonia, chronic pulmonary edema, and atherosclerosis, beginning on 12/31/15.</p> <p>On 12/31/15, Resident #2's care plan for altered cardiovascular status included O2 therapy 2 LPM per NC and to keep his O2 saturation level above 90%. The altered respiratory status care plan included O2 at 2 LPM per NC as an intervention on 11/11/15.</p> <p>Resident #2 was observed in his room on 6/20/16 at 1:49 pm, 6/21/16 at 8:16 am and 8:36 am, and on 6/22/16 at 1:15 pm and 3:14 pm, with the oxygen companion on his w/c set at 2 LPM via NC.</p> <p>Resident #2's O2 saturation summary records documented his saturation levels were checked 10/25/15 through 12/17/15. The O2 saturation level monitoring slowed down significantly, with 6 O2 saturation levels checked (12/25/15,</p>	F 328			

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F 328	Continued From page 80 12/27/15, 1/5/16, 3/6/16 x 3) in the 5 month period, and stopped 5/4/16. The last two O2 readings documented Resident #2's O2 staturation levels were 86% on 5/4/16 and 88% on 3/6/16.  On 6/23/16 at 3:50 pm, the DNS said she could not find a physician's order for checks of Resident #2's O2 staturation levels to be stopped or changed. She investigated the records and said there was an issue with the way the O2 was ordered in the computer the last time, and could see how the O2 checks were stopped. She agreed that the O2 saturation checks should not have been stopped. She also agreed that without O2 checks it would be difficult to monitor if the 2 LPM was adequate to meet Resident #2's needs.	F 328			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents 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	F 329	Please see inserted page 81 A		

1. Resident #1 Antipsychotic medication reviewed to ensure adequate indication for usage were identified and record reflects identification of Risk benefit of use, side effects to monitor, Care Plan updated to include resident specific target behavioral tracking.

Resident #2 Antipsychotic medication reviewed to ensure adequate indication for usage were identified and record reflects identification of Risk benefit of use, side effects to monitor, Care Plan updated to include resident specific target behavioral tracking.

Resident #10 Antipsychotic medication reviewed to ensure adequate indication for usage were identified and record reflects identification of Risk benefit of use, side effects to monitor, Care Plan updated to include resident specific target behavioral tracking.

Resident #5(documentation for this resident is really for resident #6)

Resident #5 - Medications reviewed including antipsychotics to ensure adequate indication for usage were identified and record reflects identification of Risk benefit of use, side effects to monitor, Care Plan updated to include resident specific target behavioral tracking. Care plan has been updated with interventions for grieving.

Resident #6 (documentation for this resident is for resident #5 Antipsychotic medication reviewed to ensure adequate indication for usage were identified and record reflects identification of Risk benefit of use, side effects to monitor, Care Plan updated to include resident specific target behavioral tracking.

2. Residents receiving antipsychotic medications and needing behavioral tracking have the potential to be affected by this practice.
3. SYSTEM CHANGE: Residents with any psychoactive medication will have the following process completed.
  - a) Psychoactive medication reviewed for adequate indications for usage. And appropriate diagnosis.
  - b) Documentation of behaviors that was present prior to initiation of psychoactive medication.
  - c) Care planning of Non-pharmacological interventions for target behaviors.
  - d) Documentation of how these interventions affected behaviors.
  - e) If psychoactive medication is initiated, documentation of review of the Black Box warning with resident and family.
  - f) Identification of the side effects and target behaviors on the Care plan

EDUCATION: Social Services and Licensed Nurses have been in-serviced on the requirements of documentation for the use of psychoactive medications, black box warnings risk benefit statements, behavioral care planning, behavioral tracking and changes to procedure on or before 07/26/2016.

4. Social Services or designee for residents on antipsychotic medications will audit; adequate indications for use, documentation of black box warnings, Care planning non pharmacy interventions and documentation of target behavioral tracking. Audits will be Weekly x4, Monthly x 2, and Quarterly x 3. Audit reports will be given to QAPI Committee for further monitoring and modification.
5. Compliance will be on or before August 11 2016

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F 329	<p>Continued From page 81</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</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 psychotropic medications were used only with adequate indication for use and monitoring. This was true for 5 of 7 residents (#1, #2, #5, #6, and #10) sampled for psychotropic medication use. The deficient practice created the potential for harm when residents received medications without clear need or monitoring of effectiveness and adverse reactions. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 12/11/15 with multiple diagnoses which included major depressive disorder (single episode), weakness, osteoarthritis and pain.</p> <p>Resident #1's June Physician Orders Review documented she received Effexor 225 mg in the morning for depression beginning 4/20/16. Resident #1 was originally started on this medication prior to admit in July 2015.</p> <p>Resident #1's H &amp; P from 11/23/15, documented she became bed ridden due to inability or unwillingness to get out of bed.</p> <p>Resident #1's 5/27/16 Quarterly MDS assessment, documented she had no behaviors, no cognitive or decision making impairments, and</p>	F 329			

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F 329	<p>Continued From page 82</p> <p>mild depression. Resident #1's Initial MDS assessment, dated 12/18/15, documented she had a moderate cognitive impairment and moderate depression signs.</p> <p>Resident #1's care plan, dated 12/29/15, documented she was on an antidepressant medication related to major depressive disorder and changed health status. Interventions included:</p> <ul style="list-style-type: none"> <li>* Staff were to monitor for increased fall risk.</li> <li>* The facility would consult with pharmacy and MD for when GDRs would be clinically appropriate.</li> <li>*The care plan documented to observe for potential adverse side effects of the medication which included: anorexia, anxiety, constipation, diarrhea, dizziness, dry mouth, headache, and nausea.</li> </ul> <p>The care plan did not include resident-specific targeted behaviors that staff were to monitor.</p> <p>Resident #1's MARS/TARS did not document the anti-depressant side effects or resident specific targeted behavior the staff were to monitor. Her record did not contain documentation of monitoring for the potential adverse reactions to the anti-depressant medication. The record did not include documentation of resident-specific target symptoms as identified by the physician for the use of Effexor or ongoing monitoring of the presence of these symptoms.</p> <p>Resident #1's CNA Kardex from December, January, February, April, May, and June</p>	F 329		

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F 329	<p>Continued From page 83</p> <p>documented CNA's were to monitor for signs of "anger" and would chart by exception. Resident #1's June, May, April, February, January, and December CNA Kardex all documented no episodes of "anger".</p> <p>On 6/23/16 at 3:15 pm, the DNS stated if the behavior monitoring and the anti-depressant side effects were completed by nursing it would be on the MARS/TARS.</p> <p>On 6/24/16 at 11:00 am the DNS stated the CNA Kardex was charted by exception and she was unaware of how nursing was notified if an episode did present itself.</p> <p>2. Resident #2 was admitted to the facility on 10/24/15, with diagnoses which included major depression recurrent and baseline cognitive impairment with memory deficit. (ICD10 codes this as dementia)</p> <p>Resident #2's June 2016 Physician recapitulation orders documented he received: * Celexa 20 mg by mouth one time a day related to major depressive disorder, recurrent beginning on 5/21/16.</p> <p>Resident #2's discontinued orders from the March, April and May MARS documented he received: * Celexa 20 mg by mouth one time a day for sign and symptom of depression increasing, beginning on 11/14/15.</p> <p>Resident #2's Quarterly MDS assessment, dated 5/26/16, documented he had no behaviors, no cognitive or decision making impairments and minimal signs of depression. Resident #2's</p>	F 329		

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F 329	<p>Continued From page 84</p> <p>Quarterly comparison MDS assessment, dated 12/22/15 documented a mild cognitive impairment, no decision making impairment, and minimal signs of depression.</p> <p>Resident #2's care plan, dated 1/4/16, documented Resident #2 was on an antidepressant related to nursing home placement, changed health status, loneliness, and frequent dialysis treatments. Interventions included:</p> <ul style="list-style-type: none"> <li>* Staff were to monitor for increased fall risk.</li> <li>* The facility would consult with pharmacy and MD for when GDRs would be clinically appropriate.</li> <li>* The care plan documented to observe for potential adverse side effects of the medication which included: anorexia, anxiety, constipation, diarrhea, dizziness, dry mouth, headache, and nausea.</li> </ul> <p>The care plan did not include resident-specific targeted behaviors that staff were to monitor.</p> <p>Resident #2's MARS/TARS did not document the anti-depressant side effects or resident specific targeted behavior the staff were to monitor. His record did not contain documentation of monitoring for the potential adverse reactions to the anti-depressant medication. The record did not include documentation of resident-specific target symptoms as identified by the physician for the use of Celexa and ongoing monitoring of the presence of these symptoms.</p> <p>Resident #2's CNA Kardex from October</p>	F 329			

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F 329	<p>Continued From page 85</p> <p>November, May, and June documented CNA's were to monitor for signs of "frustrated" and would chart by exception. Resident #1's June, May, October and November, CNA Kardex, all documented no episodes of "frustrated".</p> <p>On 6/23/16 at 3:15 pm the DNS stated if the behavior monitoring and the anti-depressant side effects were completed by nursing it would be located on the MARS/TARS.</p> <p>On 6/24/16 at 11:00 am the DNS stated the CNA Kardex was charted by exception and she was unaware of how nursing was notified if an episode did present itself. The notes did not include, and the facility could not provide, documentation of Resident #2's targeted behaviors prior to the initiation of the Celexa medication on 11/14/15.</p> <p>3. Resident #10 was admitted to the facility on 6/30/15, with diagnoses which included dementia with behaviors, violent behaviors, delusional disorder, and fall history.</p> <p>The manufacturer's recommendations for the anti-depressant, Trazadone, state the medication is indicated for the treatment of Major Depressive Disorder and other psychiatric disorders. The manufacturer's stated adverse side effects included anxiety, agitation, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness) and mania.</p> <p>The manufacturer's recommendations for the anti-psychotic, Zyprexa, state the medication is indicated for the treatment of schizophrenia and bipolar disorder. The manufacturer's stated adverse side effects include insomnia.</p>	F 329			

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F 329	<p>Continued From page 86</p> <p>The 2017 Nursing Drug Book's recommendations for the antipsychotic, Risperdal, state the medication is indicated for the treatment of schizophrenia, bipolar disorder, irritability with autistic disorder, and obsessive-compulsive disorder. Stated adverse reactions to Risperdal include, but are not limited to, insomnia, agitation, anxiety, mania, and abnormal thinking and dreaming.</p> <p>Resident #10's May 2016 physician recapitulation orders documented he received:</p> <p>* Risperdal 0.25 mg at bedtime related to dementia with behavioral disturbance, delusional disorder, and violent behavior, beginning 4/28/16.</p> <p>*Trazodone 50mg one time a day for insomnia beginning 4/8/16.</p> <p>Resident #10's discontinued orders from the March and April 2016 MARS documented he received:</p> <p>*Zyprexa 2.5mg at bedtime for frontal lobes related to dementia with behavioral disturbance, delusional disorder, and violent behaviors beginning on 3/23/16 and discontinuing on 4/26/16.</p> <p>* Trazodone 50 mg at bedtime for insomnia beginning on 1/30/16 and discontinued on 4/8/16. This was the first documentation of insomnia.</p> <p>The April 2016 MAR documented a side effects box above the administration of the Zyprexa. It was unclear what black box side effects the staff were to monitor for and what the "chart codes"</p>	F 329			

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F 329	<p>Continued From page 87</p> <p>were defined as in the side effects box. For example, 4/8/16 through 4/20/16 documentation included (in the Side Effects box):</p> <ul style="list-style-type: none"> <li>* 9 days documented "3" which the "Chart Code" defined as "Away from center without meds".</li> <li>* 1 day documented "4" which the "Chart Code" defined as "Drug not available".</li> <li>* 3 days documented "x" which the "Chart code" do not include a definition for.</li> </ul> <p>The April MAR documented the Zyprexa was "Administered" 12 times and "Drug was unavailable" one time during 4/8/16 through 4/20/16.</p> <p>The May 2016 MAR documented a side effects box above the administration of the Trazodone. It was unclear what black box side effects the staff were to monitor for and what the "Chart Codes" were defined as in the side effects box. For example, the Month of May included (in the Side Effects box):</p> <ul style="list-style-type: none"> <li>* 10 days documented "1" which the coding referenced " Drug refused".</li> <li>* 11 days documented "3" which the coding referenced "Away from center without meds".</li> <li>* 4 days documented "e" which the coding referenced "Effective".</li> <li>* 5 days documented "0" which the "Chart Code" did not include a definition for.</li> <li>* 1 day documented "+" which the "Chart Code" did not include a definition for.</li> </ul> <p>On the May MAR, the medication, Trazodone, was documented as "Administered" in the facility each day.</p>	F 329		

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F 329	<p>Continued From page 88</p> <p>The June 2016 MAR, 6/1/16 through 6/22/16, documented a side effects box above the administration of the Trazodone. It was unclear what black box side effects the staff were to monitor for and what the "Chart Codes" were defined as in the side effects box. For example, the Month of June included (in the Side Effects box):</p> <ul style="list-style-type: none"> <li>* 12 days documented "1" which the coding defined "Drug refused".</li> <li>* 2 days documented "2" which the coding defined "Away from center with meds".</li> <li>* 7 days documented "3" which the coding defined "Away from center without meds".</li> <li>* 1 day documented "x" which the "Chart Code did not include a definition for.</li> </ul> <p>However, the June MAR documented Trazodone was "administered" in the facility each day.</p> <p>Resident #10's care plan, dated 2/1/16, documented Resident #10 was on an anti-depressant related to insomnia. Interventions included:</p> <ul style="list-style-type: none"> <li>* Staff were to monitor for increased fall risk.</li> <li>*The facility would consult with pharmacy and MD for when GDRs would be clinically appropriate.</li> <li>*The care plan documented to observe for potential adverse side effects of the medication which included anxiety, constipation, diarrhea, dizziness, insomnia, headache, and nausea.</li> </ul> <p>The care plan did not include resident-specific targeted behaviors that staff were to monitor.</p>	F 329			

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F 329	<p>Continued From page 89</p> <p>Resident #10's Antipsychotic Care Plan, dated 4/13/16, documented he had behavior symptoms related to dementia with behaviors. Interventions included:</p> <ul style="list-style-type: none"> <li>* Staff were to monitor for significant decline in function or increase need for cares.</li> <li>* Staff were to monitor for behavioral symptom that presented danger to others.</li> <li>* Observe for Black Box warning from the manufacture.</li> </ul> <p>The care plan did not include resident-specific targeted behaviors that staff were to monitor.</p> <p>Physician notes from 6/27/15, 2/18/16, 3/18/16, 4/19/16, and 6/11/16 all did not include diagnoses of depression or psychiatric diagnoses. Resident #10's record did not include documentation of resident specific target symptoms as identified by the physician for the use of Zyprexa and Risperdal or ongoing monitoring of the presence, persistence and alterability of those symptoms. The notes did not include, and the facility could not provide, documentation of Resident #10's targeted behaviors prior to the initiation of the Trazodone on 1/30/16.</p> <p>Resident #10's CNA Kardex from March, April, May, and June documented CNA's were to monitor for signs of behaviors which were defined as:</p> <ul style="list-style-type: none"> <li>* "Offensive or inappropriate sexual comments or jokes"</li> <li>* Resident "Wandering into the nurses station"</li> </ul>	F 329			

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F 329	<p>Continued From page 90</p> <p>* Resident "Pacing hallway continually"</p> <p>The CNA's were to chart by exception. Resident #10's June, May, April, and March, CNA Kardex, all documented zero episodes of the three behaviors above.</p> <p>On 6/23/16 at 3:15 pm, the DNS stated if the behavior monitoring and the anti-depressant side effects were completed by nursing it would be located on the MARS/TARS.</p> <p>On 6/24/16 at 11:00 am the DNS stated the CNA Kardex was charted by exception and she was unaware of how nursing was notified if an episode did present itself.</p> <p>4. Resident #5 was admitted to the facility on 6/29/15 with diagnoses which included Parkinson's disease.</p> <p>On 7/15/15, Resident #5's care plan documented a focus area of impaired adjustment, which included difficulty adjusting to roommates.</p> <p>Resident #5's 12/9/15 Quarterly MDS assessment documented no hallucinations or delusions present.</p> <p>On 2/12/16 at 9:22 pm, Resident #5's NN documented she, "appears paranoid of roommate, stating to CNA, 'Do not drink anything that she...gives you. It's poison from her!...' There was no documentation as to what interventions were attempted, or how effective those interventions were.</p> <p>On 2/13/16 at 2:50 pm, Resident #5's NN</p>	F 329			

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F 329	<p>Continued From page 91</p> <p>documented the night shift had reported Resident #5 was having delusions about a relationship between Resident #5's roommate and husband during the previous night. The NN documented Resident #5 had been sitting in her chair reading a newspaper throughout the day.</p> <p>On 2/17/16 at 9:52 am, Resident #5's NN documented the pharmacist had performed a medication review for Resident #5.</p> <p>On 2/17/16, a consultation report from the facility's pharmacist documented, "Resident has new onset paranoid symptoms, which may be related to worsening Parkinson's Disease resulting from a Sinemet dose decrease in January. Her paranoia is further exacerbated by a new roommate. Consider incremental increases in Sinemet to help reduce paranoia, if clinically appropriate."</p> <p>On 2/17/16 at 12:31 pm, Resident #5's NN documented she was experiencing some confusion related to facility Administration, and accused the LN of lying to her. The note documented Resident #5, "just looked at me, and then she went off down the hallway."</p> <p>On 2/17/16 at 12:43 pm, Resident #5's NN documented her neurologist would be notified of her increased paranoia, the concern that it may be related to a change in her Parkinson's medications, and that Resident #5, "has a new roommate and this is traumatic to the resident."</p> <p>On 2/22/16 at 3:13 pm, Resident #5's physician's orders documented a new order for an antipsychotic medication, Seroquel 25 mg daily, for dementia related to Parkinson's disease.</p>	F 329		

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F 329	<p>Continued From page 92</p> <p>On 2/22/16, Resident #5's care plan was updated to include the use of anti-psychotic medications. Interventions included to monitor for behavioral symptoms presenting a danger to self or others. The behaviors identified in Resident #5's care plan were accusing others of conspiring against her, and confusing other residents with family members. Non-pharmacological interventions included visits from the LSW, reassuring and redirecting her, calling her family for reassurance, offering a snack or beverage, and offering bingo or crafts.</p> <p>On 2/26/16 at 1:36 pm, Resident #5's physician's orders documented a new order for Zyprexa 5 mg daily for a diagnosis of paranoid thoughts related to dementia with Lewy Bodies.</p> <p>On 2/29/16 at 1:09 pm, Resident #5's physician's orders documented the Seroquel was discontinued.</p> <p>On 3/18/16 at 7:15 am, a progress note to Resident #5's physician documented she had been noted with difficulty swallowing "for the past few weeks," and requested a speech therapy evaluation.</p> <p>On 3/23/16 at 7:19 am, an MD/Nursing Communication form documented Resident #5 stated she had been having difficulty swallowing, "for the past few weeks." The facility requested a speech therapy evaluation.</p> <p>On 4/1/16, Resident #5's record documented a visit with her neurologist. The neurologist's progress note documented Resident #5 was to continue the Zyprexa for, "Dementia associated</p>	F 329		

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PRINTED: 07/11/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/24/2016
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID .83867		
(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 329	<p>Continued From page 93</p> <p>with with underlying disease with behavioral disturbance." The note did not document the specific target behavior which required the use of Zyprexa.</p> <p>On 4/14/16, Resident #5's NN documented she was informed her daughter passed away. Resident #5's care plan was not updated to reflect this information, or approaches for the staff to use as she grieved. The care plan approach to call family to reassure her when she was paranoid or confused was not updated as to which family member the facility was now to call.</p> <p>On 5/1/16, a Physician's Progress Note documented Resident #5 was experiencing fatigue and a gradual decline in function.</p> <p>ON 5/6/16 at 1:40 pm, an MD/Nursing Communications form documented a nursing concern of a "swallowing problem" as evidenced by Resident #5 having difficulty swallowing her ham sandwich at lunch. The form documented Resident #5 attributed this development to her Parkinson's disease, and requested a speech therapy evaluation.</p> <p>On 5/24/16, a Safe Swallowing Protocol for Swallowing Deficits form documented Resident #5 was downgraded from a regular diet to a mechanical soft texture diet.</p> <p>On 6/20/16 between 1:40 pm and 2:30 pm, Resident #5 was observed on the patio in a gardening activity. Resident #5 was briefly fidgety while trying to remove her sweater (the outside temperature was 82 degrees), but calmed and watched attentively once her sweater had been removed. Resident #5 was assisted to use the</p>	F 329		

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F 329	<p>Continued From page 94</p> <p>broom to sweep dirt into a dustpan at the conclusion of the activity.</p> <p>On 6/21/16 between 8:25 am, Resident #5 was sitting in her wheelchair at a table in the day room. Resident #5's head was down, with her chin against her chest. Her eyes were closed. She remained in that position until 8:45 am.</p> <p>On 6/23/16 at 2:30 pm, the DNS stated:</p> <p>*Resident #5 began to demonstrate signs of paranoia in February 2016, as evidenced by wandering in the day room before 6:30 am, wanting to go outside, which was disruptive to Resident #5.</p> <p>*There was no documentation as to how persistent the behavior was for Resident #5, how it caused her distress, what non-pharmacological interventions had been implemented, or the effectiveness of those interventions. The DNS thought the behavior had been happening a few times a week for 3-4 weeks prior to the initiation of the anti-psychotic medication.</p> <p>*Resident #5's neurologist diagnosed her with Parkinson's dementia, and started her on anti-psychotic medication, but did not identify a specific target behavior for which the medication was prescribed.</p> <p>*Resident #5 had received a new roommate around the same time, and had been without a roommate for some time prior to that. Resident #5's family helped the facility recognize a connection between Resident #5 receiving a new roommate and the onset of her symptoms.</p>	F 329		

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F 329	Continued From page 95 *The facility's plan for Resident #5 regarding her new roommate was to provide comfort, and reassurance that her paranoid ideations about her roommate were not factual.  *The facility did not track the specific behaviors as outlined in Resident #5's care plan. CNAs could, however, document "by exception" if general behaviors occurred..  *Resident #5's behavior patterns were not tracked or evaluated by an LN or the LSW.  *The facility had not evaluated Resident #5's swallowing difficulties, fatigue, or gradual decline as possible adverse reactions to the use of anti-psychotic medications.	F 329			
F 332 SS=D	5. Similar survey findings related to lack of specific behavioral monitoring data to support the use of antipsychotics were also for Resident #6. 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to maintain a medication error rate less than 5 percent. This was true for 3 of 10 observed medication passes (11.11%) and affected 1 of 10 sampled residents (Resident #2) and 2 of 2 random residents (#12 and #13). This failure	F 332			

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F 332	<p>Continued From page 96</p> <p>created the potential for residents to receive more than the required amount of prescribed medication. Findings included:</p> <p>1. Resident #2's Recapitulation Orders for June 2016 included:</p> <p>Novolog insulin 100 units/ml - Inject subcutaneously per sliding scale before meals and at bedtime: 0 - 120 = no insulin, 121 - 170 = 1 unit, 171 - 220 = 2 units, 221 - 270 = 3 units, 271 - 320 = 4 units, 321 - 370 = 5 units, and above 371 call the medical doctor.</p> <p>On 6/23/16 at 10:30 AM, RN #1 was observed administering Novolog insulin to Resident #2. This administration was approximately 1 hour and 50 minutes before the lunch meal. The manufacturer's specification for use documented, Novolog is a fast acting insulin and the effects start working 10 to 20 minutes after injection and should immediately be followed by a meal within 5-10 minutes.</p> <p>2. Resident #12's Recapitulation Orders for June 2016 included:</p> <p>Humalog insulin 100 units/ml - Inject subcutaneously per sliding scale before meals and at bedtime: 0 - 120 = 0 insulin, 120 - 170 = 1 unit, 171 - 220 = 2 units, 221 - 270 = 3 units, 271 - 320 = 4 units,</p>	F 332			

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F 332	<p>Continued From page 97 321 - 370 = 5 units, above 371 call the medical doctor.</p> <p>On 6/23/16 at 10:55 am, Resident #12's blood sugar reading was 167 mg/dL. At 11:05 am, RN #1 was observed administering Humalog insulin to Resident #12 approximately 45 minutes before the lunch meal. The manufacturer's specification for use documented Humalog is a rapid-acting insulin, it should be administered 5 to 10 minutes before the start of a meal, and it works to lower blood sugar levels within 30 minutes of administration.</p> <p>3. Resident #13's Recapitulation Orders for June 2016 included:</p> <p>Humalog insulin 100 mg/ml - Inject subcutaneously per sliding scale three times a day at 7:00 am, 11:00 pm, and 4:00 pm: 0 - 199 = no insulin, 200 - 260 = 5 units, 261 - 320 = 7 units, 321 - 400 = 10 units, and above 400 call medical doctor.</p> <p>On 6/23/16 at 11:45 am, Resident #13's blood sugar reading was 398 mg/dL. At 11:45 am, RN #1 was observed administering Humalog insulin to Resident #13, who did not receive his lunch for approximately 1 hour and 15 minutes after administration. The manufacturer's specification for use documented Humalog is a rapid-acting insulin, it should be administered 5 to 10 minutes before the start of a meal, and it works to lower blood sugar levels within 30 minutes of administration..</p> <p>On 6/23/16 at 12:20 pm, when asked how he was</p>	F 332			

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F 332	Continued From page 98 doing Resident #13 stated, "I am hungry waiting for my food! I want to eat!"	F 332			
F 333 SS=D	On 6/23/16 at 4:10 pm, the DNS was notified of the medication errors. The DNS stated the identified residents' blood sugars should have been checked 15-30 minutes prior to the meal. She stated it would not be appropriate to administer fast or rapid sliding scale insulin 1 hour or more before a meal. 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure there were no significant medication errors. This was true for 1 of 10 sampled residents (Resident #2) and 2 of 2 Random Residents (#12 and #13) observed during medication pass when rapid acting insulin was given greater than 1 hour before the lunch meal. This failure created the potential for Residents #2, #12, and #13 to experience a hypoglycemic event (blood sugars less than 70 mg/dL). Findings include:  1. Resident #12's Recapitulation Orders for June 2016 included:  Novolog insulin 100 units/ml - Inject subcutaneously per sliding scale before meals and at bedtime:	F 333			

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F 333	<p>Continued From page 99</p> <p>0 - 120 = no insulin, 121 - 170 = 1 unit, 171 - 220 = 2 units, 221 - 270 = 3 units, 271 - 320 = 4 units, 321 - 370 = 5 units, and above 371 call the medical doctor.</p> <p>The manufacturer's specification for use documented, Novolog is a fast acting insulin and the effects start working 10 to 20 minutes after injection and should immediately be followed by a meal within 5-10 minutes.</p> <p>On 6/23/16 at 10:30 am, RN #1 was observed administering Novolog insulin to Resident #12. This administration was approximately 1 hour and 50 minutes before the lunch meal.</p> <p>2. Resident #13's Recapitulation Orders for June 2016 included:</p> <p>Humalog Insulin 100 units/ml - Inject subcutaneously per sliding scale before meals and at bedtime: 0 - 120 = 0 insulin, 120 - 170 = 1 unit, 171 - 220 = 2 units, 221 - 270 = 3 units, 271 - 320 = 4 units, 321 - 370 = 5 units, above 371 call the medical doctor.</p> <p>The manufacturer's specification for use documented Humalog is a rapid-acting insulin, it should be administered 5 to 10 minutes before the start of a meal, and it works to lower blood sugar levels within 30 minutes of administration.</p>	F 333			

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F 333	<p>Continued From page 100</p> <p>On 6/23/16 at 10:55 am, Resident #13's blood sugar reading was 167 mg/dL. At 11:05 am, RN #1 was observed administering Humalog insulin to Resident #13 approximately 45 minutes before the lunch meal.</p> <p>3. Resident #2's Recapitulation Orders for June 2016 included:</p> <p>Humalog insulin 100 mg/ml - Inject subcutaneously per sliding scale three times a day at 7:00 am, 11:00 am, and 4:00 pm: 0 - 199 = no insulin, 200 - 260 = 5 units, 261 - 320 = 7 units, 321 - 400 = 10 units, and above 400 call medical doctor.</p> <p>The manufacturer's specification for use documented Humalog is a rapid-acting insulin, it should be administered 5 to 10 minutes before the start of a meal, and it works to lower blood sugar levels within 30 minutes of administration.</p> <p>On 6/23/16 at 11:45 am, Resident #2's blood sugar reading was 398 mg/dL. At 11:45 am, RN #1 was observed administering Humalog insulin to Resident #2, who did not receive his lunch for approximately 1 hour and 15 minutes after administration.</p> <p>On 6/23/16 at 4:10 pm, the DNS was notified of the medication errors. The DNS stated the identified residents' blood sugars should have been checked 15-30 minutes prior to the meal. She stated it would not be appropriate to administer fast or rapid sliding scale insulin 1 hour or more before a meal.</p>	F 333			



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

August 17, 2016

Julie Johansen, Administrator  
Good Samaritan Society-- Silver Wood Village  
PO Box 358  
Silverton, ID 83867-0358

Provider #: 135058

Dear Ms. Johansen:

On **June 24, 2016**, an unannounced on-site complaint survey was conducted at Good Samaritan Society-- Silver Wood Village. This complaint was investigated in conjunction with the facility's Federal Recertification and State Licensure survey between June 20, 2016, and June 24, 2016.

The survey team reviewed the medical records of eleven sample residents, including the identified resident and one other resident receiving hospice services. Interviews were conducted with individual residents and resident families. A resident group interview was conducted. Staff interviews were conducted, including interviews with the facility Administrator, the Director of Nursing, the Licensed Social Worker, nurses and nurse's aides, the Ombudsman, and hospice staff. The facility's grievance file was reviewed. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007319**

**ALLEGATION #1:**

An identified resident was assessed to have an acute change in her medical condition. The facility offered to send the resident to the hospital, which the resident refused. The resident's physician and family were not notified for several hours after the onset of symptoms. The identified resident was later found to have had a heart attack.

FINDINGS:

The identified resident was noted with changes in her respiratory status and mentation at approximately 3:00 am on the date in question. The facility documented no efforts to notify either the resident's physician or family until 7:00 am.

The allegation was substantiated and cited at F157 and F309.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

An identified resident returned to the facility after being hospitalized, with a referral for a hospice consultation. When the resident and her family tried to meet with and enroll in hospice, the facility Administrator tore up the hospice paperwork. After the identified resident enrolled with the hospice of her choice, the facility made several attempts to encourage the resident to dis-enroll with hospice, including threatening to cancel the hospice contract and requesting the resident's physician discontinue the hospice order.

FINDINGS:

The allegation was substantiated and cited at F155, F242, and F250.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility sent an identified resident to the hospital for evaluation of "indigestion," but did not notify the resident's family.

FINDINGS:

The allegation was substantiated, and cited at F157.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

An identified resident opted to access hospice services for a terminal illness. Three days before the resident died, the facility requested the physician review the use of hospice for this resident, and the physician discontinued hospice without talking to either the resident or his/her responsible party. The discontinuation order was faxed to the hospice agency, and hospice was not called when the resident passed away.

FINDINGS:

The allegation was substantiated, and cited at F155, F242, F250, and F309.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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 will be 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 that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a clear "Scott" following.

David Scott, RN, Supervisor  
Long Term Care

DS/lj



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FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

January 5, 2017

Julie Johansen, Administrator  
Good Samaritan Society-- Silver Wood Village  
PO Box 358  
Silverton, ID 83867-0358

Provider #: 135058

Dear Ms. Johansen:

On **June 24, 2016**, an unannounced on-site complaint survey was conducted at Good Samaritan Society-- Silver Wood Village. The complaint was investigated in conjunction with the facility's Federal Recertification and State Licensure survey between June 20, 2016 and June 24, 2016.

The survey team reviewed the clinical records of eleven sampled residents, including the residents identified in this complaint, for quality of care and quality of life issues. Interviews were conducted with individual residents and resident families. A resident group interview was conducted. Staff interviews were conducted, including interviews with the Director of Nursing Services, the Administrator, Licensed Social Worker, nurses, certified nursing assistants, the Ombudsman, and the Medical Director.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007190**

**ALLEGATION #1:**

The Reporting Party stated a certified nursing aide assisting residents in the dining room told a resident on the other side of the dining room to "sit down," and there are not enough staff to assist all residents in the dining room.

FINDINGS:

Residents and staff interactions were observed several times during different meals in the dining room throughout the survey process.

Nine residents in the Resident Group interview, when asked if they had witnessed staff yelling at residents in the dining room, stated, "The staff here treat all residents with dignity and respect. We have no concerns related to staff yelling at residents in the dining room." The residents stated there was an adequate number of staff to assist those in the dining room who needed it.

Several individual residents and family members said they did not have concerns related to insufficient staffing in the dining room and/or staff yelling at residents in the dining room.

The facility's Resident Council meeting minutes and grievances from January 2016 to June 2016 did not document concerns related to inadequate staff in the dining room and/or staff yelling at residents in the dining room.

Based on observation, and resident, family, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The Reporting Party stated an identified resident's floor was unkept.

FINDINGS:

Housekeepers, as well as resident rooms, common areas, shower rooms, the dining room, and physical therapy room was observed.

Five residents and two family members did not indicate there was an issue related to cleanliness, and nine residents in the Group Interview stated they had no concerns related to the cleanliness of the facility.

Grievances and Resident Council meeting minutes reviewed for January 2016 to June 2016 did not document concerns related to cleanliness of the facility.

Julie Johansen, Administrator  
January 5, 2017  
Page 3 of 3

Based on observations, interviews, and record review, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Reporting Party stated a dated supplement drink sat on an identified residents bedside table for two days.

FINDINGS:

There is no federal regulation prohibiting a dated supplement drink from sitting at bedside. The Reporting Party did not identify whether the supplement was opened and/or if he/she had reported it to the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, sweeping initial "D".

David Scott, R.N., Supervisor  
Long Term Care

DS/lj