



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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July 29, 2016

Troy Thayne, Administrator  
Safe Haven Care Center f Pocatello  
1200 Hospital Way  
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Thayne:

On **July 15, 2016**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **May 19, 2016**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F164 -- S/S: D -- 483.10(e), 483.75(l)(4) -- Personal Privacy/confidentiality Of Records**
- **F241 -- S/S: D -- 483.15(a) -- Dignity And Respect Of Individuality**
- **F309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being**
- **F253 -- S/S: E -- 483.15(h)(2) -- Housekeeping & Maintenance Services**
- **F280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp**
- **F323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices**
- **F325 -- S/S: G -- 483.25(i) -- Maintain Nutrition Status Unless Unavoidable**

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

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compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 8, 2016**.

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

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

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

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

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

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As noted in the Bureau of Facility Standards' letter of **April 29, 2016**, following the survey of **April 15, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions on **July 15, 2016** and termination of the provider agreement on **October 15, 2016**, if substantial compliance is not achieved by that time. The findings of non-compliance on **July 15, 2016**, will result in a continuance of the remedy(ies) previously recommended to CMS. On **April 29, 2016**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **July 15, 2016**
- A civil money penalty

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

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

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

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

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This request must be received by **August 8, 2016**. If your request for informal dispute resolution is received after **August 8, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

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 smaller "Scott" following it.

David Scott, RN, Supervisor  
Long Term Care

DS/lj  
Enclosures

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

PRINTED: 09/30/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135071</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/15/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>SAFE HAVEN CARE CENTER OF POCATELLO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 HOSPITAL WAY</b> <b>POCATELLO, ID 83201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  The following deficiencies were cited during the follow-up survey of your facility completed July 11 to July 15, 2016.  The surveyors conducting the survey were:  Lorraine Hutton, RN, Team Coordinator Sylvia Creswell, LSW, QIDP  Definitions include: ADA - American Diabetic Association BIMS - Brief Interview for Mental Status CDM - Certified Dietary Manager CNA - Certified Nursing Assistant CP - Care Plan DON - Director of Nursing cc - cubic centimeter ED - Emergency Department I&A - Incident and Accident report lbs - pounds LPN - Licensed Practical Nurse LN - Licensed Nurse MAR - Medication Administration Record MDS - Minimum Data Assessment NAR - Nutrition at Risk MG - Milligram ML - Milliliter PRN - As needed RD - Registered Dietician RN - Registered Nurse SLP - Speech Language Pathologist TBI - Traumatic Brain Injury W/C - Wheelchair	{F 000}			
{F 164} SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and	{F 164}		9/23/16	

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

TITLE

(X6) DATE

Electronically Signed

09/26/2016

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

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{F 164}	<p>Continued From page 1 confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure the personal privacy of 2 of 10 (#7 and #18) sampled residents. This created the potential for residents to experience embarrassment and humiliation when observed in adult incontinent brief or while on the toilet, by other residents, visitors, maintenance staff, and</p>	{F 164}	<p>Affected Residents</p> <p>All residents could be affected by this citation</p> <p>Corrective Action</p> <p>Resident #18's care plan was reviewed. The facility obtained weather appropriate</p>	

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{F 164}	<p>Continued From page 2 others not directly caring for them. Findings include:</p> <p>1. Resident #18 was admitted to the facility in 2014 with diagnoses that included dementia.</p> <p>On 7/11/16 at 3:25 pm, Resident #18's bedroom door was open and he was observed sitting on a mat in front of the bed with his head and shoulders resting on the bed. Resident #18 did not have pants on and was observed in an adult incontinence brief. CNA #1 stated at that time that Resident #18's care plan documented he could be on the floor. CNA #1, without shutting Resident #18's door, left the room and returned with another CNA. CNA #1 stated they were going to change Resident #18's adult brief and closed the door.</p> <p>2. Resident #7 was admitted to the facility with diagnoses including vascular dementia, hepatic encephalopathy, and Parkinson's Disease.</p> <p>Resident #7's 5/23/16 MDS assessment documented he required extensive assistance of at least one staff with transfers and toileting.</p> <p>On 7/12/16 at 3:30 pm, Resident #7 was observed on the toilet in his bathroom with the door fully opened. Resident's #7's wheelchair sat to the side of the toilet. Two staff were in the bedroom, one by the bed and one by the bathroom door. Resident #7's roommate was in bed, turned on his side and facing the wall. The bed was positioned lengthwise in front of the bathroom door. There was no curtain pulled to obstruct Resident #7's roommate's view of Resident #7 on the toilet in the bathroom.</p>	{F 164}	<p>clothing for the resident to wear while in bed.</p> <p>The CEO of Safe Haven Health Care along with the Director of Nursing gave an in-service on 8/4/2016 in regards to resident privacy and confidentiality.</p> <p><b>Systematic Changes</b></p> <p>The facility DNS or cart nurse will conduct rounds each shift to ensure that residents' privacy and confidentiality are maintained. The facility will continue to conduct patient care audits to ensure privacy curtains, bathroom doors, and resident room doors are closed if cares are being provided. Additionally, in order to create a pervasive culture change that is more sensitive to privacy and dignity issues of our residents, brief instruction and training will be a part of each in-service training from now on.</p> <p><b>Monitoring</b></p> <p>Privacy rounds will be conducted once per shift (three shifts a day) for a month, then every shift every other day for two weeks, then weekly for 3 months. Audits will be reported to Q.A.P.I. on a monthly basis and at least quarterly to the Governing Body. The Administrator and Director of Nurses or designee is responsible for compliance.</p>		

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{F 164}	Continued From page 3	{F 164}			
{F 241} SS=D	<p>When asked the reason the bathroom door remained open, CNA #2 stated it was difficult to close the bathroom door with Resident #7, a staff person, and the wheelchair in the room.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, it was determined the facility failed to ensure residents' wheelchairs were maintained in a manner that promoted the dignity of 3 of 10 sampled residents (#19, #21 and #22) and 2 random residents (#25 and #26). This resulted in disrepair of residents' wheelchairs and wheelchair seating cushions. This practice had the potential to negatively impact residents' sense of self-worth and self-esteem, and interfere with the comfort and sanitation of the wheelchairs. Findings include:</p> <p>1. Residents' wheelchairs were not maintained in good repair. Examples include:</p> <p>a. Resident #25 was observed in the therapy room on 7/12/16 at 9:00 am, seated in his wheelchair completing arm exercises. The front half of the bottom and top seat cushions in his wheelchair were missing, exposing the interior of each. The left side of the vinyl covered bolster in</p>	{F 241}	<p>Affected Residents</p> <p>Resident #25's cushion was replaced Resident #26's arm rests were replaced Resident #22's cushion was replaced Resident #21's arm rests were replaced Resident #19's arm rest was repaired However, all residents could be affected by this citation.</p> <p>Corrective Action</p> <p>A thorough review of all facility wheelchairs, mattresses, etc. was completed by the ADON to identify any other issues with resident equipment. Issues were documented and a plan is in place to repair found issues.</p> <p>Systematic Changes</p> <p>A designated central supply employee</p>	9/23/16	

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{F 241}	<p>Continued From page 4</p> <p>the middle of the wheelchair was torn in half exposing the foam underneath. The vinyl on the arms of the wheelchair was cracked exposing the padding underneath.</p> <p>b. On 7/13/16 at 10:10 am, Resident #26 was observed awake in bed with his wheelchair near his bed. Approximately 3/4 of the vinyl on the left arm of the wheelchair was torn back and detached from the padding. The detached vinyl, roughly 6 inches in length, remained attached to the remaining vinyl and flopped to the back of the arm of the wheelchair. The vinyl on the right arm of Resident #26's wheelchair was cracked, exposing the padding.</p> <p>c. Resident #22 was observed in the hallway outside her room on 7/12/16 at 9:15 am. The left side front corner of the vinyl cushion in her wheelchair was torn, with pieces of the stuffing protruding from the tear.</p> <p>d. Resident #21 was observed in his room seated in his wheelchair on 7/13/16 at 10:15 am. The vinyl on both arms of his wheelchair was cracked with padding exposed between the cracks.</p> <p>e. Resident #19 was observed in her room resting in bed. Her electric wheelchair sat at the side of her bed. The stitching was coming apart at the back of armrest and exposed about a 3-inch long by 1-inch wide strip of yellow foam rubber. When asked if the she was aware of the tear, Resident #19 stated, "No."</p> <p>The Administrator and Assistant Administrator were interviewed on 7/13/16 at 10:45 am. Each</p>	{F 241}	<p>has been assigned to conduct monthly rounds on all resident equipment. Issues will be logged, documented, and reviewed at weekly environmental meetings. An expected completion date will be documented when an issue is identified. The item will be signed off and cleared as the repair is completed. Additionally, in order to create a pervasive culture change that is more sensitive to dignity as it relates to repair issues of our residents' equipment, brief instruction and training will be a part of each monthly all staff training meetings from now on.</p> <p>Monitoring</p> <p>Monthly rounds and identified issues will be presented to Q.A.P.I on a monthly basis and at least quarterly to the Governing Body. As issues are identified, the items will be logged by the QAPI Coordinator and an estimated completion date assigned.</p> <p>Administrator or QAPI Coordinator is responsible for compliance.</p>		

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{F 241}	Continued From page 5 confirmed the facility did not have a process in place to routinely monitor the condition of wheelchairs. They stated concerns regarding wheelchairs were brought to their attention by staff.	{F 241}			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure the environment throughout the facility was maintained in an orderly and sanitary manner. This was true for 10 of 10 sampled residents (#6, #7, #12, #18, #19 #20, #21, #22, #23, and #24), and all other residents residing in the facility. This created the potential for residents to experience embarrassment, loss of self-worth, or dissatisfaction due to the condition of the environment around them. The deficient practice also created the potential for the spread of infection due to an unsanitary environment. Findings include:  1. The environment was not maintained in an orderly and sanitary manner. Examples include:  * On 7/13/16 at 11:35 am, the electrical breaker box on the back hallway of Cape May was open, exposing a panel of breaker switches. When the Administrator, who accompanied surveyors on the tour, attempted to close the panel it popped	F 253	Affected Residents  All residents could be affected by this citation  Corrective Action  The electrical breaker box was fixed and remains shut and locked The fan was cleaned that is located at the start of Cape Elizabeth Hallway The crash cart was cleaned and the pressed wood has been painted The cabinets (inside and outside) in the Wharf dining room were cleaned and the dust was cleaned The large stains on the tablecloth were removed, where possible, by housekeeping staff. Because some stains were impossible to remove, new table cloths have been ordered. Shower Room #6 was cleaned and the cabinet was cleaned and repaired	9/23/16	

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F 253	<p>Continued From page 6 back open. The panel was bent and would not allow the box to be securely closed.</p> <p>* On 7/11/16 at 4:05 pm, a large, tall, metal stand-up fan was observed at the start of the Cape Elizabeth Hallway. Thick, black, caked on dust was observed covering all surfaces, front and back, of the metal protective cage. Dust accumulations 1-1.5 inches long trailed from the front as air blew down the hall.</p> <p>* On 7/11/16 at 4:02 pm, the crash cart located by the Pyxis machine was observed to be dusty. The black tray in the front was dusty, as were other parts of the top surface. Approximately 3/4 of the top surface consisted of unfinished pressed wood, which was dusty. Multiple, large fluid spills were noted on the pressed wood surface.</p> <p>* On 7/12/16 at 9:30 am, the counter and cabinets in the Wharf Dining Room in which the sink was located was observed with food and fluid spill inside and outside of the cabinets. The cabinet doors stood ajar and dried, dark yellow-to-brown, spilled food and/or fluid was caked along the surfaces of the inside ledge of the lower cabinet doors. The wiring covers, outlet tops, and baseboard on the wall by the sink were covered in dust.</p> <p>* On 7/11/16 at 3:40 pm, the tan tablecloths on the tables in the Wharf Dining Room were observed with multiple large stains. Outside the large span of windows in the dining room were multiple large dead weeds and overgrown bushes.</p>	F 253	<p>Handrails were re-painted The Boardwalk dining room cabinets were cleaned and repaired to ensure the surfaces are cleanable The entire Seaside dining room was deep cleaned. Cape May hallways were cleaned to remove the dark substance noted Resident #12's bathroom was cleaned to remove the black substances identified in the survey Resident #18's room was deep cleaned and no smell of urine is noted Resident #20's fan was cleaned The Wharf dining room was deep cleaned and floors were re-waxed. C.N.A. staff were in-serviced on proper method of Moping with clean rinse water. The unfinished cabinet in the Wharf dining room was painted and a new top affixed to ensure a finished surface. Base boards in the Boardwalk and Warf Dining Rooms have been Cleaned.</p> <p>Additionally, the weeds were removed by the front of the buildings and outside of the Warf Dining Room.</p> <p>Systematic Changes</p> <p>The Vice President of Compliance of Safe Haven Health Care and the Building maintenance supervisor completed a thorough environment and sanitary walk thru of the facility to identify any other environmental concerns. The facility Director of Support Services and/or</p>		

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F 253	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>* On 7/11/16 at 3:42 pm, what appeared to be black mold or mildew was observed in grout between the tiles in sections of the Shower Room #6 floor. A padlocked cabinet in the shower room had duck tape on half of the bottom front edging. The cabinet was white with light-to-dark discoloration on the front of the doors, which appeared to be from hands touching their surface.</li> <li>* On 7/11/16 at 4:00 pm, the painted wooden hand rails in the facility were observed with chipped paint.</li> <li>* On 7/11/16 at 4:25 pm, the top of the cabinet in the Boardwalk Dining Room on which the microwave was located was observed to have large dried fluid spills. The finish on wood trim around the top edges of the cabinet was worn and no longer an easily cleanable surface.</li> <li>* On 7/12/16 at 8:45 am, dark debris was observed along the bottom of the baseboards in the Boardwalk Dining Room.</li> <li>* On 7/12/16 at 9:40 am, dust and debris was observed in the Seaside Dining Room around the outer perimeter of the stainless steel sink and backsplash. The sink was discolored from what appeared to be rust or other water mineral buildup. The counter surface of the sink cabinet was stained in multiple areas. The wire cover on the wall to the right of the sink was covered in dust. The short piece of rubber baseboard by the hall door was pulled away from the wall exposing the hard, blackened glue that had held it to the wall. On the same wall, approximately 3 inches above the baseboard, was what appeared to be</li> </ul>	F 253	<p>designee will complete Environmental Rounds on a weekly basis. Environmental concerns identified by the Director of Support Services will be documented in a binder titled Environmental Audits. The Environmental Round sheet will identify the concern, date concern was reported to the Administrator or other respective party, and projected date of completion. The Director of Support Services on a weekly basis will review outstanding issues and ensure completion of identified issues.</p> <p>Monitoring</p> <p>Environmental Rounds will be reported to the leadership of the facility on a weekly basis. Audits completed will be reported to the Governing Board and then the Governing Body on a monthly basis to ensure ongoing compliance with this citation. The Administrator or designee is responsible for compliance.</p>		

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F 253	<p>Continued From page 8</p> <p>a round hard rubber pipe cover protruding approximately 1-1.5 inches from the wall. The pipe cover was approximately 4-5 inches wide. The top and edges of the pipe cover were black with dust and it appeared to be disintegrating or corroding, as parts of the pipe cover were missing and the surface was crumbling. The bottom 1/4 of the dining room door, facing the Cape May hallway, was observed to be covered with a dark substance and in need of cleaning.</p> <p>* On 7/12/16 at 10:00 am, multiple large scuff marks, and other discolorations, were observed on the floor of the Cape May unit. A dark substance, which appeared to be dirt and/or old wax, was observed along the baseboards and doorways to residents' rooms in the Cape May hall.</p> <p>* On 7/13/16 at 9:55 am, Resident #12's bathroom, which he shared with a resident in an adjoining room, was observed with 3 large clumps of a black substance near the baseboard behind the toilet. At the bottom of the remainder of the baseboard behind the toilet a black substance, which appeared to be mold or mildew, was observed.</p> <p>* On 7/11/16 at 10:17 am and 3:25 pm, 7/12/16 at 3:35 pm, 7/13/16 at 10:05 am, and 7/14/16 at 9:15 am, the smell of urine was noted in Resident #18's room.</p> <p>* The fan located on Resident #20's dresser was observed positioned to blow into the resident's side of the room. The fan was turned to "medium" and was blowing air directly towards Resident #20's bed. Resident #20 was not in the room at</p>	F 253			

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F 253	<p>Continued From page 9</p> <p>the time. The plastic caging covering the fan was caked with dust particles, some of which were stringing into the room as the fan blew. The Administrator was shown the fan on 7/12/16 at 8:30 am.</p> <p>* The Wharf Dining Room floor was observed on 7/11/16 at 6:05 pm, 7/12/16 at 8:35 am, 7/13 at 11:30 am, and 7/14/16 at 11:40 am, and appeared dingy and dirty, did not shine, and had dark debris built up along the edges of all walls. On 7/13/16 at 10:00 am, Floor Technician #1 stated the floor was scheduled to be "top scrubbed" degreased and buffed the "next" week. Floor Technician #1 stated CNA staff swept and mopped the floors after the evening meal. When asked if they had special instruction on how to mop, he said there was no special training but he made sure they had the supplies they needed. On 7/13/16 at 10:45 am, the Assistant Administrator confirmed that CNAs have floor cleaning duty after the housekeeping staff leave at 3:00 pm daily.</p> <p>* On 7/13/16 at 11:30 am, the free standing cabinet by the fireplace in the Wharf Dining Room was observed with stacks of napkins and clothing protectors. The cabinet was made of particle board and was not painted or finished on the inside. The inside surface was rough and not easily cleanable.</p> <p>The Administrator and Assistant Administrator were interviewed at 10:45 am on 7/13/16. The Assistant Administrator stated that the contract with the company providing cleaning services would end on 7/14/16 as the facility was not satisfied with the quality of the company's</p>	F 253			

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F 253	Continued From page 10 services. The Assistant Administrator said Floor Technician #1 would continue to work for the facility in a supervisor capacity. Both the Administrator and Assistant Administrator stated monthly, and sometimes weekly, walk throughs of the facility were completed with housekeeping staff.  A tour of the facility was completed with the Administrator at 11:05 am on 7/13/16 to alert him to the issues related to the unsanitary environment.  The lack of orderly and sanitary conditions throughout the facility had the potential to negatively affect the psychosocial well-being and health of sampled residents #6, #7, #12, #18, #19 #20, #21, #22, #23, and #24), and all other residents residing in the facility.	F 253			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and	F 280		9/23/16	

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F 280	<p>Continued From page 11</p> <p>periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of Incident and Accident reports (I&amp;s) and staff interview, it was determined the facility failed to ensure residents' care plans were revised to meet their needs. This was true for 3 of 10 sampled residents (#6, #22, &amp; #23). This created the potential for harm when residents' care plans did not include guidance to staff on the level of supervision necessary to prevent falls, the frequency of O2 monitoring and interventions necessary to prevent hypoxia, and guidance to prevent aspiration. Findings include:</p> <p>1. Resident #22 was admitted to the facility in February 2016 with diagnoses which included dementia with delusions, anxiety/depression, O2 therapy, pulmonary hypertension, and COPD.</p> <p>Resident #22's 6/3/16 Quarterly MDS Assessment documented that when moving from a seated to a standing position, moving on and off the toilet, and transferring from the bed to a wheelchair or other surface, she was not steady and needed the assistance of one staff to stabilize.</p> <p>Resident #22's Physician Order Flow Sheet for June 2016 included an order for continuous O2 at 2-5 liters per minute via nasal cannula.</p>	F 280	<p>Affected Residents</p> <p>All Residents could be affected by this citation</p> <p>Corrective Action The care plans for residents #6, #22, &amp; #23 were reviewed and updated. The facility completed a 100% chart review of all resident records to ensure accuracy any issues were documented with the date of changes or completion. All licensed nurses were in-serviced on 8/4/2016 in regards to the Policy and Procedure surrounding orders, care plan updates and how to complete the 24 hour chart audit. The facility re-vamped the IDT process to provide an in-depth review of the resident chart on a quarterly basis.</p> <p>Systematic Changes</p> <p>The DON, ADON, or Clinical Care Coordinator will read all new orders from the previous day and interventions in the daily stand-up meeting. The DON, ADON, or designee audit each new order or intervention to ensure that it is noted and updated on the care plan. The</p>		

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F 280	<p>Continued From page 12</p> <p>Nurses' Notes in Resident #22's clinical record documented 4 falls in March 2016, and 6 falls in April 2016:</p> <ul style="list-style-type: none"> <li>* 3/3/16 at 9:30 am - Found on bathroom floor calling out for help.</li> <li>* 3/17/16 at 9:55 am - Housekeeping staff witnessed Resident #22 fall and hit head on her O2 concentrator. The resident also hit her right side.</li> <li>* 3/17/16 - 5:25 pm - Observed by staff sitting on the floor in her room.</li> <li>* 3/20/16 at 7:00 am - Observed sitting on the floor by her bed.</li> <li>* 4/3/16 at 5:30 pm - Found sitting on the floor by her bed.</li> <li>* 4/9/16 at 5:30 pm - Found on the floor in her room, stated she was coming back from the bathroom.</li> <li>* 4/16/16 at 6:50 pm - Found on floor in her room.</li> <li>* 4/19/16 at 3:30 pm - Found on floor in her room.</li> <li>* 4/28/16 at 1:00 pm - Found on floor in bathroom.</li> </ul> <p>Resident #22 experienced 4 falls in May and June 2016. Facility Occurrence Reports, Occurrence Investigations, and accompanying Incident and Accident Committee Review forms, documented the following:</p> <ul style="list-style-type: none"> <li>* 5/25/16 at 7:30 pm - Resident #22 was found sitting on her bathroom floor behind her wheelchair. The fall was unwitnessed. The root cause of the fall was identified as "needing to toilet." The documentation indicated Resident #22 attempted to self-transfer from her</li> </ul>	F 280	<p>Administrative Nurses were all assigned specific resident rooms (7-8 rooms each) and will conduct bi-weekly audits to ensure the resident care plan matches the resident's current condition. The results of these audits will be reported to the governing board on monthly basis and to the governing body on a quarterly basis, or more frequently as needed.</p> <p>Monitoring</p> <p>A 100% of resident charts will be audited by the DNS, or Q.A.P.I. nurse, on a monthly basis to ensure orders, interventions, care plans, consents, etc., match the resident current condition for 12 months. Issues noted will be reported to the Quality Assurance Committee on a monthly basis. Data gathered will be tracked and trended to identify potential system or process failures. All audits, trending, or issues noted will be reported to the Governing Body on at least a quarterly.</p> <p>Director of Nursing, or the Q.A.P.I. nurse is responsible for compliance.</p>		

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F 280	<p>Continued From page 13</p> <p>wheelchair to the toilet and fell. The report documented that Resident #22's wheelchair alarm did not go off due to her interference with it.</p> <p>* 5/29/16 at 9:00 pm - Resident #22 was in her wheelchair in front of the medication cart, attempted to stand, caught her foot caught under the cart and her wheelchair slid out from under her. She fell on her buttocks, hit her back on the wheelchair, and sustained a reddened area along her thoracic spine area. The root cause of the fall was identified as "foot caught."</p> <p>* 6/3/16 at 3:40 pm - Resident #22 was found scooting on her buttocks from her room towards the hallway. Resident #22 stated she rolled out of bed. The physician who found her questioned if she actually fell or was getting out of bed and scooting around on her buttocks. Resident #22's O2 saturation level was 79% on room air. The reports stated Resident #22's bed alarm was in place but did not sound. Her alarm was replaced.</p> <p>* 6/6/16 at 11:30 am - Resident #22 wheeled herself to her bedroom and as she turned into the room she immediately fell forehead first onto the floor. Resident #22's O2 saturation level was assessed at 76%. She had taken off her nasal cannula prior to the fall and refused to keep it on. A self-releasing seatbelt alarm was initiated at that time.</p> <p>Nurses' Notes documented the following regarding Resident #22 lack of compliance with leaving her O2 cannula in place:</p> <p>* A Nurses' Note dated 6/7/16 documented</p>	F 280			

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F 280	<p>Continued From page 14</p> <p>Resident #22 refused to keep her O2 cannula on. It further stated "[Resident #22] becomes agitated when not wearing O2."</p> <p>* An evening Nurses' Note, documented on 6/10/16 that Resident #22 had been very irritable and aggressive during the shift. It also stated Resident #22 refused to keep her O2 cannula in place.</p> <p>* A day shift Nurses' Note, dated 7/8/16, documented Resident #22 refused to keep her O2 cannula on because the tubing was uncomfortable.</p> <p>On 7/12/16 at 9:15 am, Resident #22 was observed in the hallway without her O2 cannula in place. LN #2 stated Resident #22 did not like wearing the cannula and frequently took it off. When asked, LN #2 stated she checked Resident #22's O2 saturation levels "often." LN #2 assessed Resident #22's O2 saturation level at this time at 76%. The cannula was placed on Resident #22 and she was encouraged to keep the cannula on and provided one-to-one attention to do so until her O2 level was within acceptable parameters. Resident #22's care plan did not include goals or interventions to promote her compliance with use of the O2 cannula.</p> <p>On 7/14/16, Resident #22 was observed alone in her bedroom and not wearing her cannula. She was sitting on the edge of her bed in a hospital robe with the toes and balls of her feet just touching the floor. Resident #22's legs were spread wide apart and she was tugging with both hands on the side and bottom of her adult brief, repeatedly stating, "I got to get that out of there"</p>	F 280			

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F 280	<p>Continued From page 15</p> <p>and asking the surveyor to pull the adult brief out from under her. The adult brief was approximately 1/2 off and was noted to be soiled with feces. Resident #22 attempted to stand twice. As she moved on the bed the bed alarm sounded twice for short periods of time. Staff did not come to the room to assist Resident #22. Resident #22 was encouraged to use the call light, but did not appear to understand the suggestion. When shown the call light, Resident #22 could not figure out how to use it. The surveyor provided verbal instructions and gestures that eventually prompted her to push the call light button. A CNA arrived promptly to assist the resident.</p> <p>On 7/14/16 at 10:50 am, LN #3 was asked how frequently Resident #22 was checked by staff. LN #3 reviewed her care plan and stated she could not locate a frequency for checking on Resident #22 in the care plan. LN #3 stated Resident #22 was to be repositioned every 2-3 hours.</p> <p>On 7/14/16 at approximately 1:30 pm, the DON, when asked about the frequency Resident #22 was to be checked, stated staff were to reposition and offer assistance to the bathroom every 2 hours. She stated vital signs were assessed each shift, including O2 levels, when applicable, and that the frequency of O2 checks was based on compliance. The DON confirmed Resident #22's care plan did not include the specific frequency her O2 level was to be checked to prevent hypoxia or specific frequency of observations to be completed to protect her from attempted transfers.</p>	F 280			

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F 280	<p>Continued From page 16</p> <p>2. Resident #23 was admitted to the facility, on 6/29/16 with diagnoses that included traumatic brain injury, brain tumor, and Type II diabetes.</p> <p>Resident #23's admission orders included an ADA, regular textured, thin liquids diet. Transfer orders and Discharge Summary documented no difficulty with eating or drinking.</p> <p>One-to-two days after Resident #23's admission to the facility nursing staff observed Resident #23 experienced coughing and choking problems on a regular textured diet. A swallowing evaluation ordered on 6/30/16 was not completed until 7/13/16.</p> <p>Resident #23's clinical record documented continued problems with coughing and choking during meals between 6/30/16 and 7/12/16. Resident #23's 7/12/16 care plan was not updated to address the swallowing issues or to instruct staff on proper interventions. Resident #23's NAR Care Plan indicated she required limited assistance with meals and could eat in her room if preferred. The Diabetes Care Plan documented Resident #23 had swallowing problems on a regular diet and staff were to assist her with meals. Neither Care Plan addressed obtaining a swallowing evaluation, or how staff were to assist her with meals.</p> <p>3. Resident #6 was admitted to the facility on 6/10/15, and readmitted on 6/24/16, following a 5-day hospitalization for sepsis. Resident #6's current diagnoses included Diabetes Type II, histrionic personality, esophageal stricture, achalasia, controlled seizure disorder, osteoporosis, and indwelling catheter for chronic</p>	F 280			

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F 280	<p>Continued From page 17 urine retention.</p> <p>The most recent quarterly MDS assessment, dated 4/29/16, documented Resident #6 had minimal cognitive impairment with some short-term memory impairment, required extensive assistance with transfers, and a history of falls.</p> <p>Resident #6's Fall Risk Evaluation, dated 6/24/16, documented a history of 4 falls during the previous 90 days, required assistance with elimination, was confined to a wheelchair, and was at risk for falls.</p> <p>Resident #6's Incident and Accident reports documented she fell from her wheelchair 8 times between 5/22/16 and 7/9/16. Five of the falls occurred when Resident #6 reached for items on the floor. Three of the falls occurred when she was attempting to self transfer, and two of the falls (5/22/16 and 7/1/16) resulted in lacerations which required a visit to the ED.</p> <p>Added interventions following the falls included:</p> <ul style="list-style-type: none"> <li>* 5/22/16 - Educate resident to ask for help.</li> <li>* 5/23/16 at 11:40 am - Temporary 15-minute checks.</li> <li>* 6/9/16 at 11:10 am - Implement a reacher to assist with objects on the floor.</li> <li>* 6/11/16 at 10:55 am - Educate resident to ask for help, physical therapy to replace the resident's seat belt.</li> </ul>	F 280			

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F 280	Continued From page 18 * 6/14/16 at 3:10 pm - Educate resident on using reacher, decrease resident's Clonopin.  * 7/1/16 at 4:25 pm - Resident to ask for help getting things from floor. Try seatbelt again.  * 7/2/16 at 7:00 pm - Temporary 15-minute checks.  * 7/9/16 at 10:45 am - PT consult to consider seatbelt.  Resident #6's current Potential to Fall Care Plan, dated 6/28/16, did not address the frequency of her falls, reasons for the falls (self-transfers and/or reaching for items on the floor), time of day falls often occurred, interventions specific to the reason for the falls, such as using a reacher vs physically reaching for an item, use of self-release seatbelt, checking with Resident #6 before leaving her room to determine if she needed anything that might trigger a fall, or frequency and type of supervision and monitoring needed to prevent falls. Resident #6's Behavior Care Plan addressed checking her "often" and anticipating her needs, but did not define "often" or what her anticipated needs might be.  During an interview on 7/13/16 at 2:50 pm, the DON stated she was not sure why the Potential for Falls Care Plan did not address the reacher and seatbelt.	F 280			
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	{F 309}		9/23/16	

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{F 309}	<p>Continued From page 19</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were adequately assessed for pain after receiving PRN medications; were assessed for swallowing by a Speech Therapist after consistent reports of coughing and choking during meals; and received care and services as identified in care plans and as ordered by the physician. This was true for 3 of 10 (#6, #19, and #20) residents reviewed for effectiveness of PRN medications, and 1 of 3 (#23) residents reviewed for swallowing issues. The failure to monitor the effectiveness of PRN medications put Resident #6, #19 &amp; #20 at risk for experiencing unnecessary pain and emotional distress. The failure to ensure a swallowing evaluation was performed put Resident #23 at risk for aspiration and/or aspiration pneumonia. Findings include:</p> <p>1. Resident #23 was admitted to the facility, on 6/29/16 with diagnoses that included traumatic brain injury, brain tumor, and Type II diabetes.</p> <p>Resident #23's admission orders included an ADA, regular textured, thin liquids diet. Transfer orders and Discharge Summary from the prior facility documented no difficulty with eating or drinking.</p> <p>One-to-two days after Resident #23's admission</p>	{F 309}	<p>Affected Residents</p> <p>All residents could be affected by this citation</p> <p>Corrective Action</p> <p>The facility completed a 100% audit of all resident PRN medications. Routinely used PRN medications were reviewed with the Medical Director and changes were made as appropriate. The DON completed an in-service with all licensed nurses on 8/3/2016 and gave specific examples of non-compliance with this citation and set clear expectations about documentation and following physician orders (pain scale, effectiveness, and notification of physician when appropriate).</p> <p>Systematic Changes</p> <p>The facility revised the system and process of Medication Administrator Record (M.A.R.) audits to include PRN medications to ensure severity, description, and results of the PRN medication is documented on the front of the M.A.R. Additionally, to prevent a</p>		

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{F 309}	<p>Continued From page 20</p> <p>to the facility nursing staff observed that she experienced coughing and choking problems on a regular textured diet. A swallowing evaluation ordered on 6/30/16 was not completed until 7/13/16.</p> <p>Resident #23's clinical record documented the following:</p> <p>* 6/30/16 at 1:00 pm: A verbal order was received from Resident #23's physician for a swallowing evaluation. The indication on the order was swallowing difficulty and choking. Nurses' Notes did not include documentation of observed difficulties with swallowing or choking during meals, or the rationale for obtaining the order for the swallowing evaluation until 7/1/16.</p> <p>* 7/1/16: Day shift and evening shift Nurses' Notes documented Resident #23 was having "a very hard time" with meals and continued to cough when drinking fluids. Neither the Nurses' Notes nor the physician's orders addressed a change in diet texture consistency or other precautions that should be taken with Resident #23 when she was eating or drinking.</p> <p>* 7/3/16 at 2:00 pm: Nurses' Notes documented Resident #23 had difficulty swallowing foods at meals and a pureed diet was requested from the kitchen, which she ate without difficulty. A Physician's Order, dated 7/3/14 at 3:00 pm, documented a pureed diet was started due to a change in Resident #23's condition and the regular diet was discontinued. The nurse who wrote the order documented the order change was made per facility protocol.</p>	{F 309}	<p>delay in treatment resulting from a delay in therapy (PT, OT, &amp; ST) assessments, Safe Haven Care Center will ensure residents are transported and seen on a timely basis by the Portneuf Regional Medical Center or the Bingham Memorial Hospital if in house therapy assessments cannot occur within a timely manner.</p> <p>Monitoring</p> <p>The weekly audits completed will be reported the following day at the stand-up meeting as well as shared in the regular PDR meeting. Audit data will be reported to Q.A.P.I. nurse on a monthly basis and to the Governing Body at least quarterly. Audit data will be tracked and trended to identify any system or process failures.</p> <p>Additionally, the chart reviews, reporting and monitoring for this requirement will be followed as noted in F280.</p>		

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{F 309}	<p>Continued From page 21</p> <p>* 7/7/16 at 9:00 pm: Nurses' Notes documented Resident #23 did not have signs or symptoms of choking on the pureed diet, but choked when drinking milk.</p> <p>* 7/8/16 at 11:26 and 11:30 am: LN staff documented a verbal order from Resident #23's physician to downgrade liquids to nectar thick pending the swallowing evaluation.</p> <p>* 7/12/16 and 7/13/16 evening shift: LNs documented Resident #23 continued on the puree diet with nectar thick liquids.</p> <p>There was no documentation in Resident #23's clinical record between 6/30/16 and 7/12/13 indicating the ordered swallowing evaluation had been completed.</p> <p>On 7/13/16 at 11:50 am, Resident #23 was observed in the dining room being assisted to eat by CNA #2. Resident #23 coughed after taking a bite of pudding and then refused to continue eating. She was then offered thickened water, which she took a spoonful of and immediately started to cough. Her cough was harsh with a moist rattling sound at the back of her throat. Resident #23 became upset and asked staff to take her to her room. CNA #2 wheeled Resident #23, who continued to cough intermittently as she went down the hall.</p> <p>On 7/13/16 at 4:05 pm, the DON stated the swallowing evaluation had not yet been completed because the SLP was on vacation. The DON stated the SLP was due back from vacation and the evaluation would be completed during the week of 7/11/16 - 7/15/16. The DON</p>	{F 309}			

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{F 309}	<p>Continued From page 22</p> <p>stated nursing staff downgraded Resident #23's diet to pureed texture on 7/3/16, until the swallowing evaluation could be completed. The DON stated Resident #23 was tolerating the pureed diet without episodes of coughing or choking. The DON stated the PTA was responsible for coordinating and scheduling therapy appointments such as the swallowing evaluation.</p> <p>On 7/13/16 at 4:15 pm, the PTA confirmed Resident #23's swallowing evaluation had not been completed, but was due to be completed the week of 7/11/16. The PTA stated the SLP was on vacation between 7/5/16 and 7/8/16 and no other SLPs were available to complete the evaluation.</p> <p>An SLP Evaluation and Treatment Plan, electronically signed by the facility's SLP on 7/13/16 at 10:00 pm, documented Resident #23 was edentulous, most likely not safe on mechanical soft or regular textured diet due to distractibility and noted history of choking, had clinical signs and symptoms of dysphagia, and was at risk for aspiration. The SLP recommended continuation of puree solids and nectar thick liquids and speech therapy to address compensatory strategies and to upgrade Resident #23's diet as tolerated.</p> <p>2. Resident #19 was readmitted to the facility on 12/16/15 with diagnoses of bipolar disorder, left-sided hemiparesis due to a cerebral vascular accident, osteoarthritis and chronic pain.</p> <p>Resident #19's quarterly MDS assessment, dated 6/1/16, documented she received both scheduled</p>	{F 309}			

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{F 309}	<p>Continued From page 23 and PRN pain medication.</p> <p>Resident #19's June and July physician's orders included:</p> <ul style="list-style-type: none"> <li>* Morphine Sustained Release 30 mg by mouth every 12 hours for chronic pain.</li> <li>* Baclofen 10 mg by mouth three times per day for muscle spasms.</li> <li>* Acetaminophen 325 mg by mouth every 4 hours PRN for pain.</li> <li>* Oxycodone APAP 5/325 mg by mouth every 4 - 6 hours PRN pain.</li> </ul> <p>Resident #19's Care Plan for Chronic Pain, updated on 6/2/16, instructed staff to administer pain medications as ordered, assess the resident's level of pain on a 0 - 10 scale, and notify the resident's physician if the current medications were not effective.</p> <p>Resident #19's June MAR documented she received Oxycodone APAP 5/325 mg, 42 times between 6/1/16 and 6/30/16. The PRN Notes on the back of the MAR, as well as the June Nurses' Notes, documented Resident #19's level of pain for 1 of the 42 administrations. The effectiveness of the Oxycodone was documented for 6 of the 42 administrations.</p> <p>Resident #19's July MAR documented she received Oxycodone APAP 5/325 mg 21 times between 7/1/16 and 7/14/16. The PRN Notes and the Nurses' Notes did not document pain levels for any of the 21 administrations, while the effectiveness of the Oxycodone was documented for 6 of the 21 administrations.</p>	{F 309}			

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{F 309}	<p>Continued From page 24</p> <p>3. Resident #20 was admitted to the facility on 12/20/13 with diagnoses that included Huntington's Chorea, dementia with behavior disturbances, psychotic disorder, and cerebral cysts.</p> <p>Resident #20's quarterly MDS assessment, dated 5/26/16, documented she received PRN pain medication and vocalized pain 1 - 2 times per week.</p> <p>Resident #20's June and July physician's orders included:</p> <ul style="list-style-type: none"> <li>* Tylenol, or a generic equivalent, 650 mg by mouth every 6 hours PRN for pain, not to exceed 1000 mg in 6 hours or 4000 mg in 24 hours.</li> <li>* Ibuprofen, or equivalent, 800 mg twice a day PRN for pain. LNs were to notify the physician if the resident's pain was not relieved.</li> <li>* Norco 5/325 mg by mouth twice a day PRN for pain. The resident was to receive a maximum of 10 tablets per week. If the resident needed more than the 10 per week, the LN was to call the physician for authorization.</li> </ul> <p>Resident #20's June and July MARs instructed LNs to monitor for breakthrough pain by using the 0 - 10 pain scale and document her level of pain on the back of the MAR if pain was noted.</p> <p>June 2016 MAR, PRN Notes and Nurses' Notes documented Resident #20 received Tylenol 650 mg 15 times, Ibuprofen 3 times, and Norco 6 times between 6/1/16 and 6/30/16. The reason the Tylenol was administered and the</p>	{F 309}			

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{F 309}	<p>Continued From page 25</p> <p>effectiveness of the Tylenol was documented for 1 of 15 administrations. The reason the Ibuprofen was administered and the effectiveness was not documented for any of 3 three administrations, and the reason the Norco was administered and the effectiveness was documented for 2 of 6 administrtrtions. Resident #20's level of pain was not documented for the Tylenol, Ibuprofen, or Norco administrations.</p> <p>July 2016 MAR, PRN Notes and Nurses' Notes documented Resident #20 received Norco 1 time (7/9/16), and did not receive Tylenol or Ibuprofen between 7/1/16 and 7/13/16. The reason the Norco was administered on 7/9/16 and the effectiveness was not documented on the PRN notes, but was documented in the Nurses' Notes. Resident #20's level of pain was not documented in either location.</p> <p>4. Resident #6 was readmitted to the facility on 3/7/16 following a fall with fracture. Her diagnoses included hepatic failure, vascular dementia, hepatic encephalitis, Type II diabetes, and fracture of the right hip.</p> <p>Resident #6's quarterly MDS assessment, dated 5/23/16, documented her speech was clear and easily understood and she understood when others spoke to her. Resident #6 was on both scheduled and PRN pain medication, vocally expressed pain, and indicators of pain were observed daily.</p> <p>Resident #6's June 2016 and July 2016 physician's orders included:</p> <p>* Neurontin 600 mg by mouth at bedtime for</p>	{F 309}			

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{F 309}	<p>Continued From page 26</p> <p>diabetic neuropathy.</p> <p>* Tylenol or generic equivalent 650 mg every 6 hours, not to exceed 3500 mg in 24 hours.</p> <p>* Oxycodone/APAP 7.5/325 mg 1 - 2 tablets every 4 to 6 hours PRN pain. Not to exceed 8 tablets in 24 hours.</p> <p>Resident #6's Pain Care Plan, listed on the June and July MAR, instructed LNs to monitor for breakthrough pain by using the 0 - 10 pain scale and document Resident #6's level of pain on the back of the MAR.</p> <p>The June MAR documented Resident #6 received Oxycodone APAP 5/325, 56 times between 6/1/16 and 6/30/16. The June PRN Notes and the Nurses' Notes did not document Resident #6's level of pain for the 56 administrations. The effectiveness of the Oxycodone was documented for 7 of the 56 administrations.</p> <p>Resident #6's July MAR documented she received Oxycodone APAP 5/325, 26 times between 7/1/16 and 7/14/16. The resident's level of pain was not documented on the July PRN Notes or Nurses' Notes. The effectiveness of the Oxycodone was documented for 4 of the 26 administrations.</p> <p>LN #1, LN #2, and LN #4 were interviewed on 7/14/16 between 1:45 pm and 2:45 pm. When asked where PRN medications were documented, each of the 3 LNs stated PRN medication administrations were documented on the front of the MAR. The severity of the pain, description of the pain, and the results of the pain medication were documented on the back of the</p>	{F 309}			

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{F 309}  F 323 SS=D	Continued From page 27 MAR. LN #1 and LN #2 stated the effectiveness of the medication might be documented in the Nurses' Notes, if not on the back of the MAR. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of I&As and resident records, it was determined the facility failed to ensure residents were protected from falls and that toxic chemicals were stored in locked enclosures. This was true for 2 of 8 sample residents reviewed for falls (#6 and #22) and all cognitively impaired residents with independent mobility. These deficient practices placed Resident #6 and Resident #22 at risk of serious harm due to falls. The practices also placed all cognitively impaired residents at risk of serious harm or death due to ingestion of, or contact with, toxic chemicals. Findings include:  1. Resident #6 was admitted to the facility on 6/10/15, and readmitted on 6/24/16, following a 5-day hospitalization for sepsis. Resident #6's current diagnoses included Type II diabetes, histrionic personality, esophageal stricture, achalasia, controlled seizure disorder, osteoporosis, and indwelling catheter for chronic	{F 309}  F 323	Affected Residents  All residents could be affected by this citation.  Corrective Action Staff was in-serviced by the C.E.O. of Safe Haven Healthcare on 8/3/2016 about the importance of ensuring that all chemicals remain behind a locked door.  Resident #6 and #22 fall incidents were tracked, trended, and care plans were appropriately updated. A new table with a raised edge was provided for resident #6. The facility also scheduled appropriate activities during the trended times where the resident experiences the bulk of the falls.	9/23/16	

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F 323	<p>Continued From page 28 urine retention.</p> <p>Resident #6's most recent quarterly MDS assessment, dated 4/29/16, documented minimal cognitive issues with some short-term memory impairment, extensive assistance required with transfers, and history of falls.</p> <p>Resident #6's Fall Risk Evaluation, dated 6/24/16, documented she had experienced 4 falls during the previous 90 days, required assistance with elimination, was confined to a wheelchair, and was at risk for falls.</p> <p>Incident and Accident reports documented Resident #6 fell from her wheelchair 8 times between 5/22/16 and 7/9/16. Five of the falls occurred when she reached for items on the floor and three of the falls occurred when attempting to self-transfer. Two of the falls (5/22/16 and 7/1/16) resulted in lacerations which required a visit to the ED:</p> <p>* 5/22/16 at 11:30 am - Resident #6 fell from her wheelchair while reaching for an item on the floor. She lacerated her left ring finger which required an ED visit and sutures. The IDT/Fall Review documented this was an isolated incident. Interventions added to Resident #6's Potential for Fall Care Plan included educating resident to ask for help.</p> <p>* 5/23/16 at 11 40 am - Resident #6 was found on the floor by her bed after attempting to self-transfer. Interventions added to Resident #6's Potential for Fall Care Plan included temporary 15-minute checks.</p>	F 323	<p>The facility reviewed 100% of care plans to define "often" with regard to supervision levels for residents. The term often was deemed to mean a range between 15 minutes to two hours. However, the actual time will be determined on a case by case basis.</p> <p>Systematic Changes</p> <p>C.N.A.s will check each cabinet during their respective end of shift rounds to ensure cabinets are locked. The daily cleaning checklist for the housekeeping staff was updated to include checks to ensure storage cabinets are locked, and to ensure chemicals are not stored in non-locked cabinet areas.</p> <p>A fall committee will meet on a weekly basis to review incident reports, interventions, care plans, and potential hazards in the facility.</p> <p>A fall prevention program will be developed by the "fall committee" which will include monthly training with fall prevention techniques at each nurses meeting and all staff meetings. The facility will also publish these trainings on the internal e-mail distribution for employees to refer to as a reference. Additionally, these fall prevention techniques will become part of a regular daily discussion with the help of our QAPI nurse who will periodically review and quiz care staff as well as indirect care staff.</p>		

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F 323	<p>Continued From page 29</p> <p>* 6/9/16 at 11:10 am - Resident #6 reached for an item on the floor and fell from her wheelchair. Interventions added to the Potential for Fall Care Plan included a reacher to assist with picking up objects on the floor.</p> <p>* 6/11/16 at 10:55 am - Resident #6 fell by her bed during an attempted self-transfer that resulted in a hematoma to the back of her head. Interventions added to Resident #6's Potential for Fall Care Plan included education to ask for help, and replacement of her wheelchair seatbelt.</p> <p>* 6/14/16 at 3:10 pm - Resident #6 reached for an item on the floor and fell from her wheelchair. Interventions added to her Potential for Fall Care Plan included education on the use of the reacher and to decrease her Klonopin.</p> <p>* 7/1/16 at 4:25 pm - Resident #6 fell from her wheelchair while reaching for an item on the floor and lacerated her forehead. Interventions to prevent future falls were for Resident #6 to ask for help with getting things from floor and to try the seatbelt again.</p> <p>* 7/2/16 at 7:00 pm - Resident #6 fell when attempting to self-transfer. The Intervention added to her Potential for Fall Care Plan was temporary 15-minute checks.</p> <p>* 7/9/16 at 10:45 pm - Resident #6 fell from her wheelchair when reaching for an item on the floor. The intervention added to her Potential for Fall Care Plan was for a PT consultation to consider a seatbelt.</p> <p>Resident #6's current Potential for Fall Care Plan,</p>	F 323	<p>Monitoring</p> <p>Cabinet, chemical, and fall incidents will be reported to Q.A.P.I. monthly, and at least quarterly, to the Governing Body; as well as the Governing Board monthly. All data will be tracked and trended to identify areas for improvement.</p> <p>Additionally, the chart reviews, reporting and monitoring for this requirement will be followed as noted in F280.</p> <p>Finally, during each all staff meeting, the trended results of facility falls will be disseminated to staff in order receive feedback, to keep the training "top of mind," and so employees can become knowledgeable regarding the fall trends in the building.</p>		

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F 323	<p>Continued From page 30</p> <p>dated 6/28/16, did not address the frequency of her falls, reasons for the falls (resident self-transfers and/or reaches for items on the floor), interventions specific to the reason for the falls, such as using the reacher, checking with Resident #6 before leaving her room to see if she needed anything that might trigger a fall, and frequency and type of supervision and monitoring needed to prevent falls. Resident #6's Behavior Care Plan addressed checking Resident #6 "often" and anticipating her needs, but did not define "often."</p> <p>On 7/12/16 at 2:55 pm, Resident #6 was observed playing Yahtzee in her room. She sat in a w/c with an overbed table over her lap. While rolling dice two fell to the floor. Resident #6 looked for the dice and once she spotted them began to reach for the dice with her hands. When asked if she needed assistance, Resident #6 righted herself in the wheelchair and said, "Yes." Resident #6 made no attempt to use the call light, which was about 3.5-feet from her bed, before reaching for the dice.</p> <p>On 7/13/16, at 2:50 pm, the DON stated Resident #6 fell while reaching for Yahtzee dice that had fallen off of her table to the floor. The DON said Resident #6 also fell while attempting to reach for other items that had fallen onto the floor. The facility addressed this by obtaining a reacher for Resident #6, but the DON acknowledged Resident #6 continued to fall while attempting to reach for items on the floor. When asked if the facility had considered other interventions to prevent the dice from rolling onto the floor, she stated, "No." When asked if the IDT had considered that 5 of the 8 falls occurred around</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>the same time each morning and analyzed why that might be so, the DON stated, "No."</p> <p>Resident #6 had 8 falls between 5/19/16 and 7/12/16. Two of the falls resulted in lacerations requiring sutures. The facility's failure to consistently explore and implement interventions that addressed Resident #6's reaching to the floor for fallen dice and other objects, as well as self transferring out of bed, put her at risk for falls resulting in serious injury.</p> <p>2. Resident #22 was admitted to the facility in February 2016 with diagnoses which included dementia with delusions, anxiety, depression, O2 therapy, pulmonary hypertension, and COPD.</p> <p>Resident #22's 6/3/16 Quarterly MDS Assessment documented that when moving from a seated to a standing position, moving on and off the toilet, and transferring from the bed to a wheelchair or other surface, she was not steady and needed the assistance of one staff to stabilize.</p> <p>Resident #22's Physician Order Flow Sheet for June 2016 included an order for continuous O2 at 2-5 liters per minute via nasal cannula.</p> <p>Nurses' Notes in Resident #22's record documented 4 falls in March 2016, and 6 in April 2016:</p> <p>* 3/2/16 at 9:30 am - Found on floor in bathroom * 3/17/16 at 9:55 am - Housekeeping staff witnessed Resident #22 fall and hit her head on her O2 concentrator. The resident also hit her right side.</p>	F 323			

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F 323	<p>Continued From page 32</p> <ul style="list-style-type: none"> <li>* 3/17/16 - 5:25 pm - Observed by staff sitting on the floor in room.</li> <li>* 3/20/16 at 7:00 am - Observed sitting on the floor by her bed.</li> <li>* 4/3/16 at 5:30 pm - Found sitting on the floor by her bed.</li> <li>* 4/9/16 at 5:30 pm - Found on the floor in her room, stated she was coming back from the bathroom.</li> <li>* 4/16/16 at 6:50 pm - Found on floor in her room.</li> <li>* 4/19/16 at 3:30 pm - Found on floor in her room.</li> <li>* 4/28/16 at 1:00 pm - Found on floor in bathroom.</li> </ul> <p>Resident #22 experienced 2 falls in May 2016 and 2 falls in June 2016. Facility Occurrence Reports, Occurrence Investigations, and accompanying Incident and Accident Committee Review forms documented the following:</p> <ul style="list-style-type: none"> <li>* 5/25/16 at 7:30 pm - Resident #22 was found sitting on her bathroom floor behind her wheelchair. The fall was unwitnessed. The root cause of the fall was identified as "needing to toilet." The documentation indicated Resident #22 attempted to self-transfer from her wheelchair to the toilet and fell. The report documented that Resident #22's wheelchair alarm did not sound due to her manipulation of the alarm.</li> <li>* 5/29/16 at 9:00 pm - Resident #22 was in her wheelchair in front of the medication cart, attempted to stand, caught her foot under the cart and her wheelchair slid out from under her. She fell on her buttocks, hit her back on the</li> </ul>	F 323			

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F 323	<p>Continued From page 33</p> <p>wheelchair, and sustained a reddened area along her thoracic spine area. The root cause of the fall was identified as "foot caught."</p> <p>* 6/3/16 at 3:40 pm - Resident #22 was found scooting on her buttocks from her room towards the hallway. Resident #22 stated she rolled out of bed. The physician who found her questioned if she actually fell or was getting out of bed and scooting around on her buttocks. Resident #22's O2 saturation level was 79% on room air. The reports stated Resident #22's bed alarm was in place but did not sound. The alarm was replaced.</p> <p>* 6/6/16 at 11:30 am - Resident #22 wheeled herself to her bedroom and as she turned into the room she immediately fell forehead first onto the floor. Resident #22's O2 saturation level was assessed at 76%. She had taken off her nasal cannula prior to the fall and refused to keep it on. Resident #23 sustained a hematoma on her forehead. A self-releasing seatbelt alarm was initiated at that time. The root cause of the fall was documented as hypoxia.</p> <p>Nurses' Notes documented the following regarding Resident #22 lack of compliance with leaving her O2 cannula in place:</p> <p>* A Nurses' Note, dated 6/7/16, documented Resident #22 refused to keep her O2 cannula in place. It further stated, "[Resident #22] becomes agitated when not wearing O2."</p> <p>* An evening Nurses' Note, dated 6/10/16, documented Resident #22 had been very irritable and aggressive during the shift. It stated Resident #22 refused to keep her O2 cannula in</p>	F 323			

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F 323	<p>Continued From page 34 place.</p> <p>* A day shift Nurses' Note, dated 7/8/16, documented Resident #22 refused to keep her O2 cannula because the tubing was uncomfortable. Further assessment of the reason for Resident #22's discomfort, to determine options for that may ease her discomfort, was not documented.</p> <p>On 7/12/16 at 9:15 am, Resident #22 was observed in the hallway without the O2 cannula in place. LN #2 stated at that time that Resident #22 did not like the cannula and frequently removed it. When asked how often Resident #22's O2 saturation levels were checked, LN #2 stated, "often." LN #2 assessed Resident #22's O2 saturation level at that time, and it was 76% on room air. The cannula was placed on Resident #22, and she was encouraged to keep the cannula in place and provided one-to-one attention to do so until her O2 level was within acceptable parameters. Resident #22's care plan did not include goals or interventions to promote compliance with use of the O2 cannula.</p> <p>On 7/14/16 at 9:07 am, Resident #22 was observed alone in her bedroom without the O2 cannula in place. She was sitting on the edge of her bed in a hospital gown and with the toes and balls of her feet only touching the floor. Resident #22's legs were spread wide apart and she was tugging with both hands on the side and bottom of her adult incontinent brief, repeatedly stating, "I got to get that out of there," and asking the surveyor pull the brief out from under her. The brief was approximately 1/2 off and was noted to be soiled with feces. Resident #22 attempted</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>twice to stand. As she moved on the bed, Resident #22's bed alarm sounded twice for short periods of time. Staff did not come to the room to assist Resident #22. Resident #22 was encouraged to use her call light, but did not appear to understand the suggestion. When shown the call light, Resident #22 could not determine how to use it. Resident #22 was prompted verbally and with gestures on how to operate the call light until she did so successfully and a CNA arrived promptly to assist.</p> <p>On 7/14/16 at 10:50 am, LN #3 was asked how frequently Resident #22 was checked by staff. LN #3 pulled Resident #22's chart and reviewed her care plan, then stated she could not locate a frequency for monitoring Resident #22 in her care plan. LN #3 stated, however, that Resident #22 was to be repositioned every 2-3 hours.</p> <p>On 7/14/16 at 1:30 pm, the DON was informed of the 7/14/16, 9:07 am observation of Resident #22. Based on the described observation, she said Resident #22 was at risk of falling. She stated Resident #22 preferred to sleep late and staff usually assisted her out of bed between 9:00 to 9:30 am, however there was no way to know when staff may have arrived to assist her out of bed or check on her status. When asked about the frequency Resident #22 was to be checked, she stated staff were to reposition and offer assistance to the bathroom every 2 hours. She stated vital signs were assessed each shift, including O2 levels, when applicable. She stated the frequency of O2 checks was determined based on residents' compliance. The DON confirmed Resident #22's care plan did not include the specific frequency her O2 level was</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>to be checked to prevent hypoxia, and the specific frequency of observations to be completed to protect her from attempted self-transfers.</p> <p>Resident #22 experienced 14 falls. Of the 14 falls, 13 occurred while in her bedroom or bathroom. Resident #22 was also observed in her bedroom unsupervised and at imminent risk of falling.</p> <p>Resident #22 did not receive assessments, interventions, and supervision necessary to protect her from falls.</p> <p>3. During an environmental tour of the Wharf and Seaside Dining rooms on 7/13/16 at 11:30 am, 3 spray bottles of environmental cleaners were found under the sink in the Wharf Dining Room and 1 aerosol can of stainless steel spray cleaner was observed under the sink in the Seaside Dining Room. Neither cabinet containing the cleaning items were locked.</p> <p>One of the bottles of cleaner in the Wharf Dining Room was labeled a Quaternary Cleaner. The label indicated the cleaner was harmful if swallowed or if it came into contact with the skin or eyes. The other bottle was labeled a Power Cleaner/disinfectant that could cause skin irritation and/or damage to the eyes.</p> <p>The aerosol can of stainless steel spray found in the Seaside Dining room stated it was harmful or fatal if swallowed.</p> <p>The Administrator who accompanied the surveyors on the tour immediately removed the</p>	F 323			

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F 323	Continued From page 37 items from both dining rooms and stated he was aware none of the items should have been stored in an unlocked cabinet.	F 323			
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure prompt identification and assessment of residents who experienced severe weight loss, and implementation of interventions to deter further weight loss and promote weight gain and nutritional health. This was true for 2 of 7 (#6 and #22) residents reviewed for weight loss and resulted in harm to Resident #6 when she	F 325	Affected Residents  All residents could be at risk for this citation  Corrective Action  All nursing staff were in-serviced about the importance of documenting the	9/23/16	

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F 325	<p>Continued From page 38</p> <p>experienced a severe unplanned weight loss of 22.7 lbs (14.5% weight loss) from 6/24/16 to 7/9/16, and harm to Resident #22, when she experienced a severe unplanned weight loss of 15.8 lbs in 7 days (18.4% weight loss). Findings include:</p> <p>1. Resident #6 was readmitted to the facility on 6/24/16 following a hospitalization for sepsis. Her current diagnoses included Type II diabetes, histrionic personality, esophageal stricture, achalasia, controlled seizure disorder, and indwelling catheter for chronic retention.</p> <p>Resident #6's 6/24/16 readmission weight, documented on a Weight Flow Sheet, was 156.4 pounds.</p> <p>Admit Physician's Orders, dated 6/24/16, included: * Full liquid diet * Jevity 1.2 100 ml for 12 hours, 200 ml Free Water four times per day.</p> <p>Physician's Orders dated 6/25/16 instructed LN staff to: * Assess for feeding intolerance * Hold feeding if intolerance was suspected * Flush NG tube as directed, replace NG tube as needed...</p> <p>Nursing Notes, dated 6/25/16, documented Resident #6 pulled out her feeding tube.</p> <p>Physician's orders, dated 6/26/19, instructed staff to D/C the feeding tube, give the resident Mighty Shakes three times per day between meals, weigh the resident weekly every Monday and</p>	F 325	<p>resident's meal intake on a daily basis. C.N.A.'s now will present the meal monitor to the charge nurse at the end of each meal for a signature to show completion of the meal monitor sheet.</p> <p>Resident #6 and #22 were reassessed by the Nutrition-at-risk committee with new interventions and updates to the care plan as needed.</p> <p>The N.A.R. (nutrition at risk) committee reviewed and revised the meeting minute sheets to include a space to document physician and R.D. notification, care plan updated, and new order if indicated. A nurse from the facility will be in attendance at the weekly Nutrition-at-Risk meeting.</p> <p>Systematic Changes</p> <p>All residents affected by scale calibration in June are now being weighed twice per week until baseline weights are established. Residents identified with significant weight loss, or weight gain, will be reviewed at the following day's stand-up meeting to compare historical measurements and provide interventions. The identified residents will be reviewed at the next scheduled N.A.R. meeting. Additionally, the staffing development coordinator will check the resident weighing procedure periodically, but not less than monthly, to ensure the proper weighing techniques are utilized by staff. It will also be the Staffing Development</p>		

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F 325	<p>Continued From page 39</p> <p>report the results to the resident's physician every Monday.</p> <p>Between 6/25/16 and 7/9/16, the Weight Flow Sheet documented a 22.7 pound weight loss over 14 days:</p> <ul style="list-style-type: none"> <li>* 6/24/16 (Friday) - 156.4</li> <li>* 6/25/16 (Saturday) - 154.9</li> <li>* 6/29/16 (Wednesday) - 139.8</li> <li>* 6/30/16 (Thursday) - 140.1</li> <li>* 7/7/16 (Thursday) - 137.5</li> <li>* 7/9/16 (Saturday) - 133.7</li> </ul> <p>There was no documentation in Resident #6's clinical record, including June and July 2016 Nursing Notes, Weight Flow Sheets, NAR Notes and Medical Nutritional Therapy Assessment notes, that indicated Resident #6's weights were checked each Monday and/or the physician was notified of her significant weight loss between 6/25/16 and 7/13/16.</p> <p>In addition, there was no documentation in Resident #6's clinical record that the facility's RD was notified of Resident #6's significant weight loss until 7/10/16, and there was no record of an RD visit until 7/13/16.</p> <p>On 7/10/16, the Medical Nutritional Therapy Assessment documented Resident #6 had a significant weight loss over the previous 30, 90, and 180 days, was on NAR due to the significant weight loss, the Care Plan would be revised and Resident #6 would be referred to the RD. No revisions were made on either the 6/28/16 Nutritional Risk Care Plan or the 6/28/16 Swallowing Care Plan. Neither of the Care Plans addressed Resident #6 pulling out her NG tube,</p>	F 325	<p>Coordinator's responsibility to ensure the staff performing residents weights are competent to do so. This will be evidenced by the notes and audit check lists compiled as a result of the periodic checks.</p> <p>Monitoring</p> <p>Meal monitoring sheets (meal percentage or intake logs) will be audited on a weekly basis to ensure all meal percentages are documented with the accompanying nurse's signature by the Q.A.P.I. Nurse. N.A.R. information, which includes trended resident data will be reported to Q.A.P.I. on a monthly basis and at least quarterly to the Governing Body. Audit data will be tracked and trended to identify opportunities to improve the system or process. Additionally,</p> <p>The Administrator or DNS is responsible for compliance with this citation.</p>		

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F 325	<p>Continued From page 40</p> <p>her current poor intake or her weight loss of 22.7 pounds since readmission from the hospital.</p> <p>On 7/13/16, the RD visited the facility and wrote a recommendation for placement of a PEG tube as Resident #6 was unable to meet her nutritional needs on a full liquid diet.</p> <p>On 7/14/16 at 3:00 pm, the DON, CDM, and MDS Nurse were interviewed regarding Resident #6's weight loss. The CDM stated she became aware of the readmission weight and weight loss on 7/9/16. On 7/10/16, the CDM put Resident #6 on the RD's list to assess when she visited the facility. The RD received this information on 7/13/16. Resident #6 had been placed on NAR earlier in the year due to significant weight loss. When Resident #6 returned to the facility on 6/24/16, she weighed 154.9-pounds, compared to her pre-hospitalization weight of 143.1 pounds. Both the CDM and DON stated the facility's weight scale broke during the last week in June, which may have led to the pre- and post-hospitalization weight discrepancy. However, on 7/15/16 the Assistant Administrator shared a copy of the receipt for fixing/recalibrating the scale, which left the facility on 6/16/16 and returned on 6/20/16. The Assistant Administrator stated another scale, correctly calibrated, was provided for the facility between 6/16/16 and 6/20/16 to use for residents' weights.</p> <p>When asked how weights were monitored and loss followed up on, the DON and CDM state CNA #3 was assigned to take all resident weights. The weights were entered into a computer and then reviewed weekly by the CDM.</p>	F 325			

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F 325	<p>Continued From page 41</p> <p>The names of those with significant changes in weight were then placed on a Weight Change Notification form given to the RD during her visits. Weight losses/gains were reviewed during NAR for residents identified as at risk for significant weight loss or other nutritional concerns.</p> <p>Resident #6 was harmed when she continued to have significant weight losses upon her return to the facility that were not responded to in a timely manner. After Resident #6 removed her own feeding tube on 6/25/16 and the physician asked for weekly weights and reports, the facility failed to notify Resident #6's physician or the RD of her continued weight loss until 7/13/16. Between 6/24/16 and 7/9/16 (15 days), Resident #6 lost 22.7 pounds.</p> <p>2. Resident #22 was admitted to the facility in February 2016 with diagnoses which included, dementia with delusions, anxiety/depression, O2 therapy, pulmonary hypertension, and COPD.</p> <p>Resident #22's record documented the following related to her nutritional status:</p> <p>* The Weight Flow Sheet in Resident #22's record noted her weight was 102.8 lbs on 2/27/16. The Weight Flow Sheet documented that between 2/27/16 and 6/9/16, Resident #22's weight fluctuated between 101.2 lbs on 4/28/16, and 106.4 lbs on 6/9/16.</p> <p>* A Quarterly/Follow up Nutritional Progress Note, signed by the CDM on 6/6/16, and by the RD on 6/8/16, stated Resident #22 ate independently, however was not meeting her</p>	F 325			

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F 325	<p>Continued From page 42</p> <p>nutritional or fluid needs due to poor intake. The note stated Resident #22 ate a regular mechanical soft diet. The documentation indicated Resident #22 had gained weight, which was noted as desirable. The note also remarked on Resident #22's reduced intake. The note stated that at the time of the prior review, Resident #22 was eating 50-75% of her breakfast meals, 75-100% of her lunch meals, and 50-75% of her dinner meals, and as of 6/6/16 her intake for breakfast, lunch, and dinner meals was 25-50%. A fortified diet was recommended to discourage weight loss. Resident #22's medical record did not include documentation that the recommendation for a fortified diet was implemented at that time.</p> <p>* On 6/6/16, the CDM updated the interventions on Resident #22's care plan to include small portions.</p> <p>* On 6/16/16 Resident #22's weight was documented as 100.9, a 5.5 lb decrease in 7 days. Resident #22's average weight between 2/27/16 and 6/9/16, was 103.8 lbs. Using 103.8 lbs as Resident #22's usual body weight (UBW), Resident #22 experienced a 2.8% weight loss over the prior 7 days.</p> <p>* A Nutrition At Risk IDT Review documented on 6/21/16 that weight loss was identified as the reason for the review. A goal of keeping Resident #22's weight above 100 lbs was documented on the review form. Addition of a fortified diet, originally recommended by the RD on 6/8/16, was again recommended.</p> <p>* On 6/21/16, the CDM added an intervention to</p>	F 325			

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F 325	<p>Continued From page 43</p> <p>Resident #22's care plan of, "Wt. [Weight] trending down add to NAR." When interviewed on 7/14/16 at 2:10 pm, the CDM stated she did not have information related to Resident #22 on the NAR log.</p> <p>* The Weight Flow Sheet documented that on 6/22/16 at 1:00 pm, Resident #22's weight was 84.7 lbs, a decrease of 15.8 lbs in 7 days. Based on Resident #22's UBW of 103.8, she lost 18.4% of her body weight in 7 days. A physician order, dated 6/22/16 at 1:00 pm, documented the addition of a fortified diet "per RD recom[endation]". Documentation that facility staff notified the physician of Resident #22's severe weight loss was not found in her record. Additionally, Resident #22's record did not include documentation that the RD was notified of Resident #22's severe weight loss.</p> <p>* Resident #22 was re-weighed on 6/23/16, and her weight was recorded as 83.8 lbs, a loss of 17.1 lbs. Based on Resident #22's UBW of 103.8, she experienced a 19.2% weight loss since 6/16/16 (8 days). Resident #22's record did not include documentation that the RD and physician were notified of Resident #22's severe weight loss. New interventions were not added to Resident #22's care plan to address the severe weight loss</p> <p>* Resident #22 was weighed on 6/29/16 at 89.5 lbs. She was re-weighed on 6/30/16, and her weight was 90.1 lbs. Her weight on 7/7/16 was noted to be 87.8 lbs, a decrease of 2.3 lbs in 7 days. Resident #22 remained at 15.4% below her average body weight of 103.8 lbs.</p>	F 325			

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F 325	<p>Continued From page 44</p> <p>* A Nutrition at Risk IDT Review was documented on 7/12/16. The review questioned the accuracy of Resident #22's weight as the scale had been calibrated a couple weeks prior to 7/12/16. Interventions added during the IDT Review included eating at the RNA table during meals, 4-ounce supplements to be used during medication administration, and finger food snacks twice a day and at bedtime. The IDT Review documented Resident #22's intake during breakfast meals was 11%, at lunch meals 25%, and at dinner meals 21%. Her fluids per day were documented as 181 [whether cc's, ml, or ounce, was not stated], and indicated the fluid intake was inadequate. The IDT Review noted Resident #22 experienced a 17% weight loss in one month and a 14% weight loss over the prior 3 months.</p> <p>Resident #22's care plan stated staff were to document her food and fluid intake at meals. Resident #22's record did not include a meal or fluid intake documentation sheet for June 2016. On 7/14/16, at approximately 1:30 pm, copies of all food and fluid intake documents for Resident #22 for May, June, and July 2016 were requested from the DON. Meal and fluid intake documentation sheets for June 2016 were not included in the copies provided. At approximately 10:55 am on 7/15/16, the DON said a June 2016 meal food and fluid intake documentation form was not completed. She stated the information available was what was documented on 1:1 Shift Report forms. The following food and fluid intake documentation was included on the 1:1 Shift Report forms:</p> <p>* 6/5/16 evening shift - juice, coffee, and few</p>	F 325			

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F 325	<p>Continued From page 45</p> <p>bites of food referenced one time each, amounts not included</p> <ul style="list-style-type: none"> <li>* 6/6/16 evening shift - refused dinner</li> <li>* 6/7/16 evening shift - up for dinner and ate a sandwich, amount of each not documented</li> <li>* 6/8/16 day shift - 25% breakfast, 360 cc and some coffee [amount not documented]</li> <li>* 6/9/16 day shift - reference to eating breakfast, no other information</li> <li>* 6/9/16 evening shift - 1/2 sandwich, 3 bites of dinner, another 1/2 sandwich, 360 cc of fluid</li> <li>* 6/10/16 evening shift - coffee, prune juice, cc's not documented</li> <li>* 6/11/16 day shift - 50% of breakfast, refused lunch, 120 cc fluid</li> <li>* 6/12/16 day shift - breakfast 50%, lunch 100%, 2 ice cream, 940 cc fluid</li> <li>* 6/12/16 evening shift - wanted coffee, very sleepy but tried to eat, couple sips of water</li> <li>* 6/13/16 day shift - 50% sandwich, cup of coffee, cottage [cheese]</li> <li>* 6/13/16 evening shift - 3/4 of sandwich, refused dinner</li> <li>* 6/14/16 day shift - 25% breakfast and lunch, 400 cc fluid</li> <li>* 6/15/16 day shift - 50% of breakfast and lunch, 1200 cc fluid</li> <li>* 6/16/16 day shift - 25% breakfast and lunch, 1200 cc of fluid</li> </ul> <p>Comprehensive documentation of Resident #22's June 2016 food and fluid intake was not completed.</p> <p>Resident #22's Meal Intake Record for 7/1/16 - 7/15/16 [through lunch], documented the following:</p>	F 325			

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F 325	<p>Continued From page 46</p> <ul style="list-style-type: none"> <li>* Meals for which Resident #22 refused all food and fluids, including alternatives offered - 14</li> <li>* Meals for which Resident #22 refused all food, including alternatives offered - 5</li> <li>* Meals for which Resident #22 ate 25% of her meal - 17</li> <li>* Meals for which Resident #22 ate 50% of her meal - 6</li> <li>* Meals for which Resident #22 ate 100% of her meal - 1</li> </ul> <p>Based on the above intake record, Resident #22 refused all food offered during 44% of the 43 meals. She refused all fluids during 33% of the 43 meals. During 40% of the 43 meals, Resident #22 ate 25% of the food offered. Sixteen percent of the time, Resident #22 consumed 50-100% of the food offered.</p> <p>Resident #22's average fluid intake documented from 7/1/16 - 7/15/16 [through lunch], was 517 cc's per day. Based on a UBW of 103.8 lbs, Resident #22 required 1400 cc's of fluid per day to maintain adequate hydration. Resident #22 was observed on 7/12/16 at 9:15 am seated in her wheelchair in the hall just outside her room. Her lips were cracked and dry and she intermittently attempted to pull off pieces of dead skin hanging on her lips. Resident #22's lips were also observed to be dry and cracked on 7/13/16 at 3:00 pm.</p> <p>The intervention of finger food snacks twice a day and at bedtime was added on 7/12/16. From the 7/12/16 dinner meal through the 7/15/16 lunch meal, consumption of bedtime and between meal snacks was not documented, except to indicate the bedtime snack was refused</p>	F 325			

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F 325	<p>Continued From page 47 on 7/13/16.</p> <p>On 7/14/16 at approximately 1:30 pm, the DON stated an intake record of all food and fluids consumed by Resident #22 was not maintained by the facility.</p> <p>On 7/13/16 at 12:05 pm, Resident #22 was observed eating in the Wharf Dining Room. She was in her wheelchair, which was approximately 16-18 inches from the table. Reaching food and fluids required Resident #22 to fully extend her arm. She ate independently and slowly. The Meal Intake Record documented Resident #22 ate 25% of the lunch meal on 7/13/16.</p> <p>On 7/14/16 at 2:10 pm, the CDM was asked if Resident #22's preferred foods was documented. The CDM stated the food preference assessment documented the foods residents did not like, and did not include assessment of preferred foods.</p> <p>Resident #22's record did not include documentation of an assessment to determine the reason(s), or possible reasons, for her weight loss, and interventions to address them.</p> <p>When the Administrator and Assistant Administrator were interviewed on 7/13/16 at 10:45 am, each confirmed the weight scale was picked up on 6/16/16 to be recalibrated, and was returned to the facility on 6/20/16. On 7/14/16 the Assistant Administrator provided a copy of the repair order. The repair order documented the start and end time of the worker's visit to the facility was 3:00 pm to 5:00 pm. On 6/16/16 Resident #22's weight was documented at 10:00 am, as 100.9, a 5.5 lb decrease in 7 days, using</p>	F 325			

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F 325	Continued From page 48 the same scale she was previously weighed on. Resident #22 was weighed on 6/22/16 after the recalibrated scale was returned to the facility on 6/20/16.  Resident #22 was harmed when she experienced a severe weight loss and assessments and interventions necessary to ensure she received food and fluids sufficient to meet her needs, protect her from further loss, and promote her nutritional health, were not implemented.	F 325			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001620</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/15/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SAFE HAVEN CARE CENTER OF POCATELLO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 HOSPITAL WAY POCATELLO, ID 83201</b>
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{C 000}	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the follow-up survey of your facility completed July 11 - July 15, 2016.  The surveyors conducting the survey were:  Lorraine Hutton, RN, Team Coordinator Sylvia Creswell, LSW, QIDP  Abbreviation: RN = Registered Nurse	{C 000}		
{C 762}	02.200,02,c,ii When Average Census 60-89 Residents  ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift.  This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an RN was on duty for each day shift and evening/night shift 7 days a week to provide care and treatment to residents. This was true for 14 of the 21 evening/night shifts reviewed and affected 10 of 10 (#s 6, 7, 12,18, 19, 20, 21, 22, 23, & 24) sampled residents, 2 random residents (#25 & 26) and all other residents in the facility. It also created the potential for residents' skilled nursing	{C 762}	This requirement can affect all the residents in the facility at Safe Haven Care Center. To this end, Safe Haven Care Center will ensure a Registered Nurse will be on duty for each day and evening shift (16 hours each day).  Each day during stand up meeting, the Director of Nurses, Assistant Director of Nurses, or nursing designee will report to	9/23/16

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>09/26/16</b>
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001620</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/15/2016</b>
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{C 762}	<p>Continued From page 1</p> <p>needs to go unmet. Findings included:</p> <p>The Three-Week Nursing Schedule between 6/19/16 and 7/9/16 documented 14 of 21 evening shifts (approximately 3 pm to 11 pm) did not have eight hours of RN coverage. For example:</p> <ul style="list-style-type: none"> <li>* 6/21/16 there was no RN coverage between 5:00 pm and 9 pm.</li> <li>* 6/22/16 there was no RN coverage between 5:00 pm and 9 pm.</li> <li>* 6/23/16 there was no RN coverage between 4:00 pm and 11 pm.</li> <li>* 6/24/16 there was no RN coverage between 2:00 pm and 10 pm.</li> <li>* 6/25/16 there was no RN coverage between 2:00 pm and 10 pm.</li> <li>* 6/26/16 there was no RN coverage between 5:00 pm and 9 pm.</li> <li>* 6/27/16 there was no RN coverage between 2:00 pm and 9 pm.</li> <li>* 6/28/16 there was no RN coverage between 5:00 pm and 9 pm.</li> <li>* 6/29/16 there was no RN coverage between 5:00 pm and 9 pm.</li> <li>* 6/30/16 there was no RN coverage between 6:00 pm and 11 pm.</li> <li>* 7/2/16 there was no RN coverage between 12:00 pm and 11 pm.</li> <li>* 7/5/16 there was no RN coverage between 5:00 pm and 9 pm.</li> <li>* 7/6/16 there was no RN coverage between 5:00 pm and 9 pm.</li> <li>* 7/7/16 there was no RN coverage between 5:00 pm and 11 pm.</li> </ul> <p>In addition there was no RN coverage between 6:00 am and 2:00 pm on 6/26/16.</p> <p>This decreased, and on one day eliminated, the</p>	{C 762}	<p>administration the status of RN coverage hours. If there is a shortage, we will pull additional RN staff from within the building from other assigned duties to cover the shortage. If facility staff are not available, additional staff from the hospital will be called in to cover the shortage.</p>	
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Bureau of Facility Standards

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{C 762}	Continued From page 2  availability of an RN to all sampled residents, and similarly impacted all other residents in the facility.	{C 762}		