IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, Idaho 83720-0009
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August 9, 2016

Mike Borup, Administrator
Holly Lane Rehabilitation And Healthcare Center
2105 12th Avenue Road
Nampa, ID 83686-6312

Provider #: 135094

Dear Mr. Borup:

On **July 18, 2016**, a survey was conducted at Holly Lane Rehabilitation And Healthcare Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiencies in your facility to be **WIDESPREAD PATTERN** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) verbally and in writing on **July 15, 2016**.

On **July 27, 2016**, the facility submitted a credible allegation that the immediate jeopardy was removed. After review of your Plan of Correction, and the onsite survey of **August 2, 2016**, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the Form CMS-2567 remain and require a Plan of Correction.

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 19, 2016**. Failure to submit an acceptable PoC by **August 19, 2016** , may result in the imposition of additional civil monetary penalties by **September 2, 2016**.

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

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

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

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

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

- Include dates when corrective action will be completed <u>in column (X5)</u>.

  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*.

Based on the immediate jeopardy citations identified during this survey:

F-224 -- S/S: L -- 483.13(c) -- Prohibit Mistreatment/neglect/misappropriation

F-490 -- S/S: L -- 483.75 -- Effective Administration/resident Well-Being

F-353 -- S/S: L -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed in addition to the denial of payment for new Medicare and Medicaid admissions which was imposed on July 23, 2016:

Civil money penalty **July 18, 2016**.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 18, 2017**, if substantial compliance is not achieved by that time.

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

Your facility's noncompliance with the following:

F-224 -- S/S: L -- 483.13(c) -- Prohibit Mistreatment/neglect/misappropriation

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

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **1-11, #13, #15, #20, # 2, #24, and #25** as identified on the enclosed Resident Identifier List.

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

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

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **August 19, 2016**. If your request for informal dispute resolution is received after **August 19, 2016** , the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DS/pmt
Enclosures
cc: Chairman, Board of Examiners - Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY LANE REHABILITATION AND HEALTHCARE CENTER	2105 12TH AVENUE ROAD NAMPA, ID 83686

(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 Federal Recertification and Complaint survey was conducted at the facility from July 11, 2016 to July 18, 2016. Immediate Jeopardy was identified at: * 42 CFR 483.13(c) [F224] * 42 CFR 483.30(a) [F353] * 42 CFR 483.75 [F490] The immediate jeopardy was not removed prior to the exit conference. The surveyors conducting the survey were: Presie C. Billington, RN, Team Coordinator Nina Sanderson, LSW Teresa Kobza, RD, LD Jennifer McCants, RD Ophelia McDaniels, RN Rachel Moorhead-Lopez, LSW Angelia Newsome, RN Definitions include: Abx = Antibiotic AD = Activities Director ADL = Activities of Daily Living ADON = Assistant Director of Nursing A-Fib = Atrial Fibrillation AKA = Above the Knee Amputation ALF = Assisted Living Facility ALS = Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) ASA =Acetyl Salicylic Acid (Asprin) Bacteremia = Bacteria in the blood (blood infection) B&B = Bowel and Bladder	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/2016

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 000	Continued From page 1 BID = Twice a Day BIMS = Brief Interview of Mental Status CAA = Care Area Assessment CAD = Coronary Artery Disease CNA = Certified Nurse Aide CVA = Cerebral Vascular Accident (stroke) DM = Diabetes Mellitus DME = Durable Medical Equipment DON = Director of Nursing dsg = dressing DVT = Deep Vein Thrombosis Dyphasia = difficulty swallowing ESRD = End Stage Renal Disease FWW = Front Wheeled Walker GERD - Gastro Esophageal Reflux Disease G-tube = Feeding Tube gms = Grams H&P = History and Physical HR = Human Resources Hypernatremia = elevated sodium level in the blood due to inadequate fluid intake HX = History IDT = Interdisciplinary Team kcals = Kilocalories lbs = pounds LN=Licensed Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record MD = Physician MDS= Minimum Data Set mg = milligrams MI = Myocardial Infarction (hear attack) mL= milliliter mL/hr = milliter per hour NAR = Nutrition At Risk NP = Nurse Practitioner NN = Nurses Note NPO = Nothing by mouth	F 000		

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F 000	Continued From page 2 NS = Normal Saline OOB = Out of Bed OT = Occupational Therapy POA = Power of Attorney PO = by mouth PRN = As needed PEG = Percutaneous Endoscopic Gastrostomy tube QID = Four times a day R = Right RA = Rheumatoid Arthritis RD = Registered Dietitian RN = Registered Nurse ROM = Range of Motion RT = Respiratory Therapist RVP = Regional Vice President SDC = Staff Development Coordinator SE = Side Effects SNF =Skilled Nursing Facility S/P = Status Post s/s = signs and symptoms ST = Speech Therapy TAR = Treatment Administration Record TF = Tube Feeding Trach = Tracheostomy Tx = Treatment UA = Urinalysis UTI = Urinary Tract Infection w/ = With X = times II = Two	F 000		
F 155 SS=G	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.	F 155		8/12/16

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F 155	Continued From page 3 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and POA interview, it was determined the facility failed to ensure 1 of 27 sampled residents (#11) had the right to refuse medical treatment. Resident #11 was harmed when the facility repeatedly declined to honor his expressed wishes to have water and ice chips. Findings include: Resident #11 was admitted to the facility on 10/15/15; diagnoses included paraplegia, neuromuscular dysfunction of bladder, dysphagia (difficulty swallowing), chronic kidney disease, pressure ulcers, history of urinary tract infections, and respiratory failure. Resident #11 received nutrition via a feeding tube, had a urinary catheter, was on a ventilator and had a tracheostomy. A 10/23/15 Social Service Progress Note indicated Resident #11 was alert	F 155	Holly Lane 7/18/16 POC for Annual Preparation and submission of this plan of correction by, Holly Lane Rehabilitation and Healthcare, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.	

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F 155	Continued From page 4 and able to communicate needs and preferences with a goal of weaning from the ventilator and returning to the group home where he previously resided. Resident #11 remained in the facility until he was transferred to the hospital on 1/21/16; he died two days later in the hospital. The 10/22/15 admission MDS assessment indicated Resident #11 usually made himself understood and usually understood others. The MDS documented Resident #11 was totally dependent on staff for eating and required the assistance of one staff. He was documented as having a swallowing disorder and receiving nutrition via a feeding tube. The ADL CAA stated Resident #11 was dependent for all ADLs due to limited mobility of his arms and legs. The feeding tube care area assessment documented use of a gastrostomy tube (G-tube) for all calories, nutrition and fluids. According to the initial physician's orders, Resident #11 was prescribed a tube feeding formula via G-tube; the only items allowed orally were ice chips and ice cream. Nurses' notes documented Resident #11 received ice cream one time only, on 11/11/15. Resident #11 and his POA expressed their joint interest in the resident's transition to oral intake of food and fluids that was documented as follows: -A 12/29/15 "Speech Therapy Plan of Care" indicated Resident #11 was to start working with ST with a goal of pureed foods and thin liquids being safely consumed. Documentation indicated Resident #11 had been wanting to eat/drink for several weeks. Swallowing difficulties were noted due to the trach and the trach being recently	F 155	F 155 1. Resident #11 discharged from the facility effective 1/21/16; no corrective action indicated. 2. An audit was conducted by social services department for residents who are NPO to determine desire for ice chips/water; no additional corrections indicated. Resident Council meeting was conducted on 8/10/16 with Administrator (ADM) present, resident rights were reviewed with the group and no additional concerns were indicated. 3. Root Cause Analysis by Interdisciplinary team (IDT) concluded that members of the facility clinical staff were following recommendation of modified barium swallow and not resident and family expressed care desires. The Facility staff were educated in regards to Resident Rights on 7/28/16 and again beginning on 8/10/16 by Social Services Director (SSD) and Staff Development Coordinator (SDC) regarding Residents Rights, communicating resident expressed desires and reporting resident care concerns. Therapy staff were educated on 8/12/16 by Regional Therapy Manager regarding Resident Rights. 4. Beginning the week of 8/15/16 interviewable residents will be interviewed by Administrator (ADM)/designee regarding care concerns, including but not limited to desire for ice chips/water. Audits will be conducted three times	

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F 155	Continued From page 5 de-cannulated. -A 1/4/16 "Speech Therapist Progress" note documented Resident #11's pureed diet had not been initiated. The resident's positioning in bed was documented as being a challenge with an increased risk for aspiration and lethargy being present. Caregiver education on proper positioning was given. -A 1/8/16 nurse practitioner "Progress Note" indicated Resident #11's family inquired whether he would be able to begin to eat and drink. Documentation indicated the speech therapist was spoken to and a barium swallow evaluation was scheduled. On 1/8/16, a diet requisition form from speech therapy indicated a diet trial would be completed at lunch on 1/11, 1/12, and 1/13/16. -On 1/13/16, the Resident Care Conference notes showed nursing, dietary, activities, and family were present for the meeting. The family was documented as expressing concerns with Resident #11's fluid restriction. -A 1/19/16 NAR note documented Resident #11 was receiving 100 percent of nutrition via the feeding tube, he was being seen by speech therapy for possible initiation of oral feeding and for the potential discontinuance of the feeding tube. -On 1/19/15, a new speech therapy goal to complete oral care to reduce the risk of decline of oral debris was initiated. Resident #11 was determined to be unsafe for oral intake based on the barium swallow evaluation results. A recommendation for small ice chips via one-half teaspoon was written; the trial of pureed foods was discontinued. Resident #11 was to be allowed a small amount of ice chips. -A 1/21/16 Nurse's Note at 4:25 pm documented Resident #11 being sent to the emergency	F 155	weekly for four weeks, then weekly for four weeks, then quarterly thereafter. A Resident Council meeting will be conducted weekly for four weeks, then monthly thereafter, to review resident rights with the group; concerns will be addressed as indicated. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for three months for further recommendations. The Administrator is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 155	Continued From page 6 department to be evaluated for a stroke. A note later that day at 10:00 p.m. documented, "No ice chips or water should be left in pt (patient's) room." -On 1/21/16, in the nurse practitioner Progress Note Resident #11 was documented with altered mental status, decreased oxygen saturation in the 80's, and somnolence. He was hospitalized on this date. Resident #11 was hospitalized on 1/21/16 due to a change in mental status. The ED Physician Note documented at 2:50 p.m., stated, "He has quite poor hygiene, primarily oral hygiene...Oral mucosa is significantly dry with brownish crusting over tongue and oral mucosa. He is edentulous. Tongue is significantly dry with a layer of brownish crusting...Severe dehydration and rehydration high risk for cerebral edema." Resident #11 passed away on 1/23/16 in the hospital. According to the 2/5/16 hospital Discharge Summary, admitting diagnoses included severe dehydration, severe hypernatremia (elevated sodium level in the blood due to inadequate fluid intake), acute kidney injury, and acute urinary tract infection with a suprapubic catheter related. Resident #11's POA was interviewed on 7/12/16 at 9:40 a.m. and stated he had cared for Resident #11 for 12 years prior to Resident #11's admission to the facility. He stated Resident #11 was not provided adequate fluids and he was severely dehydrated when he went to the hospital on 1/21/16. The POA stated the resident was very thirsty and often asked for ice chips, which he had been allowed to have previously	F 155		

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F 155	Continued From page 7 when he was on the ventilator. The POA stated he observed Resident #11 with a dry mouth and with cracked dry lips in the week preceding his hospitalization. The POA stated once Resident #11 moved to a different room after his trach came out and use of the ventilator was dicontinued, he was no longer allowed ice chips. The POA stated the plan was for the facility to start with oral feeding after the ventilator came out; however, this was not done. The POA stated the facility was afraid Resident #11 would aspirate. During the care plan meeting (1/13/16) the POA stated he expressed his desire that Resident #11 be allowed to have ice chips and he be allowed to eat and drink, but this was not allowed. The POA stated Resident #11 was denied fluids, ice chips and food. CNA #13 was interviewed on 7/13/16 at 3:15 p.m. and stated she remembered Resident #11 requested ice chips. CNA #13 stated, "He wanted ice chips, but he was NPO (nothing by mouth). We were not able to give them (ice chips) due to the (physician's) order." CNA #1 was interviewed on 7/15/16 at 10:10 a.m. and stated, "He (Resident #11) asked for ice chips constantly." CNA #1 stated she was told by the nurses not to give the resident ice chips. Nurse #5 was interviewed on 7/14/16 at 2:20 p.m. and stated she remembered being able to give Resident #11 ice chips and then not being able to. She stated, "He got ice chips for a while. At the end I could not let him have them (ice chips). I felt bad." Nurse #5 verified Resident #11 asked repeatedly for ice chips.	F 155		

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F 155	Continued From page 8 The NP was interviewed on 7/14/16 at 2:40 p.m. and when asked about Resident #11's desire to eat and drink in light of his swallowing impairment, the NP stated, "He doesn't get it (food or fluids orally) if it is not safe, except if he is able to make an informed decision. We tell him the consequences; he can sign a waiver." The NP further stated if the resident was not competent; his medical decision maker could make the decision for him. The licensed social worker was interviewed on 7/14/16 at 9:50 a.m. and was asked if there was a process for a resident who wanted foods and fluids outside their physician prescribed diet order. The social worker stated, if a resident refused treatment this would be directed to the physician first. She stated the family and resident would then be approached to discuss the risks and benefits. The social worker stated a resident or the power of attorney had the right to make healthcare decisions as long as they understood the ramifications. When asked if this had been offered to Resident #11, she stated she was newly employed when the events concerning Resident #11 occurred, but it would be documented under the pertinent discipline if the conversation was held. The following sections of the medical record were reviewed: physician, nursing, social service, dietary, and speech therapy. There was no documented evidence of a conversation being held concerning Resident #11 and his POA being explained the risks, the waiver process, or the possibility of being allowed food or fluid contrary to physician's orders if all proper steps were taken. The SLP was interviewed on 7/14/16 at 10:10	F 155		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 9 a.m. and stated she completed an evaluation on 12/19/15 due to Resident #11's desire to eat and drink. She stated the goal was to begin a pureed diet trial with thin liquids. The SLP stated Resident #11's positioning in bed was poor and this delayed the initiation of the feeding trial. She stated she first fed him 4 ounces of applesauce with 100 percent accuracy, on 1/8/16. A 3-day feeding trial for lunch was then ordered to take place on 1/11- 1/13/16. The SLP stated, when she reviewed therapy records, the feeding trial occurred on 1/12/16 only and was provided by the other SLP. She stated it was not provided on 1/11/16 or 1/13/16 by the other SLP; she stated she was not sure why. It was discontinued after this date. The SLP stated ice chips were discontinued due to the results of the barium swallow that showed the resident was a silent aspirator. When asked if there was a protocol if a competent resident or family/decision maker requested food or fluids outside of the diet order, she stated a waiver could be signed if a resident/decision maker was informed of the risks of not adhering to the diet order. When asked if this was pursued or explored as a possible option for Resident #11, she stated it was not.	F 155		
F 156 SS=F	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the	F 156		8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

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F 156	Continued From page 10 resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of	F 156		

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F 156	Continued From page 11 resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Admission Agreement and staff interview, it was determined the facility failed to ensure residents were fully	F 156	1. Clarification was provided to the Administrator and Business Office Manager (ADM/BOM) regarding the intent	

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F 156	Continued From page 12 informed of their right to choose their own code status, and of their right to have sufficient nursing care to meet their needs, at the time of admission. The failed practice had the potential to adversely effect all sample Residents (#1 - #27), and all residents admitted to the facility, if they felt they would have to hire private duty nursing care or did not have a choice regarding code status. Findings include: 1. The facility's "Idaho Admission Agreement," dated April 2014, documented on page 5 of 9, "The Parties specifically understand and agree that the quality of care provided by the Facility is limited by staffing levels provided and quality of staff. Therefore, if the Resident and/or Responsible Party desire to reduce the risks of injury associated with staffing provided by the Facility, they shall arrange for and provide supplemental private duty nursing." Please refer to; F224 and F353 as it relates to the facility's failure to ensure adequate numbers of qualified nursing staff to meet residents' needs. On 7/15/16 at 9:40 am, the Administrator stated he would have to check with the facility's legal department before he could weigh in on the intent of that statement in the Admission Agreement. 2. The facility's Admission Agreement contained a page entitled, "No Code Policy," which documented, "The physician will dictate the need for a no code order for any patient. He/she must discuss in detail the meaning of a 'no code' with the resident and responsible party. The physician	F 156	and meaning of the language of Idaho□s-Admission Agreement on page 5 that the facility must inform resident and families that if the resident or family request more care than the facility can provide while complying with all applicable laws and regulations, including, without limitation, all conditions of participation, the facility can arrange for supplemental private duty nursing, but this will be an out-of-pocket charge. And, that the statement quality of care provided by the Facility is limited by staffing levels and quality of staff reflects the fact that, while the facility provides at least the minimum of nurses required by law/regulation to be at the facility in ratio to residents and staff, and while there are nurses available 24 hours a day, such nurses are not available to provide care to just one resident on a one-on-one basis in the same manner and to the same extent as would a private duty nurse. The No Code Policy was reviewed by the QAPI committee on 8/10/16 and removed from the admission packet. 2. Legal team representing Orianna and Holly Lane Rehabilitation & Healthcare reviewed the verbiage of the admission agreement and will continue to utilize on 8/12/16. 3. Root Cause Analysis by Interdisciplinary Team (IDT) concluded that admission packet had been supplemented by previous administration to include the No Code Policy. Social	

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F 156	Continued From page 13 must write a note in the Progress note that he/she has discussed this decision with the immediate family. It is strongly encouraged that a family member countersign this note..." On 7/15/16 at 10:00 am, the RVP stated the "No Code Policy" simply meant that after a resident had decided on their code status, the physician would "dictate" a note to that effect.	F 156	Service Director (SSD) was educated on 8/11/16 by Regional Vice President regarding resident/responsible party right to choose code status and the choice to hire private staff but that the facility is responsible for providing care needs of the residents. Facility staff were educated beginning on 8/10/16 on regarding Resident Rights and provision of care by the facility by the SDC and Regional Nurse Consultant (RNC). ADM and Business Office Manager (BOM) were provided education by Assistant General Counsel regarding the intent of the verbiage in the former admission agreement on page 5. The Admission Agreement was revised by legal counsel and the following was removed: The Parties specifically understand and agree that the quality of care provided by the Facility is limited by staffing levels provided and quality of staff. Therefore, if the Resident and/or Responsible Party desire to reduce the risks of injury associated with staffing provided by the Facility, they shall arrange for an provide supplemental private duty nursing. The revised admission agreement will be utilized for new admissions from 8/12/16 forward. 4. Beginning the week of 8/15/16 a Resident Council meeting will be conducted weekly for four weeks and then monthly thereafter where resident rights will be reviewed including but not limited to right to choose code status and	

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F 156	Continued From page 14	F 156	facility responsibility for provision of staff to meet resident care needs and residents/responsible party choice to supplement facility staffing privately. A report will be submitted to the QAPI committee monthly for three months at which time the QAPI team will make further recommendations regarding auditing based on substantial compliance being maintained. The Administrator is responsible for monitoring and compliance. Date of Compliance: 8/12/16	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		8/12/16

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F 157	Continued From page 15 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure physicians and/or NPs and residents' family members were notified of changes in residents' conditions. This was true for 3 of 27 (#7, #11 and #26) sampled residents. This failed practice had the potential for more than minimal harm if a) residents experienced life-threatening conditions requiring aggressive intervention, and the physician and/or NP were not notified, b) physicians were not informed of lab tests ordered but not completd, and c) if a resident's family and POA were not available to provide emotional support and advocate for the resident when she was ill and required treatment. Findings include: 1. Resident #11 was admitted to the facility on 10/15/15; diagnoses included paraplegia, neuromuscular dysfunction of bladder, dysphagia, chronic kidney disease, pressure ulcers, history of urinary tract infections, and respiratory failure. had a urinary catheter, was on a ventilator and had a tracheostomy. He remained in the facility until he was transferred to the hospital on 1/21/16; he died two days later in	F 157	F157 1. Resident #7 was assessed for signs/symptoms of infection and physician was notified regarding labs by SDC on 7/25/16, new physician orders received. Resident #11 discharged from the facility effective 1/21/16; no corrective action indicated. Resident #26 discharged from the facility effective 10/1/15; no corrective action indicated. 2. Beginning on 8/8/16 an audit was conducted for active residents clinical records for the preceding 30 days to validate family notification for change in condition, physician notification in regards to laboratory tests and omission of enteral feedings by facility Registered Nurses; results of audit were corrected as indicated. 3. Root Cause Analysis by the IDT concluded that facility process was not	

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F 157	Continued From page 16 the hospital. The 10/22/15 admission MDS assessment indicated Resident #11 had a swallowing disorder and received nutrition via a feeding tube. The Nutrition CAA in full read, "Resident is at nutritional risk due to respiratory failure, hypothyroid, trach and sacral wound. He is on a tube fed diet and is being followed by the RD." The feeding tube care area of the assessment documented use of a Gastrostomy tube (G-tube) for all calories, nutrition and fluids. On 1/7/16, a NP Progress Note documented, "Dysphagia with a plugged gastrostomy tube - apparently the tube was unplugged yesterday evening and perhaps night. I was never notified and he did not receive his feeds or meds." There was no documentation the NP or physician were notified that Resident #11's feeding tube had become plugged, or that the plugged tube caused him to not receive his feeding tube formula or medications. The NP was interviewed on 7/14/16 at 2:40 pm and stated nursing was responsible to let him know of anything abnormal. He stated he did not remember the specifics regarding the incident of Resident 11's feeding tube becoming clogged in early January 2016; however, he verified if he documented he was not notified, then he was not. 2. Review of Resident #7's clinical record documented he was admitted on 4/1/16 with diagnosis of left CVA and had been ventilator dependent since 4/1/16. Resident #7's	F 157	being followed to validate timely notification of resident/responsible party and/or provider for change of status and/or laboratory tests. Facility licensed nurses were educated on 7/28/16 by Registered Nurse regarding the requirement to notify the resident/responsible party/provider for resident□s change of condition and notification of physician regarding laboratory testing and omission of enteral feedings. The Director of Nursing and members of the Interdisciplinary team were educated on 7/26/16 by Registered Nurse regarding Clinical Morning Meeting process to include review of 24 hour report for change in condition and laboratory tests and validation of resident/responsible party/provider notification. Beginning on 7/26/16 a new laboratory tests tracking log was implemented and IDT/unit mangers were educated on process by Registered Nurse on 7/26/16. The Unit Managers will be responsible for any follow up that is indicated. 4. Beginning week of 8/15/16 an audit will be conducted by Director of Nursing (DON)/designee, of 24 hour reports to confirm notification of family for resident□s change of condition and notification of physician related to laboratory testing and omission of enteral feeding during the morning clinical meeting. The audits will be conducted weekly for four weeks, then monthly for two months and quarterly thereafter. A	

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F 157	Continued From page 17 Physician's Orders, dated 6/30/16, included, "Sputum culture to be obtained on 7/01/16 related to increased oral secretions." Results for the sputum culture were not found in Resident #7's clinical record. During an interview on 07/12/16 at 4:12 pm, the Regional Nurse Consultant confirmed the sputum culture had not been collected and Resident #7's physician was not notified. 3. Resident #26 was admitted to the facility for rehabilitation after a surgical repair of a fractured hip. Resident #26's Admission MDS assessment, dated 8/31/16, documented she was cognitively intact with a BIMS of 15, and required set-up only for eating, two person assistance for transfer and one person assistance for hygiene and bathing. Resident #26's Nurse's Notes documented the following: *9/8/15 at 5:32 pm, "Res returned from appt. No new order noted..." *9/19/15 at 3:30 am, "...resting quietly with no s/s of distress or pain at this time. Alert with confusion..." *9/19/15 at 2:30 pm, "Alert with confusion. Speech clear. Able to make needs know..." *9/19/15 at 4:45 pm, "UA with C & S if indicated, dip her. Amoxicillin 500 mg PO TID x 10 days..." *9/20/15 at 9:50 pm, "Resident on abx for UTI. No adverse s/s at this time..." *9/22/15 at 2:35 pm, "Pt started on abx for UTI. Alert charting in place, monitoring for s/s of adverse reaction..."	F 157	report will be submitted to QAPI committee monthly for three months for further recommendations. The Director of Nursing is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 157	Continued From page 18 *9/23/15 at 8:45 am, "...c/o [chapped] face area around her mouth-resident applying mint flavored chapstick to this area..." *9/23/15 at 11:05 am, "Pt was previously started on Amoxicillin 500 mg... culture and sensitivity back, abx change to Levaquin 9-21 x 10 days..." There were no documentation found on Resident #26's medical record her family was notified when she had a UTI, started on antibiotic, and when her antibiotic was changed. Resident #26's Nurses' notes dated 9/8/15, documented she returned from her appointment. The type of the appointment and whether the family was notified of the appointment or if a family member accompanied her to the appointment, was not documented. On 7/13/15 at 4:30 pm, LN #2 said Resident #26's family or her POA were always notified of any change in her condition and any change in her medications. LN #2 said the documentation should be in the Nurses' Notes. LN #2 said she did not know why documentation of notification was not in the Nurses' Notes.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		8/12/16

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F 164	Continued From page 19 Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents' clinical records remained confidential. This was true for 1 Random Resident (Resident #28). This deficient practice had the potential to cause loss of self esteem when the resident's personal health information was available to seen by the public. Findings include: On 7/11/16 at 2:30 pm, an uncovered MAR for Resident #28 was observed on top of the Vent #1 medication cart which was parked unattended in 500 Hall. A resident was observed propelling her wheelchair down the hall and passed the unattended cart. Resident #28 MAR documented, "Pain assessment..., Miralax 17 gms, give per PEG tube once daily...Docusate	F 164	F164 1. Registered nurse responsible for Medication Administration Record (MAR) was provided re-education by Registered Nurse on 7/11/16 and again on 8/7/16 by RNC on maintaining privacy of resident clinical records. 2. An audit was conducted of remaining MARs in the facility to demonstrate privacy was being maintained by RNC on 8/4/16. 3. Root Cause Analysis by the IDT concluded that the Registered Nurse indicated that by keeping the MAR open she was able to keep up with where she was in the med pass. Facility staff was educated regarding	

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F 164	Continued From page 20 Sodium 100 mg 10 ml, give per PEG tube every 12 hours for constipation." LN #1 said the LN responsible for the Vent #1 cart was with a resident. She said she would tell the LN about the MAR being uncovered and closed the MAR.	F 164	maintaining privacy, including but not limited to clinical records and MARs by RNC on 7/28/16. 4. Beginning the week of 8/15/16 an audit will be conducted to confirm privacy is being maintained of the clinical records/MARs by DON/designee three times weekly for four weeks, then weekly for four weeks, monthly for one month and quarterly thereafter. A report will be submitted to the QAPI committee monthly for three months for further recommendations. The DON is responsible for monitoring and compliance. Date of Compliance: 8/12/16	
F 224 SS=L	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation; resident, staff, resident group, and resident family interviews; and review of residents' records and the facility's policies and procedures, staffing records, in-service records, and menus and food service; it was determined the facility failed to ensure residents were free from abuse and neglect. The failed practice placed the health and safety of 17 of 27 sampled	F 224	1. The Regional Vice President provided education on the requirements of the abuse and neglect prevention program on 7/16/16 to the Administrator and Director of Nursing. 2. An audit was conducted beginning on 7/16/16 by Administrator/designee by	8/12/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 21 residents (#1-#10, #15, #20, #24, and #25) ,8 of 8 residents in the resident group in Immediate Jeopardy of serious harm, impairment, or death, and had the potential to adversely affect the remaining residents receiving services and treatment at the facility. The deficient practice also resulted in serious harm, injury, or death for 3 of 4 sampled residents (#s 11, 13, and 22) no longer residing in the facility. The facility failed to ensure there were sufficient numbers of trained and qualified RNs, LPNs, and CNAs to protect residents from neglect and/or abuse, meet residents' needs, including those with special needs, and provide care as planned. Facility Administration was informed of the Immediate Jeopardy and the need to develop and implement an acceptable plan to remove the Immediacy at 4:20 pm on 7/15/16. Findings include: 1. Resident Group Interview: On 7/13/16 at 11:00 am, a resident group interview was held with 8 residents. One resident stated, "Please help us. We are suffering." The other seven residents agreed with that statement. The group reported a consensus on the lack of care and services in the facility. The group consensus included: * It was customary for call lights to be unanswered for anywhere from an hour to two and a half hours, especially in the evenings and at night, starting between 5:00 and 6:00 pm. * Staff responding to call lights enter the room in a hurry, address the primary need identified by the resident, then "bolt out" without finding out if	F 224	interviewing interviewable residents regarding concerns of abuse or neglect. Non-interviewable residents were assessed by licensed nurses regarding signs/symptoms of abuse or neglect. Any allegations of abuse of neglect noted were handled according to facility policy and procedure. 3. Root Cause Analysis by the IDT concluded facility staff could not actively describe the Abuse/Neglect prevention program, that resident needs were not being attended to timely as residents expected, and that facility staff required additional education on attending to resident needs, following care plans and care cards. Facility staff was educated on abuse/neglect prevention program by RVP/RNC beginning on 7/28/16 on understanding of the abuse/neglect prevention program. The knowledge of the program was validated with staff members by staff submitting a post-test with a minimum score of 80% correct responses; for scores less than 80% additional one-to-one training was conducted at that time. Staff were further educated by RVP/RNC beginning on 7/28/16 regarding abuse/neglect prevention program. And beginning on 8/10/16 the SDC provided additional education to facility staff on abuse/neglect prevention program. The DON/ADON/SDC/RN Supervisor will provide orientation to new agency staff	

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	135094		07/19/2016

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F 224	Continued From page 22 residents have additional needs, and did not follow up later. * The group reported, "They (staff) don't have time for you or time to do their job. They rush us at bedtime, yet you have to wait an hour and a half to use the toilet." * One resident in the group stated if they re-activated their call light "too much" it was taken away from them. * One resident stated s/he was "yelled at" for putting his/her call light on, which "hurts my feelings." * Other residents in the group reported their call lights were often placed out of reach, prompting them to call out when they needed assistance. * The group stated they suspected this happened to other residents as well, as they could often hear residents "hollering out" for assistance at night. Residents who resided on the 500 hall stated they could hear residents calling out from other units in the facility and that this was so loud and so frequent their sleep was often disrupted. * Staff would "vent" their frustrations regarding facility practices to one another while providing cares. One resident stated, "We have our own issues. I know they are venting to each other, but it feels like they are venting to me." * The resident group reported staff frequently addressed them "like two year olds." One resident in the group stated s/he had been scolded when trying to retrieve personal beverages from the community refrigerator. Another resident stated when s/he took his/her last soda from the refrigerator, s/he was repeatedly reminded in a condescending tone that was their last soda, and s/he had "better not be seen" near the refrigerator again until s/he had purchased more.	F 224	prior to them beginning an assignment, including but not limited to abuse prevention program. During the morning meetings, the Staffing Clerk will review yesterday□s staffing as well as current day□s forecasted staffing with the ADM/DON/IDT, changes will be made as indicated to ensure sufficient numbers of qualified RNs, LPNs and C.N.A.s to meet the residents□ needs. 4. Beginning on the week of 8/15/16 an audit will be conducted by the Administrator/designee by interviewing ten percent of the interviewable residents weekly regarding concerns of abuse/neglect, interviewing five (5) staff members to validate understanding of abuse/neglect prevention program, and review of the following weeks staffing schedule weekly for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee for further recommendations monthly for three months. The Administrator will be responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 224	Continued From page 23 * Cares were per staff convenience, not per resident need or preference, and when providing these cares at night staff enter the room abruptly, turn on all the lights, and do not lower their voices. * The resident group reported the facility suffered from a lack of sufficient staff for quite some time, but "it is getting worse instead of better." This included a lack of both nurses and CNAs. * The residents reported many of them required 2 staff assistance for ADLs, transfers, and mobility. The residents reported there was rarely enough staff on duty for evening and night shift to meet their needs. The residents reported there were many times when the facility had only 2-3 CNAs on the specialty care (ventilator and tracheostomy)unit, but they needed at least 5. The residents stated, "With only two or three staff, they can all be in the room helping one person, and there is nobody else to answer call lights for the rest of us." * The residents reported they frequently had to stay in bed too long. sit up in their chairs too long, could not get assistance to come out of their rooms for meals. and could not get assistance for ADLs. * The residents reported the facility frequently served small portions of food. One resident stated, "A two-year old eats more than they give us sometimes." * Residents stated whether they ate in their rooms by choice or because there was no one to get them up, they could not get substitutions if they did not like their meal or second helpings if their portion was not sufficient. 2. Individual Resident Reviews:	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

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F 224	Continued From page 24 a. Resident #11 was admitted to the facility on 10/15/15 with diagnoses including paraplegia, neuromuscular bladder, dysphagia, chronic kidney disease, pressure ulcers, history of urinary tract infections, and respiratory failure. Resident #11 had a urinary catheter, was on a ventilator and had a tracheostomy, when admitted to the facility. Resident #11 remained in the facility until he was transferred to the hospital on 1/21/16 where he died two days later. The 1/23/16 hospital discharge summary documented Resident #11's cause of death included intracranial mass of the brain, urinary tract infection, bacteremia, severe hypernatremia with dehydration, and acute kidney injury. Resident #11's 10/29/15 H&P documented erosion of the tip of his penis from long term catheter use and the number of times the catheter had become dislodged. On 11/11/15 and 12/18/15, the NP documented Resident #11 was at risk for sustaining further injury or interruption should the catheter become dislodged again, and ordered the facility to ensure the catheter was secured. Resident #11's record contained no evidence his catheter was consistently secured to his leg by staff. Resident #11 experienced a change in condition prior to his hospitalization on 1/21/16. In the 3 weeks leading up to his hospitalization, Resident #11's Tube Feeding Record did not document the facility was following the physician's orders for tube feeding administration, free water administration, or monitoring urinary output. The facility had no documentation of Resident #11's	F 224		

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	135094		07/19/2016

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F 224	Continued From page 25 condition for the 52 hours leading up to his hospitalization. When Resident #11 was admitted to the hospital on 1/21/16, the ED Physician Note, documented at 2:50 pm, stated, "He has quite poor hygiene, primarily oral hygiene ... Oral mucosa is significantly dry with brownish crusting over tongue and oral mucosa. He is edentulous. Tongue is significantly dry with a layer of brownish crusting." Resident #11 received all nutrition via a feeding tube.The facility's weight record did not have documentation that Resident #11's weights were measured each week as ordered by the physician and directed in his care plan. Resident #11 experienced a severe unplanned weight loss from 176.8 pounds to 159.6 pounds (17 lbs/9.6%)between 10/20/15 and 1/4/16, less than 3 months. His tube feeding regimen, however, was not adjusted to stop further weight loss and promote weight gain, and to provide physical and psychosocial comfort. Resident #11's POA was interviewed on 7/12/16 at 9:40 am. The POA stated he had cared for Resident #11 for 12 years prior to admission to the facility. He stated Resident #11 was "not provided adequate fluids" and he was "severely dehydrated" when he went to the hospital on 1/21/16. The POA also stated Resident #11 had a large growth at his right eye that the facility had not identified or addressed. The POA stated Resident #11's cognition had already begun to deteriorate on 1/13/16, when the facility scheduled a care conference. The POA stated Resident #11 was alert and oriented at baseline,	F 224		

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F 224	Continued From page 26 but became increasingly incoherent over the last month of his life. The POA stated Resident #11 was very thirsty and often asked for ice chips, which he had been allowed to have until he was moved off of the ventilator unit on 12/21/15. The POA stated he observed Resident #11 with a dry mouth and with cracked dry lips in the week preceding his hospitalization. The POA stated once Resident #11 moved to a different room after his trach came out and the use of the ventilator was discontinued, he was no longer allowed ice chips, as the facility expressed concern that Resident #11 would aspirate. During a 1/13/16 care plan meeting the POA stated he expressed his desire that Resident #11 be allowed to have ice chips and that he be allowed to eat and drink. The POA further stated Resident #11's mouth was dry and he was not provided with adequate oral care. Concerns regarding Resident #11's oral hygiene were raised at the care plan meeting held on 1/13/16. The POA stated Resident #11 was denied fluids, ice chips and food. The POA stated, "He died at the hospital. The doctor said he didn't know how Resident #11 could get so dehydrated. His electrolytes were through the roof. It was like he had been in the desert for weeks. Nobody bothered giving him fluids." On 7/13/16 at 3:15 pm, CNA #13 stated she remembered Resident #11 requested ice chips, and said, "His urine had a lot of sediment; he had low urine output. He wanted ice chips, but he was NPO. We were not able to give (ice chips) due to the (physician's) order." On 7/14/16 at 5:40 am, LN #8 stated output was recorded per shift for all residents who had	F 224		

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F 224	Continued From page 27 catheters. When asked who totaled and monitored the daily output records, he stated, "I don't know who reviews it. The nurse practitioner looks at the MAR. I don't know who in nursing is responsible." On 7/14/16 at 2:20 pm, LN #5 stated she remembered being able to give Resident #11 ice chips and then not being able to. She stated, "He got ice chips for a while. At the end I could not let him have them. I felt bad." LN #5 stated Resident #11 asked repeatedly for ice chips. On 7/14/16 at 2:40 pm, the NP stated nursing was responsible for monitoring urine output and it was nurses' responsibility to let him know of abnormal output. The NP did not remember if he was notified of decreased urine output for Resident #11. However, there was no evidence in the medical record of physician notification of low urine output. On 7/15/16 at 10:10 am, CNA #1 stated Resident #11 was not provided with adequate oral care. The CNA stated there was not enough staff to take care of the residents. She stated there were a number of instances when she came on her shift and found Resident #11 had not been provided oral hygiene. She stated, "He never got oral care done." CNA #1 stated, "He asked for ice chips constantly." CNA #1 stated she was told by the nurses not to give Resident #11 ice chips. b. Resident #8 was admitted to the facility on 12/23/14, with diagnoses which included hemiplegia of the left side following a CVA, dysphagia following CVA, acute respiratory	F 224		

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F 224	Continued From page 28 failure with a tracheostomy, and muscle weakness. Resident #8's most recent Quarterly MDS assessment, dated 6/14/16, documented moderate cognitive impairment with mild depression, and 1-2 staff assistance required with all cares, except eating. The MDS documented Resident #8 rejected cares 1-3 days per week and was totally dependent on 2 staff with toileting needs. The MDS documented a bladder retraining trial had not been attempted. On 7/12/16 at 8:45 am, Resident #8 stated that during the night of 7/11/16 and early morning hours of 7/12/16, "I had to yell and yell and that got old fast. I was left alone in here and they took away all my communication." Resident #8 was asked to show what was removed from her reach and she touched her call light and stated, "They took this away." On 7/12/16 at 4:25 pm, when the surveyor asked to observe peri-care on Resident #8, CNA #19 and CNA #20 stated Resident #8 received peri care three times a day on a scheduled basis and that it was scheduled to be completed before breakfast, at about 2:45 or 3:00 pm, and after dinner. On 7/13/16 at 2:45 pm, CNA #19 stated Resident #8 would not receive peri-care that shift because she was in an activity, but that Resident #8 would be offered peri-care at her next scheduled time after dinner. On 7/13/16 at 5:56 pm, CNA #19 stated Resident #8 did not receive peri-care in the afternoon after the activity because she was up in her chair and it was almost time to eat	F 224		

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F 224	Continued From page 29 dinner. c. Resident #6 was admitted to the facility on 5/1/14 with diagnoses which included RA, dysphagia, muscle weakness, joint pain, osteoarthritis, malnutrition, and chronic pain. Resident #6's Quarterly MDS assessment, dated 6/22/16, documented no cognitive impairment with minimal signs of depression, total dependence on staff for nutrition via a feeding tube. The MDS documented Resident #6 was able to perform transfers, dressing and ambulation with staff supervision. On 7/12/16 at 8:36 am, Resident #6 had a meal tray delivered to her room, where she was lying flat on her back with the tube feeding pump still connected to her . Resident #6 was wearing a hospital gown and used a blanket to cover herself because she was not dressed and was "embarrassed." She stated she wanted to get out of bed and dressed, but could not because she was still hooked up to the tube feeding pump. Resident #6 reported the pump stopped pumping at 8:00 am, but should have been finished at 7:00 am. Resident #6 stated the tube feeding would often get started late. Resident #6's call light was hooked onto the tube feeding pump stand, out of her reach, and she stated it was placed there by staff. Resident #6 stated she was instructed to remain in bed until a nurse came and unhooked her from the tube pump. On 7/12/16 from 9:00 am to 10:00 am, Resident #6 remained in her bed and hooked up to the tube feeding pump. The call light remained secured to the tube feeding pump stand and out	F 224		

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F 224	Continued From page 30 of her reach. Resident #6 asked the surveyor to get her a nurse because she "really" wanted to get up and get dressed and could not reach the call light. On 7/12/16 at 10:01 am, the surveyor informed LPN #4 that Resident #6 requested to get out of bed. On 7/12/16 at 10:19 am, LPN #4 unhooked Resident #6 from the tube feeding pump. On 7/13/16 at 8:39 am, Resident #6 was lying flat on her back hooked up to the tube feeding pump, and wearing the same clothes as the day before. Resident #6 again used a blanket to cover herself and the call light was hooked onto the tube feeding pump stand, out of her reach. She remained hooked up to the tube feeding pump until 10:49 am, when LPN #4 administered medications. On 7/13/16 at 11:00 am, LPN #4 stated she was late getting to Resident #6, as the LPN had to be in the dining room as a licensed nurse was required to be present during residents' meals. On 7/15/16 at 10:19 am, CNA #1 stated Resident #6 was ignored often by staff and waited for extended periods of time for assistance. On 7/13/16 at 5:45 pm, the ADON stated it was not acceptable for the tube feeding pump to be left on for extended periods of time after her feeding was finished, or to place Resident #6's call out of her reach. d. Resident #2 was admitted to the facility on	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 31 6/14/16 with diagnoses which included quadriplegia, DM, acute respiratory failure, seizures and altered mental status. Resident #2's Initial MDS assessment, dated 6/21/16, documented cognitive impairment, mild depression, and that he required extensive assistance of 2 staff members required for all transfers, and extensive assistance of 1 staff member for hygiene, dressing, and eating. Resident #2's ADL Care Plan, dated 6/13/16, documented he required extensive assistance or was totally dependent on staff for ADL assistance. On 7/11/16 from 2:37 pm to 3:50 pm, Resident #2 was observed laying in his bed with his call light on his pillow behind his head and was out of his reach; his water cup was on a table about 3 feet from the bed. Resident #2 remained without access to his call light or his water throughout this seventy-three minute observation. On 7/12/15 from 8:35 am to 12:30 pm, Resident #2 was observed lying in his bed without being moved or repositioned. Resident #2's water cup was on the bedside table about 3 feet from him from 8:35 am until his lunch arrived at 12:30 pm. Resident #2 was observed in his bed with his call light out of reach, on his pillow behind his head; the call light was moved to within his reach at 10:35 am. On 7/15/16 at 10:15 am, CNA #1 stated Resident #2 "often did not have his call light within reach because the staff was too busy to help him.	F 224		

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F 224	Continued From page 32 e. Resident #9 was admitted to the facility on 8/18/14 with current diagnoses that included DM and ALS, degenerative disease that affects nerve cells in the brain, the spinal cord and causes muscle to waste away. His breathing muscles were affected and he subsequently had a tracheostomy. He required a ventilator to assist with breathing. Resident #9 was quadriplegic and had total loss of the use of all four limbs and torso. Resident #9 was totally dependent upon staff for all activities of daily living. Resident #9's annual MDS assessment, dated 6/16/16, documented his cognitive skills for daily decision making were not impaired and he was "alert and oriented." Resident #9 required the assistance of 2 staff for toileting and personal hygiene. He was able to use his 'blow by' call light to alert staff when he needed to toilet. Resident #9 was dependent upon staff to place the urinal and to assist him onto the bedpan. On 7/11/16 at 2:20 pm, Resident #9 stated, "There is a lack of staff and they are stressed out. They are almost always shorthanded." On 7/12/16 at 9:05 am, Resident #9 stated, "One night they were shorthanded. I was left on the bed pan for 4 hours. Sometimes I have to wait an hour to go pee. What if I had an emergency? I am just scared for the others [residents]. Something is going to happen." f. Resident #13 was admitted to the facility on 5/18/16 with diagnoses including chronic respiratory failure, neuromuscular dysfunction of the bladder, dysphagia and quadriplegia. Resident #13 used a ventilator, had a tracheostomy, and was fed via PEG tube.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 33 Resident #13 was discharged to the hospital on 6/11/16 due to blood in his trach and decreased oxygen saturations. Resident #13 was readmitted to the facility on 6/17/16. Resident #13 was again discharged to the hospital on 7/8/16 for a diagnosis of dehydration, refusing respiratory care, and because the facility was unable to meet his needs. Nurse's notes documented: * 5/29/16, 4:40 am: "Resident was [sic] explained implications that can arise from him refusing his feeding and [water]. Resident stated 'You guys don't listen!' Resident did allow pm [night] meds to be given and allowed PEG tube to be flushed. Resident stated he will not take his feedings and [water] because he is not toileted quickly enough and does not like to have accidents." * 6/1/16, 1:00 pm: "Resident is alert and oriented, able to make his needs known ... He is able to be continent of B & B but tends to need someone right as he is pushing the call light ... He says he doesn't like being incontinent and afraid if he eats he will be." * 6/30/16, no time documented: "Resident has refused all meds, food, [and] fluids stating that he will not be eating or anything else until CNAs [and] other staff answer his light with no longer than (illegible number) min (minutes) from time it goes on, because he does not want to have an accident. I proceeded to inform him I'd be there to help & he said no not till everyone does this. I educated him on the issues this would cause like dehydration [and] he said that he was willing to risk this. This stance did not change throughout the shift." * 7/1/16, 11:00 pm: "Pt c/o constantly being incont (incontinent) of urine due to slow response	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 34 of CNA ...Mother reported pt sat in urine for over 45 minutes w/o anyone answering call light. When talking with mother I informed her it had only been 25 minutes since I had been in and there was no mention of needing to be changed when asked." On 7/15/16 at 9:15 am, LN #5 stated she cared for Resident #13 a total of 3 times. She stated the first 2 times she did not have any issues with Resident #13; he allowed all care and did not refuse anything. She stated she answered his call light and Resident #13 told her it was not that way when other nurses were working. LN #5 stated the last time she cared for Resident #13 he refused his tube feeding, medications and respiratory care because he stated his call light was not answered quickly enough. LN #5 stated Resident #13 could remain continent if staff toileted him quickly. On 7/15/16 at 9:45 am, Resident #13's guardian stated Resident #13 was "medically complex" and acted younger than his 28 years. She stated, "He does not have much control but he can say 'No.' She verified Resident #13 got very irritated and upset and as a result refused cares. Resident #13's guardian stated Resident #13 refused tube feeding and water flushes because staff did not toilet him quickly enough. She verified Resident #13 knew when he needed to use the toilet and was incontinent if staff did not toilet him in a timely manner. She stated she visited Resident #13 twice when he waited 25 minutes for staff to respond to the call light and stated, "We timed it." On 7/15/16 at 10:10 am, CNA #1 stated Resident	F 224		

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F 224	Continued From page 35 #13 was not toileted due to short staffing. CNA #1 stated Resident #13 knew when he needed to use the urinal and put on his call light, but that he could be continent if he was toileted in a timely manner. CNA #1 stated "It is a lot of work to toilet him and it takes 2 people. He could use the urinal. He was not toileted; it was easier to change him than toilet him." On 7/15/16 at 1:30 pm, Resident #13's family member stated she had been Resident #13's care giver previously and had removed him from the facility a couple of years prior due to "poor care." She stated the care had deteriorated since then and was "worse now." Resident #13's family member stated Resident #13 refused to allow his tube feeding and water flushes to be administered because staff would not toilet him, which resulted in him soiling himself. The family member stated "He told me, 'If I have to piss and shit on myself, I would rather be dead.' He does pretty well with his bladder (remaining continent)if he is toileted. I timed it; he waited 51 minutes for someone to respond(to his call light)while I was there and not just once. (Resident #13)is stubborn. He(Resident #13)never liked to be messy since he was a small child. I have been in tears a lot of times to see him that way(soiled with urine and feces)." Resident #13 was not provided with adequate assistance for toileting and as a result was incontinent. He was aware of the need to void and could be continent most of the time if staff answered his call light in a timely manner. Resident #13 required the assistance of 2 staff for toileting. He was extremely distressed by soiling himself; he refused food/fluids (tube	F 224		

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F 224	Continued From page 36 feeding and flushes) because he did not want to soil himself. g. Resident #5 was admitted to the facility on 6/24/16 with diagnoses that included spina bifida and pressure ulcers to the right buttocks and left sacral region. Resident #5's 7/15/16 Admission MDS assessment documented he required extensive assistance from staff for bed mobility, transfers and toileting; had impaired range of motion with contractures of both lower extremities; had 2 stage IV pressure ulcers; and was cognitively intact. On 7/11/16 at 2:36 pm, Resident #5 stated, "I am paralyzed from the waist down and need a Hoyer lift and 2 people (for transfers)." Resident #5 stated he voluntarily admitted himself to the facility to receive treatment and services to heal his 6 pressure ulcers. He stated he allowed himself 2 hours per day to be up in his wheelchair and remained in bed the remainder of the time to promote healing of the pressure ulcers. Resident #5 reported, "Staffing on days is good. Evenings are a problem. We had a barbecue on Friday. There was one CNA for the whole floor. I can only stay up for 1 hour. I wanted to go to bed at 7:00 pm. They did not get back to me until 8:30 pm. I was up an hour and a half longer than I should have been." Resident #5 also reported having problems when staff transferred him with the Hoyer lift. He stated there were staff that came to transfer him that did not know how to use the Hoyer. Resident #5 stated there was one instance when he was not transferred properly and was leaning over to the	F 224		

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F 224	Continued From page 37 side. Resident #5 stated he no longer allowed certain CNAs to transfer him. A Nurse's Note, dated 6/30/16, documented Resident #5 complained of shoulder pain relating to a Hoyer lift transfer. Upon investigation, it was determined the CNAs reported the sling was too small. On 7/12/16, CNA #12 stated Resident #5's transfer approach had been changed a couple weeks prior by Physical Therapy and that a Hoyer was to be used with the assistance of 2 staff, using the sling with 2 straps under his legs. h. Resident #25 was re-admitted to the facility on 3/22/16 with diagnoses that included paraplegia and respiratory failure. Resident #25's 5/5/16 Quarterly MDS assessment documented she was cognitively intact, had minimal depression, displayed physical behavioral symptoms 1-3 days of the previous 7 days, and was dependent on two staff for bed mobility and personal hygiene. On 7/15/16 at 10:10 am, CNA #1 stated there was not enough staff to take care of the residents. She said there were several female residents whose hair did not get brushed and that resulted in severe tangling and matting. CNA #1 stated Resident 25's hair was so matted her head had to be shaved. On 7/15/16 at 11:15 am, Resident #25 was observed lying in bed in a hospital gown. Her hair was approximately1/2 inch long. She was on a ventilator with a trach in place. The respiratory	F 224		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 38 therapist came into the room and provided treatment that enabled Resident #25 the ability to talk and then left the room. Resident #25's mouth was dry with a white substance around her lips and a foul odor emanated when she spoke. She had difficulty speaking. When asked if she was provided oral care and baths, she said, "No." When asked if staff brushed her hair, she said they did not and stated her hair was tangled and matted prior to it being cut. i. Resident # 20 was admitted to the facility on 7/23/08 with diagnoses which included CVA with mild left-sided hemiparesis. Resident 20's 5/12/16 Annual MDS assessment documented he had moderately impaired cognition; difficulty communicating but was able to make himself understood; and required staff assistance for all activities of daily living. A "Corrective Action Plan," dated 4/30/15, and written by LN #10 for CNA #23, documented, "I had gone in to give [Resident 20] his meds. He was still in w/c and CNA #23 came in behind me. She goes to [Resident #20] and starts patting him on his left shoulder somewhat forcefully. I told her not to hit his shoulder that it was the one injured. She came back with 'Oh, he's ok. He's not hurt.' Since I had given him something for pain a couple of hours before I was not able to give him anything else at the time. Due to her attitude I stayed in room and helped get him to bed before leaving ... You were corrected by the nurse, yet you continued with rough treatment. The nurse felt she could not leave you alone with the resident."	F 224		

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	135094		07/19/2016

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F 224	Continued From page 39 On 7/13/16 at 3:15 pm, the ADON stated she did not know if CNA #23 was an employee of the facility. Later that day she stated CNA #23 was an employee and scheduled to work. Upon arrival to the unit where CNA #23 was scheduled to work, the surveyor was informed CNA #23 had left the unit to go home and was not scheduled to work the rest of the week. On 7/13/16 at 3:30 pm Resident #20 responded to some yes/no questions regarding activities of daily living but did not respond to questions regarding the incident. The facility failed to ensure allegations of abuse/neglect were investigated. 3. Staff Interviews: a. On 7/13/16 at 4:55 pm, CNA # 13 reported: * CNAs were directed to assist less cognitively impaired residents before those residents with greater impairment, as the more cognitive residents were more likely to "complain about the lack of care." * If CNAs were in a room caring for a lesser cognitive resident, and a more cognitively aware resident put their call light on, the CNAs had been instructed by the charge nurses to leave the lesser cognitive resident to take care of the more cognitively aware resident, then return to the lesser cognitively aware residents as time allowed. * It was uncommon for either facility LNs or agency LNs to assist with responding to resident requests for assistance. * One of the CNAs from the 300 hall was	F 224		

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F 224	Continued From page 40 assigned to set tables in the dining room prior to a meal, and clear the tables after the meal. This meant that in the time leading up to and following the evening meal, there was only one CNA to answer call lights on that hall. Many of the residents on that hall required 2 person assistance. * In the evenings, the specialized unit typically had 3 CNAs, although most of the residents required 2 person assistance for ADLs, mobility, and transfers. The CNAs responded to this by having one CNA take vital signs and "turn the trachs(reposition residents with tracheostomies)," and the other two CNAs assisting residents with ventilators. CNA #13 stated all residents on ventilators required 2 staff assistance, and the only way to successfully provide assistance to all of the residents on ventilators was to go from room to room, rather than retrace their steps to answer call lights. * CNAs did not always have time to provide water, or the necessary assistance for residents to drink water. CNA #13 reported it was not uncommon for residents with catheters to have low urine output, with dark colored urine with sediment. * The facility did not stock up-to-date mechanisms to secure catheters, but instead used a "rubber band type thing to hook the catheters to the sheet or bed." CNA #13 stated residents frequently complained of a pulling sensation, and she had known of catheters to become dislodged or pulled out from this practice. b. On 7/15/156 at 10:10 am, CNA #1 reported: * There were not enough CNAs to reposition	F 224		

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	135094		07/19/2016

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F 224	Continued From page 41 residents. Examples of this included "shearing" type skin issues for residents who did not have adequate assistance for repositioning, including Resident #s 10 and 12. CNA #1 stated Resident #10 was "lucky to get repositioned once a shift." * Residents are not assisted with toileting needs. CNA #1 cited examples including Resident #13, who had been incontinent at least in part because "it was easier to change him than toilet him;" Resident #36, who would sit for hours in his/her own urine and feces because s/he was "too heavy to change and there was no time for a shower;" and Resident #23 and #34 who had been left sitting on the toilet up to 90 minutes. She said Resident #11 would be left sitting in feces for "hours at a time" and pleading for ice. CNA #1 stated staff often had to choose between passing meal trays and changing incontinent residents. CNA #1 stated the result was that "residents pee on themselves and cry." * Cares are provided to "verbal" residents before "non-verbal" residents. CNA #1 stated she had been in a room in the midst of caring for a "non-verbal" resident on more than one occasion, and was interrupted to leave and provide care for a "verbal" resident who was capable of complaining. CNA #1 stated during one recent shift, non-verbal residents did not have their adult briefs changed or be repositioned from 4:00 pm until 1:00 am the next day. * Call lights were placed out of reach for residents who used them "too much." Specific residents who had their call lights placed out of reach at times were identified as Resident #s 2, 6, and 15. CNA #1 stated staff would deliberately wrap Resident #8's call light in blankets so she could not see or use it. * LNs at the facility were overworked and unable	F 224		

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F 224	Continued From page 42 to help residents aswell. When residents make CNAs aware of a concern requiring LN intervention, and that message is passed along, the LNs will address the concern "if they get time," but they don't always have time. LNs did not have time, or would not, assist CNAs with direct resident care. * Staff often must choose which cares to provide, due to low staffing levels. Resident #32 did not have his sheets changed after he became incontinent, but instead staff "wiped them (the sheets) with bleach wipes." CNA #1 stated the resident's sheets would often have rings of dried urine in varying colors before his sheets were changed. Resident #35 rarely had her hair brushed, and though it was her preference to have her hair braided, staff almost never had time to braid it for her. CNA #1 stated Resident #s 25 and 30 went so long without their hair being combed that it had to be cut. * Oral care was not consistently provided. CNA #1 stated when Resident #11 was in the facility he was NPO and did not receive oral care. CNA #1 stated the overall attitude of staff was, "He doesn't use it, why spend time cleaning it?" CNA #1 stated Resident #7, who was still residing in the facility, often had "his mouth completely glued shut" from a lack of oral care. CNA #1 reported at times, when s/he removed dentures from residents' mouths, it was "almost like a layer of bread underneath," because dentures were rarely removed. * CNAs were pressured to document residents had refused cares, when cares had not been provided due to lack of staffing. CNA #1 stated that on one occasion, a CNA documented 26 showers were completed on one shift, which CNA #1 stated would have been "impossible" for	F 224		

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F 224	Continued From page 43 one CNA to complete given the number of residents requiring 2 staff assistance. * Residents did not receive enough food, and did not receive adequate attention at meals. CNA #1 reported it took a long time for residents to receive their food at meals, and which they then complained had poor flavor and was cold. CNA #1 stated the evening cooks would not provide second helpings to a resident if they felt the resident was overweight. * CNA #1 stated she had addressed her concerns with Administration, but was "threatened" with having her shifts cut. * CNA #22 was "rough" with the residents, and did not follow care plans. This was reportedly widely known amongst facility staff, and had been reported repeatedly to management, but management had not acted until very recently. Abuse and Neglect Prevention, Recognition, and Reporting: a. On 7/11/16 at 2:45 p.m., the DNS stated, "We have agency staff that we use to include RNs, LPNs, and CNAs. We use four different agencies and I would think it would be up to the agencies to make sure staff is trained on abuse and neglect." b. On 7/11/16 at 3:00 pm regarding abuse and neglect, the Housekeeping Supervisor stated housekeeping and laundry staff were in-serviced on abuse and neglect by being provided written information on the definitions of abuse and neglect, which they were to take home, read, and sign that they understood. c. On 7/11/16 at 3:05 pm, Housekeeping	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 44 Employee #1, "I don't remember a formal training for abuse or neglect. We are given a bunch of papers and a packet at orientation. I know there is someone that will go around and ask us if we read any in-services then we just sign them. There is a clip board that is at the nurses' station and a couple of times a week someone will ask us to just read this form and sign it. It can be anyone who does this at the time. They just explain what abuse/neglect is, who to report to, and then sign a form. For us in housekeeping and laundry, in-services are posted on a bulletin board with our name on it and we are just supposed to take it home, read it, sign it, and then bring it back the next day." d. On 7/12/16 at 8:35 am, Housekeeping Employee #2 stated, "Usually my supervisor tells me to take some papers home to read and sign them, then bring them back." e. On 7/12/16 at 8:45 am, CNA #11 stated, "The person who hired me gave me some papers on abuse and neglect and I just signed them. The other CNAs told me if I see something, then to report to the nurse. That is how I got my orientation. It was from the other CNAs." f. On 7/12/16 at 9:00 am, CNA #12 stated, "I get my training when the ADON comes around and has me sign some papers on abuse, like if we see abuse and to report it, then I sign the papers." When the CNA was asked if there were any other training materials or discussion on abuse and neglect, CNA #12 stated she had not received any additional training. g. On 7/12/16 at 2:15 pm, the HR Payroll	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 45 Coordinator stated, "I'm the one who sits down with our new hires and I go over the orientation paperwork. I go over abuse and neglect." h. On 7/12/16 at 3:00 pm, the District Manager for the contracted Housekeeping/Laundry company stated, "Our staff (referring to Housekeeping/Laundry staff) receive abuse/neglect training through our own company so they probably don't attend the facility's abuse training. It has not been mandatory for our staff to attend." i. On 7/12/16 at 3:15 pm the Facility Scheduler stated, "I'm with the understanding that the agencies are responsible for training their staff on abuse and neglect before they come to work here. I don't receive any paperwork on their trainings they have completed on abuse and neglect. I would think the agency keeps all that on file." j. On 7/12/16 at 3:30 pm, the SDC stated, "Regarding the use of agency staff, it is up to the agency to make sure they are certified and trained in abuse and neglect. I would expect they would be up to date with their competencies. It would be up to the agency to get their employees trained on abuse and neglect and they should have their own in-services. If they (agency staff) are here when we have an abuse/neglect training, then I guess they would attend. If there is an issue of abuse or neglect brought to my attention regarding our own staff, then I would take 3 to 4 of our staff at a time and go over an in-service then just have them sign off on it." The SDC was unable to state what training agency staff had on the expectation of how abuse and	F 224		

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F 224	Continued From page 46 neglect allegations were to be reported in the facility. k. On 7/12/16 at 4:10 pm, the Administrator stated, "Our CNAs are licensed by the State of Idaho and the State mandates all of that. They should know their clinical competencies that they go through with the State. It is my expectation that the agency staff are qualified and trained in abuse and neglect. That would be the responsibility of the agency to ensure that. If there is any suspected abuse or neglect, I would expect the staff would report to their immediate supervisor, then to the DON, then to myself (sic) immediately. With the housekeeping staff, they are in-serviced through their own company and it would be up to the Housekeeping Company to ensure their staff is trained." l. On 7/13/16 at 8:30 am regarding abuse and neglect, CNA #23 stated, "Usually [SDC] will go around and tell us verbally about abuse and neglect, then we just read and sign some papers. We really didn't have a formal training on abuse and neglect. [SDC] just comes around and asks us to read and sign a paper." m. On 7/13/16 at 4:20 pm, the SDC stated, "I haven't gotten to all of that yet with the in-services. I'm supposed to be doing the orientation, but I haven't gotten my training yet so [HR] is doing it. [HR] does the company orientation and she goes over abuse and neglect and they fill out paperwork with her. The SDC person before me did all the training and in-services, but I would have to look to see where they are. I would have to find out about the in-services. That is one of the tasks I've been	F 224		

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F 224	Continued From page 47 given this week for new employees and I just haven't gotten to it yet. With our housekeeping/laundry staff, I need to find out what I'm responsible for as far as teaching them, or what their company teaches them. I haven't found out that process yet. We had no DNS or SDC and I was doing everything and when something is called to my attention, then I make some staff aware, but then [HR] took over." n. On 7/13/16 at 4:30 pm, the Housekeeping/Laundry Supervisor stated, "My District Manager told me that as long as our staff (housekeeping/laundry) do (sic) in-services once a year for abuse/neglect, then they are ok." o. On 7/13/16 at 5:20 pm, the DNS stated, "We should have something specific to that. In the two weeks I've been here, I have not done any mandatory education as of yet. The SDC should track and monitor staff who completed abuse and neglect. My SDC would monitor all in-services. That would be the responsibility of the SDC. I don't know what our system is now. I don't know specifically how we are tracking of employees who completed what." p. On 7/13/16 at 6:00 pm, the Activity Assistant stated, "Since there has been a lot of change over, we do a lot of read and signs meaning, if there are accusations of abuse or neglect, we do read and signs. Usually a form is brought to us by the SDC, the Social Worker, or the DNS and we read it, and sign." q. On 7/13/16 at 6:50 pm, the Administrator was asked if there was a specific policy and procedure for CNA in-services on abuse and	F 224		

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F 224	Continued From page 48 neglect. The Administrator stated, "We go by what the State of Idaho regulates." 4. Resident's Rights Deficiencies: * Refer to F155 as it relates to the facility's failure to ensure Resident #11 was afforded the opportunity to direct his own care, and receive water and ice chips, with the full knowledge that doing so could result in adverse health outcomes. * Refer to F156 at it relates to the facility's admission agreement, which documented residents could hire their own private duty nursing staff if they were dissatisfied with the quantity of the facility's staff, or the quality of the care that was provided. 5. Quality of Life Deficiencies: * Refer to F241 as it relates to the facility's failure to ensure residents were treated with dignity and respect. * Refer to F244 as it relates to the facility's failure to follow up on grievances brought forward by the Resident Council. * Refer to F246 as it relates to direct care staff being instructed to intentionally place call lights out of reach, or hide them from residents due to "excessive use." 6. Quality of Care Deficiencies: * Refer to F309 as it relates to the facility's failure to adequately monitor residents with changing medical conditions; assess, treat, and monitor residents in pain; provide treatment as ordered by the physician; or obtain laboratory studies.	F 224		

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F 224	Continued From page 49 * Refer to F312 as it relates to the facility's failure to provide assistance with ADLs and grooming. * Refer to F314 as it relates to the facility's failure to implement measures to prevent pressure ulcers. * Refer to F315 as it relates to the facility's failure to ensure care and services to maintain or restore urinary continence, or maintain urinary catheters. * Refer to F322 as it relates to the facility's failure to provide stoma care for feeding tubes, and provide sufficient nursing staff to disconnect a resident from her feeding tube mechanism once the tube feeding was complete. * Refer to F323 as it relates to the facility's failure to provide adequate supervision to protect residents from falls and incidents. * Refer to F325 as it relates to the facility's failure to ensure residents were adequately hydrated. 7. Nursing Services Deficiencies: * Refer to F 353 as it relates to the facility's failure to ensure adequate nursing staff to meet resident needs. The facility's failure in this regard placed the health and safety of all residents in the facility in Immediate Jeopardy of serious harm, impairment, or death. 8. Dietary Services Deficiencies: *Refer to F363 as it relates to the facility's failure to ensure quantities of food served were consistent with a planned menu, or were nutritionally adequate. *Refer to F364 as it relates to the facility's failure to ensure food was appetizing, palatable, and served at the proper temperature.	F 224		

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F 224	Continued From page 50 10. Administration Deficiencies: * Refer to F490 as it relates to the facility's failure to ensure effective and efficient administration in the use of its resources to help residents attain or maintain their highest practicable physical, mental and psychosocial well-being. The failure at F 490 placed all residents in the facility in Immediate Jeopardy of serious harm, impairment, or death. 11. Administration Interviews: On 7/13/16 at 4:15 pm, the Administrator stated the facility had been through a number of leadership changes in the preceding months, starting with a long-time administrator and a number of staff in leadership positions leaving the facility en masse. The Administrator stated he had been working in the facility a little over four months, and when he started there was a DNS in place who was not effective. The Administrator stated he had to "go through the process" to remove the DNS, which took some time, before bringing on the current DNS. The Administrator stated the current DNS had been in place for 2 weeks prior to survey. The Administrator stated he knew the facility had some "serious problems," but had not had a chance to address them due to the short time he had been in the facility. The Administrator stated the facility had identified a staffing shortage, and had been utilizing agency nurses from four different agencies, but through their recruiting efforts anticipated they would be able to rely solely on facility staff by 8/1/16.	F 224		

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F 224	Continued From page 51 On 7/15/16 at 9:00 am, the RVP stated he had been aware of the facility staffing shortages and the use of agency staff. The RVP stated he was aware the use of agency staff could be "problematic" in terms of consistency of care, but did not think there had been significant care outcomes for facility residents. The RVP stated the facility's former parent organization had eliminated most nursing policies and procedures approximately a year prior.	F 224		
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the dignity of residents was maintained. This was true for 4 of 27 sampled residents (#4, #6, #8, and #15). The deficient practice caused psychosocial harm for Resident #4 when her self-worth declined. The deficient practice created the potential for psychosocial harm when residents were not provided the care and assistance necessary to ensure a) they did not smell of urine, b) their clothes were changed when they were incontinent, c) they received timely assistance to dress and were appropriately dressed, and d) they received showers to prevent body odors. Findings include: The facility's undated Resident Rights Policy	F 241	1. Resident #4 was assessed by RNC on 7/16/16 related to personal care needs and provided toileting assistance with no negative findings indicated. Resident #4 was assessed by Regional Clinical Reimbursement Specialist (CRS) on 8/10/16 related to toileting assistance and care plan/care card review and update provided. Resident #4 was assessed by Licensed Social Worker (LSW) on 7/26/16 regarding her psychosocial outcome; no negative outcomes indicated. Resident #6□s was assessed by RNC on 7/16/16 related to personal care needs and provided toileting and grooming assistance with no negative findings	8/12/16

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F 241	Continued From page 52 included, "This is to assure that (Name of Resident) a resident at (Name of Facility) is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs." This policy was not followed. Examples include: 1. During the initial tour of the facility on 7/11/16 at 10 a.m., LPN #9 stated Resident #4 was incontinent of urine, needed total assistance from staff with toileting, and used a bed pan. On 7/11/16 at 4:00 p.m., CNA #5 stated, "She (Resident #4) can't get out of bed on her own. It takes two people to get her up. We always put her on the bed pan to toilet her and lay her down after each meal. She is always, usually wet, and she will let us know if she needs to go. She is always incontinent and will ask for the bed pan. She can't walk to get to the toilet and can't stand, so this is why we use a bed pan for her." Review of the 12/31/15 History and Physical indicated Resident #4 had a past medical history of urinary incontinence. Review of the undated Face Sheet indicated Resident #4's admitting diagnoses included fracture of the lower end of the femur, dementia, functional urinary incontinence, and chronic kidney disease stage 3. The 1/5/16 Bladder Evaluation indicated Resident #4 had, "hx (history) of incontinence per H&P." Review of the 1/12/16 admission MDS	F 241	indicated. Resident #6 was reassessed on 8/10/16 by the Regional CRS regarding incontinence and pain; care plan was reviewed and revised to reflect current status. Resident #6 was assessed by LSW on 8/9/16 regarding her psychosocial outcome; no negative findings noted. Resident #6 continues to see her mental health provider per physician orders. Resident #8 was discharged from facility on 7/25/16; no further interventions. Resident #15 was assessed by licensed nurse on 7/16/16 in regards to care needs being met and call light being responded to timely; no additional negative findings indicated. Resident #15 validated improvement with call light response and needs being met timely. Resident #15 was assessed by LSW on 8/3/16 in regards to psychosocial outcome; no negative findings noted. 2. Residents of the facility were assessed beginning on 7/16/16 by facility and regional licensed nurses to confirm provision of cares including but not limited to hygiene, grooming, toileting/pericare, appropriate clothing; findings were addressed as indicated. 3. Root Cause Analysis by the IDT concluded that facility staff required further education regarding providing care that meets individual specific needs. Facility staff were educated beginning on 7/16/16 and again on 7/28/16 and again	

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F 241	Continued From page 53 assessment and the 6/30/16 quarterly MDS assessment documented Resident #4 had no signs of delirium, disorganized thinking, or altered level of consciousness and the BIMS score was 12 out of 15 on 1/12/16, and 15 out of 15 on 6/30/16. The 1/12/16 Admission MDS Assessment noted Resident #4, "Requires assistance with ADLs related to impaired mobility...she is able to make needs known. She is incontinent of B&B and is unaware of urge." An undated Care Plan documented Resident #4 "Is always incontinent of urine, and requires staff assistance for all ADL's related to impaired mobility, cognitive deficit." Interventions for staff were, "Toilet the resident with AM and PM care before and after meals and PRN." The undated Nurse Aide's Information Sheet stated Resident #4 was incontinent of bladder. However, there was no indication of the use of a bed pan. A 7/11/16 In-service Training document stated, "Resident is able to tell you when she needs to toilet. Please offer bed pan...She needs to be as continent as possible." On 7/13/16 from 8:15 a.m. to 11:32 a.m. (a total of 3 hours and 15 minutes) Resident #4 was observed sitting on a blue Hoyer sling in her wheelchair in the main dining room, eating breakfast, then again in her room still seated on the blue Hoyer sling in her wheelchair. During this time, Resident #4 had a strong smell of urine and no staff were observed asking her if she	F 241	on 8/10/16 by RNC/Registered Nurses/SDC regarding providing cares and services to meet residents specific hygiene/toileting/grooming and clothing needs in a dignified manner. Beginning the week of 7/18/16 Resident Council meetings have been held to provide residents opportunities to voice care concerns as a group. Beginning the week of 7/18/16 daily observations/interviews have been conducted by members of the IDT/facility management/Registered Nurses and staff/Corporate staff with residents and staff members related to provisions of resident specific care needs being met. 4. Beginning the week of 8/15/16, the members of IDT/facility management/Regional staff members will conduct an audit by observation/interview of provision of resident care needs being met by staff regarding hygiene, grooming, toileting/pericare, appropriate clothing. Audits will be conducted five times weekly for four weeks, then weekly for four weeks and monthly for two months and quarterly thereafter. A report will be submitted to QAPI committee monthly for three months for further recommendations. The DON is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 241	Continued From page 54 needed to use the restroom, or offering to assist her with using the bed pan. On 7/13/16 at 9:30 a.m., CNA #9 was interviewed and stated, "We are supposed to be offering her a bed pan, but I was not aware of a bed pan prior to this morning. There was some in-service book I was told to read today when I came in, and it just said to offer a bed pan to her. I didn't know this. I worked with her last week on Tuesday and Wednesday and I was not made aware of her using a bed pan. She is a 'heavy wetter.' When I've worked with her before, I usually lay her down after meals because she would already be wet. The other CNA working today didn't mention anything to me about a bed pan. The nurse didn't mention anything either about a bed pan. When I came in this morning, she was already wet in bed so no bed pan was offered." On 7/13/16 at 10:05 a.m., CNA #10 was interviewed and stated, "I have never given her a bed pan. I've never known her to ask for one. I'm not sure if she has ever had a bed pan or not. She is very incontinent and is usually, always wet. When I came in this morning, she was wet. The nurse never informed me of a bed pan or to even encourage her to use a bed pan. I guess we could offer her a bed side commode but I've never seen her use one." When the CNA was asked how she was made aware of each of the residents assigned to her, the CNA stated, "There is a sheet in the CNA ADL book, at the nurse's station that tells us about each resident." When the CNA was asked if she was made aware of an in-service book at the nurses' station regarding Resident #4 and the need to use a bed pan, the CNA stated, "I have never seen this	F 241		

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F 241	Continued From page 55 (referring to the in-service book) before. All I know is she (Resident #4) likes to be laid down after breakfast, but we haven't done that yet." On 7/13/16 at 10:30 a.m. LPN #4 stated, "She (Resident #4) is continent. Most of the time she lets us know when she needs to go to the bathroom and she uses a bed pan." When the LPN was asked, how staff knew Resident #4 used a bed pan, the LPN stated, the "CNAs have an ADL book that they are supposed to review and it tells them about each resident and those get updated whenever anything changes." When the CNA ADL booklet was reviewed with LPN #4 specifically for Resident #4, the LPN was asked how staff knew about a bed pan. The LPN stated, "It's not checked here. It also says the resident is incontinent and a bed pan is not checked here, so I could see how the CNAs wouldn't know." On 7/13/16 at 10:50 a.m., Resident #4 was observed sitting in her wheelchair on a blue Hoyer sling with a strong urine odor. Resident #4 was interviewed at that time and stated, "They don't let me use the bathroom because I can't walk, so I have to use the restroom in my clothes." When Resident #4 was asked how this made her feel, she stated, "Like an idiot." Resident #4 then stated, "I can't say how often they change me here. Sometimes they leave me wet for a very long time and I can't feel it coming when I have to go, so I just go, and by then it's just too late when they come around. I have really sensitive skin and I feel like I'm not worth much here." When Resident #4 was asked if any staff had offered the bed pan to her or offered to toilet her after breakfast this morning, she stated, "No, I've been sitting here in my chair this whole	F 241		

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F 241	Continued From page 56 time and I would really like to lay down." During a second interview with CNA #9 on 7/13/16 at 11:25 a.m. she was asked why Resident #4 had not been assisted to her bed or offered the bed pan after breakfast, the CNA stated, "Yeah, I know. The other CNA went to lunch and she (CNA #10) said she asked her (Resident #4) if she wanted to be laid down and said she didn't want to, so I went to lunch, and I just came back a few minutes ago. Especially with our residents who are Hoyer lifts (as she is) we need two people to transfer and since there is only one person on the unit, we can't do it by ourselves. We were planning on changing her before she goes to lunch though." During a second interview with CNA #10 on 7/13/16 at 11:30 a.m., she was asked why Resident #4 was not in bed or offered the bed pan after breakfast, the CNA stated, "Part of the reason was, I was helping other people." On 7/13/16 at 11:32 a.m., Resident #4 was observed still sitting on the blue Hoyer sling in her wheelchair and there was still a strong smell of urine coming from the resident. During an interview with CNA #22 on 7/14/16 at 5:00 a.m. she stated, "She (Resident #4) uses a bed pan and she doesn't know when she has to go so we have to change her a lot because she is incontinent." During an interview with the OT on 7/14/16 at 9:10 a.m. she stated, "She (Resident #4) could never advance to using a bedside commode because she was non-weight bearing, had a leg	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY LANE REHABILITATION AND HEALTHCARE CENTER	2105 12TH AVENUE ROAD NAMPA, ID 83686

(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 241	Continued From page 57 brace and could never make it to her feet, so it would be up to the nurses to utilize a bed pan if she couldn't get up. Nursing knows she needs to use a bed pan and I would assume that if the staff can't get her on a commode, then the way to toilet her would be with a bed pan." 2. Resident #6 was admitted to the facility on 5/1/14 with diagnoses which included RA, dysphagia, muscle weakness, joint pain, osteoarthritis, malnutrition, and chronic pain. On 7/12/16 at 8:36 am, Resident #6's bed was flat and she was lying on her back hooked up to the tube feeding pump. She was wearing a hospital gown and used a blanket to cover herself up because she was not dressed yet. She was embarrassed to have someone see her like this. Her hair was disheveled and she kept trying to push it out of her face and she kept covering her mouth because her teeth were not brushed. Resident #6 stated she wanted to get up and get dressed but could not because she was still hooked up to the tube feeding pump. She stated she was to remain in bed until nursing came and unhooked her. Resident #6 stated she liked her door open when she was not hooked up to the pump but since she would be hooked up to the tube feeding pump for extended periods of time it was closed often. On 7/12/16 at 9:00 am through 10:00 am, Resident #6 remained in her bed and hooked up to the tube feeding pump. Resident #6 asked the surveyor to get her a nurse because she really wanted to get up and get dressed. On 7/12/16 at 10:01 am, LPN #4 was informed of	F 241		

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F 241	Continued From page 58 Resident #6's request to get up. On 7/12/16 at 10:19 am, LPN #4 unhooked Resident #6 from the tube feeding pump. Resident #6 got up shortly after being unhooked from the TF pump. She could not get up to complete her morning grooming activities because she had been hooked up to the TF pump. She stated she would have to wait long periods of time before she could. On 7/13/16 at 8:39 am, Resident #6's bed was flat and she was lying on her back hooked up to the tube feeding pump. She was wearing the same clothes as the day before and used a blanket to cover herself up because she was not dressed yet. She was embarrassed to have someone see her like this. Her hair was disheveled and she kept trying to push it out of her face and she kept covering her mouth because her teeth were not brushed. She stated that she had RA and her hands could not grab things well and staff would have to help her with something's but she could manage most things. The pump had stopped pumping at 8:30 am per Resident #6. She remained hooked up to the tube feeding pump until 10:49 am when LPN #4 gave her morning medications to her. Resident #6 had a comode sitting next to her bed. The room smelled of urine and she stated she had used it in the night. It was emptied and changed at 10:39 am. On 7/13/16 at 5:45 pm, the ADON stated the tube feeding pump being left on Resident #6 was not ok. She agreed being left on the pump interfered with her ability to get up and get dressed.	F 241		

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F 241	Continued From page 59 On 7/15/16 at 10:19 am, CNA #1 stated Resident #6 gets ignored often by staff and will have to wait for extended periods of time before getting help. Resident #6 had complained that staff members would talk about her and they did not want to give her a reason to think they were talking about her. She stated Resident #6 used to have really long hair and it had to be cut because Resident #6 could not brush it out by herself, and it kept getting tangled. CNA #1 stated if staff did not have time to do cares like grooming or showers they would document the residents' refused. On 7/15/16 at 12:35 pm, Resident #6 stated she used to have long hair and it used to get tangled and it had to be cut. 3. Resident #8 was admitted to the facility on 12/23/14, with diagnoses which included hemiplegia of the left side following a CVA, dysphagia following CVA, acute respiratory failure with a tracheostomy, and muscle weakness. Resident #8's ADL Care Plan, dated 4/25/14, documented she required staff assistance for all ADL's related to left hemiplegia and history of CVA. The care plan included the intervention that Resident #8 was dependent on 1-2 staff members for extensive assistance with all cares. On 7/11/16 at 2:30 pm, Resident #8 was in her bed wearing a hospital gown and it was off of her left shoulder and her breast was exposed. On 7/11/16 at 3:27 pm, Resident #8 was scheduled to get her incontinence briefs changed	F 241		

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F 241	Continued From page 60 and staff exited her room at 3:30 pm and told an RN in the hall that Resident #8 had hit one of them and they would not be doing pericare at this time, they would try and come back later. On 7/11/16 from 3:28 pm through 3:40 pm Resident #8 could be heard calling out "I need a knife to cut this; give me something to cut this. Do something right for a change you ignorant Bitch." On 7/11/16 at 3:40 pm, Resident #8 remained in her bed wearing a hospital gown, it was off of her left shoulder and her arm was almost out of the gown. CNA #8 entered the room and helped her put her arm back in the gown. Resident #8 stated to CNA #8 she needed a knife to cut this. CNA #8 stated "what do you need a knife for?" Resident #8 stated "come here and I will show you." Resident #8 lifted up her hospital gown and tugged on her incontience briefs. CNA #8 told Resident #8 that it could not be cut because it was there to keep her incontience briefs on. CNA #8 loosened the incontience briefs and left them on the resident. Resident #8 was heard telling the CNA that she had loosened the incontience briefs and had not remove them. Resident #8 stated she needed them off because there was poop on them. CNA #8 told Resident #8 that she took care of the problem and threw the briefs in the trash. Resident #8 stated "no you did not you just loosened them." On 7/12/16 at 8:45 am, Resident #8 was wearing a hospital gown. The gown was coming off the shoulder and her breast was exposed. She attempted to lift up her gown and place it back on her shoulder. She was unable to complete this	F 241		

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F 241	Continued From page 61 task herself and the gown remained off of her shoulder. Resident #8 could be seen in the hall as people walked by her room. On 7/12/16 at 4:25 pm, CNA #19 and CNA #20 stated the facility completed peri care three times a day for Resident #8. It was scheduled to be completed in the early mornings, at about 2:45 or 3:00 pm, and after dinner. CNA #19 stated they had just completed pericare and the surveyor would have to wait until tomorrow afternoon to watch. They would come get the surveyor in the afternnon before they stated pericare. On 7/13/16 at 2:45 pm CNA #19 stated Resident #8 was not going to get pericare at this time because she was in an activity. On 7/13/16 at 5:56 pm CNA #19 stated Resident #8 did not receive peri care in the afternoon after the activity because she was up in her chair and it was about time to eat dinner. Resident #8 last pericare was early in the morning at change of shift. On 7/15/16 at 10:19 am, CNA #1 stated Resident #8's cares got neglected often because the staff did not like going into her room. Resident #8 was reported to have a history of refusing cares and the staff did not like to deal with her. CNA #1 stated Resident #8 did not reject cares if people treated her like a person and talked to her first. If staff went into her room and started "whipping her around then she would get upset." In addition, CNA #1 stated if staff did not have time to do cares like grooming or showers they would document the resident refused.	F 241		

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F 241	Continued From page 62 4. Resident #15 was admitted to the facility on 4/20/15, with diagnoses which included dementia, and chronic kidney disease stage. On 7/13/16 at 4:30 pm, Resident #15 was in his room sitting in his wheelchair about 2 and 1/2 feet from the bed. He had his head bent over and he was tearful. Resident #15 smelled of urine. When asked how he was doing, Resident #15 stated "not good." When asked "why not," Resident #15 stated he did not know what he did to deserve this, he had lived a good life, raised his kids, made good money, and now he was here. Resident #15 stated he smelled bad. Since his call light was not in his reach, the surveyor saw a CNA in the hall and CNA #16 came in the room. He started to talk to her but she interrupted him and asked if he was thirsty. He stated "yes I am so needing fluids." She gave him a drink of water. Resident #15 thanked her for the water and continued to talk. CNA #16 interrupted him and stated "Do you want to call your son in a bit that always cheers you up." He stated yes he would like that, but he smelled bad. CNA #16 did not respond to Resident #15 when he stated he smelled bad.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced	F 244		8/12/16

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F 244	Continued From page 63 by: Based on review of menus, Resident Meal Forum and Resident Council meeting minutes, and resident and staff interview, it was determined the facility failed to ensure grievances from the Resident Council and from the Food Committee were addressed for 10 residents who attended Resident Meal Forum Meetings and for all residents attending resident council meetings. The failed practice created the potential for psychosocial harm when the facility failed to acknowledge and respond to resident concerns. Findings include: 1. Resident Meal Forum concerns were not addressed. Residents met monthly with dietary staff to discuss the food and menus and to provide their input. Residents requested menu changes. Menu suggestions were raised, but no action was taken. a. Minutes from the Resident Meal Forum Meetings were reviewed from January 2016 through May 2016. No meetings were held in June or through July 19, 2016. Based on review of the minutes, residents had suggestions for foods to be incorporated into the menus as follows: 1/21/16 Minutes: * "They would like more Jello desserts." 4/18/16 Minutes: * "Discussed the rollout of the next menu series. Shooting for May 1st." * "Verified current menu that they would still like to see in the new menu, i.e. soup, instead of veggies with grilled cheese sandwiches, omelets,	F 244	F 244 1. A Resident Council meeting was held on 7/20/16 to discuss the residents concerns related to food and dietary services; the Administrator and Dietary Manager were invited to attend. On 7/21/16 the Dietary Manager/ADM followed up with residents regarding the concerns. 2. An audit of Resident Council meeting minutes for the previous three months was conducted to validate no unresolved concerns; no additional findings were indicated. Beginning on 7/18/16 the Regional and facility Dietary Managers conducted resident specific interviews for review of personal preferences and Menu review; findings were corrected as indicated. 3. Root Cause Analysis by the IDT concluded that the former facility Dietary Manager was not providing follow up in a timely manner when the Residents voiced concerns over food and menus. The Dietary Manager and Activity Director were educated by the Regional Vice President on 8/12/16 regarding resolution of concerns brought forth during Resident Council and communicating with residents so that they know what was done to resolve concerns. The Administrator will review Resident Council minutes monthly to validate documentation of resolution of concerns. Beginning on 8/10/16 the facility staff were educated on communicating	

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F 244	Continued From page 64 yogurt and cottage cheese breakfasts." * "Substitute some hamburger meals with hot dog meals." * "Some are tired of carrots and of all of the chicken choices." * "Please add cream pies to the new menu and ice cream." 5/16/16 Minutes: * "Discussed the rollout of the new menu. They understand that HCSG (food service management company) wanted me to do a complete meal rotation, as ordered, with the new menu. After the rotation then we will meet and discuss any changes that they might want to do." * "Residents want more Jello. I will work that in." b. The resident group interview was held on 7/13/16 at 11:05 a.m. with 8 residents in attendance. Five residents expressed concerns with the food. Residents verified they were served too much chicken and carrots; these were concerns previously identified in the Resident Meal Forum Meetings. c. Review of the 4-week cycle menu (regular and alternate menu items) demonstrated issues raised in the Resident Meal Forum Meetings were not incorporated into the 4-week cycle menu: * Chicken was on the menu 5 times in week 1, 8 times in week 2, 6 times in week 3, and 7 times in week 4. Concerns were raised of chicken being served too often. * Carrots were on the menu 5 times in week 1, 3 times in week 2, 4 times in week 3, and 4 times in week 4. Concerns were raised of carrots being	F 244	resident concerns, including but not limited to food concerns, by the SDC. 4. Beginning week of 8/15/16 Resident Council meeting will be conducted weekly until the Resident Council decides to decrease the frequency; the ADM and Dietary Manager have been invited to attend. The Resident Meal Forum information will be reviewed in the Resident Council meetings. The QAPI committee will review minutes of the Resident Council meetings monthly for three months to validate documentation of resolution and communication of follow up. The Administrator will be responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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	135094		07/19/2016

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F 244	Continued From page 65 served too often. * Jello was on the menu once in week 1, and once in week 2. Jello was not on the menu in week 3 or week 4. Concerns were raised of Jello not being served often enough. * Omelets were not included on the menu during the 4 weeks. Omelets were requested. * Soup with grilled cheese or grilled ham and cheese sandwich was not the menu during the 4-week cycle. Grilled cheese sandwich or grilled ham and cheese sandwich with vegetables (not soup) was on the menu twice in week 1, once in week 2, and once in week 3. A request had been made to serve grilled cheese sandwich with soup instead of grilled cheese sandwich with vegetables. * Hamburgers (or beef patties) were on the menu 8 times during the 4-week cycle menu. Hot dogs were not on the menu. A request had been made to substitute some hamburger meals with hot dog meals. * Cream pies were not included on the menu during the 4-week cycle menu. Cream pies were requested. d. The Regional Dietary Manager, facility Dietary Manager (employed at facility approximately 1 month) and the Dietitian, were interviewed together on 7/14/16 at 11:50 a.m. The Regional Dietary Manager stated a new cycle menu was rolled out approximately 2 months earlier. When asked if any of the residents' suggestions from the food committee had been incorporated into the current menus, the Regional Dietary Manager stated they had not. He stated they been instructed by the Corporate Dietitian to run through the menu cycle at least once prior to making any changes.	F 244		

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F 244	Continued From page 66 2. The Resident Council Meeting Minutes, for a meeting held on 4/18/16 at 2:30 p.m. included the concern, "Call lights not being answered timely." The facility's response, dated 4/25/16, indicated, "Call light Audit will be conducted." During an interview on 7/13/16 at 4:30 p.m., the Regional Nurse Consultant stated she would search to see if a call light audit had been conducted. On 7/15/16 at 11:15 a.m., the Regional Nurse Consultant confirmed that the call light audit had not been conducted. During the Resident Group meeting on 7/13/16 at 11:00 a.m., 8 of 8 residents stated that the answering of their call lights timely remained a problem and that they had not seen any improvements. The Resident Council Meeting Minutes, for a meeting held on 5/15/16 at 2:15 p.m., documented the concern, "Meal trays are being left in rooms overnight and all day." The facility's response, dated 5/16/16 on the Resident Council Follow-up Form, indicated "Education in-service and rounds at shift change will be done." During an interview with the AD on 7/14/16 at 11:30 a.m., the AD stated that she documented the facility's response on the Resident Council Follow-up Form but she had no evidence the education/ in-service was conducted. During the Resident Group meeting conducted on 7/13/16 at 11:00 a.m., 8 of 8 residents stated when concerns were voiced in the group meeting, the facility did not "get back with you to let you know what they plan to do to correct the	F 244		

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F 244	Continued From page 67 problem."	F 244		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, review of resident records and the facility's I&As, and staff and resident interviews, it was determined the facility failed to ensure residents had access to and the ability to use call lights. This was true for 4 of 14 sampled residents (#2, #6, #8, #15) residing in the facility. The deficient practice created the potential for more than minimal harm as residents were not provided with, or unable to request, assistance to meet their physical, psychosocial, and if necessary, emergency needs. Findings include: 1. Resident #8 was admitted to the facility on 12/23/14, with diagnoses which included hemiplegia of the left side and dysphagia following a CVA, acute respiratory failure with a tracheostomy, and muscle weakness. Resident #8's ADL Care Plan, dated 4/25/14, documented she required staff assistance for all ADL's related to left hemiplegia. Interventions documented Resident #8 was dependent on 1-2	F 246	F246 1. Residents #2, 6, 8, 15 were observed to validate that their respective call lights were in reach along with any personal items desired to be kept in reach including but not limited to the remote control where indicated by members of IDT on 7/16/16. Resident #8 discharged from the facility on 7/25/16. Resident #6 was assessed by licensed nurse on 7/16/16 regarding care needs being met and call light being responded to timely; no additional negative findings indicated. Resident #6 was assessed by Regional CSR on 8/10/16 in regards to additional toileting needs, pain and care plan/care card were reviewed and revised as indicated at that time. Resident #6 was assessed by LSW on 7/17/16 in regards to psychosocial outcome; no negative findings indicated. Resident #15 was assessed by licensed	8/12/16

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F 246	Continued From page 68 staff members for extensive assistance with all cares. On 7/12/16 at 8:45 am, Resident #8 stated the nurses took all her "communications" away yesterday during the night time. She stated "I had to yell and yell and that got old fast. I was left alone in here and they took away all my communication." Resident #8 was asked to show what was removed from her reach and she touched her call light and stated, "They took this away." On 7/14/16 at 5:05 am, Resident #8 was observed in her bed asleep. Her call light was on her pillow above her head on the left side of her body. Resident #8 was unable to use her left arm due to her CVA. On 7/14/16 at 5:46 am, Resident #8 was calling out "hello, hello, hello, Rocky." The call light remained on her pillow above her head on the left side of her body, out of Resident #8's reach. On 7/14/16 at 5:51 am, a staff member entered the room to assist Resident #8. Resident #8 stated she was thirsty and needed water. The staff member filled up her water and left the room. On 7/14/16 at 5:59 am, Resident #8 was observed to laying in bed. She had a water mug in front of her with a straw in it. She had white around her mouth, dry lips, and was licking her lips. Resident #8 kept picking up her cup and was attempting to get the straw to her mouth. She stated she was calling out for staff this morning because she could not reach her call	F 246	nurse on 7/16/16 in regards to care needs being met and call light being responded to timely; no additional negative findings indicated. Resident #15 validated improvement with call light response and needs being met timely. Resident #15 was assessed by LSW on 8/3/16 in regards to psychosocial outcome; no negative findings noted Resident #2 was discharged from the facility on 8/4/16; no further corrective actions indicated. 2. Observational audit was conducted on 7/16/16 by members of the IDT to validate call lights and desired personal items were within reach and evidence of needs being met for residents of the facility. IDT is also conducting on-going interviews and observations with residents to observe for call lights being kept in reach, timeliness of call lights being responded to and resident care needs being met. 3. Root Cause Analysis by the IDT concluded that call light placement was not being monitored to ensure that it was within reach of residents. Facility staff were educated on 7/15/16 and by RNC, on 7/21/16 by ADM/DON and on 8/2/16 by SDC regarding keeping call lights in reach for resident use, answering call lights timely, not turning call lights off until care is provided, providing care and services requested by residents timely and mechanical lifts not obstructing the hallways. The VIP daily	

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	135094		07/19/2016

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F 246	Continued From page 69 light and she was thirsty. The call light was now located on her chest near the right side of her body. She stated "I need help I don't want to dribble on myself." "Help me, why are you not helping me?" She grabbed her cup and attempted to get it to her mouth again. She could not get it to her mouth and put it down. Resident #8 stated "Are you going to help or not?" The surveyor asked her what she usually did to get help. She stated she used this and pointed to her call light. She said, "They never help me." On 7/15/16 at 8:16 am, Resident #8 was calling out "hello, hello, hello," continuously until 8:20 am. Her call light was observed above her left shoulder on the outside of the pillow and out of her reach. She had her meal tray in front of her and the food was whole and not cut up. She was observed periodically attempting to get the food to her mouth and the food kept falling off of her fork. On 7/15/16 at 8:29 am, CNA #2 exited Resident #8's room and the call light remained on the outside of her pillow on her left side. CNA #2 was asked where Resident #8's call light was and if she could reach it. CNA #2 showed the surveyor where the call light was and stated no she could not reach it were it was placed. CNA #2 was asked if Resident #8 could use her left arm effectively to reach where it was placed and CNA #2 stated no. CNA #2 moved the call light to Resident #8's chest area on her right side. On 7/15/16 at 9:50 am, the ADON was notified of the above observations. The ADON stated the call light should have been where she could reach it to call for help.	F 246	rounds sheet utilized by department heads for audits/observations of respective assigned areas of the facility was revised 8/12/16 by Regional Nurse Consultant to include validation of placement of the call light. 4. Beginning the week of 8/15/16 rounds will be conducted by department heads and members of the Interdisciplinary team to validate call lights being in reach for residents, call lights being answered timely, care and services being provided timely when requested by residents and mechanical lifts not obstructing the hallways. Audits will be conducted five times weekly for four weeks, weekly for four weeks, monthly for two months and quarterly thereafter. Resident Council meeting will continue to be conducted weekly until residents decide to decrease frequency so that ADM/designee can continue to monitor resident satisfaction. A report will be submitted to the QAPI committee monthly for three months for further recommendations. The Administrator is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 246	Continued From page 70 On 7/15/16 at 10:19 am, CNA #1 stated Resident #8's call light was often moved where she could not reach it or access it. It would be placed on the pillow or wrapped up in her blankets where she could not get it. 2. Resident #6 was admitted to the facility on 5/1/14, with diagnoses which included RA, dysphagia, muscle weakness, joint pain, osteoarthritis, malnutrition, and chronic pain. On 7/12/16 at 8:36 am, Resident #6's call light was hooked to the tube feeding pump stand and out of her reach. She stated she did not place her call light there. On 7/12/16 at 9:00 am - 10:00 am, Resident #6 remained in her bed and hooked up to the tube feeding pump. The call light remained hooked up to the tube feeding pump stand. Resident #6 asked the surveyor to get her a nurse because she really wanted to get up and get dressed and could not reach the call light. On 7/13/16 at 8:39 am, Resident #6's call light was hooked to the tube feeding pump stand and it was out of her reach until 10:49 am, when LPN #4 gave her morning medications. On 7/13/16 at 5:45 pm, the ADON stated it was not ok for call lights to be outside the reach of residents, as it is the way residents communicate with nurses. 3. Resident #15 was admitted to the facility on 4/20/15 with diagnoses which included dementia, fall, and chronic kidney disease stage.	F 246		

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F 246	Continued From page 71 On 7/13/16 at 4:30 pm, Resident #15 was in his room sitting in his wheelchair about 2 and 1/2 feet from the bed. He had his head bent over and was tearful. The call light was on his bed out of his reach. He was asked how he was doing and Resident #15 stated not good. When asked "why not?" Resident #15 stated he did not know what he did to deserve this, he had lived a good life, raised his kids, made good money, and now he was here. While talking he stated "I am so needing fluids can you help?" Since his call light was not in his reach the surveyor saw CNA #16 in the hall and CNA #16 came in the room. Resident #15 could not move himself to access the call light. On 7/15/16 at 9:50 am, the ADON was informed of the observation and agreed residents should have call lights where they can reach them to be able to call for help. On 7/15/16 at 10:19 am, CNA #1 stated Resident #15 was often not given his call light to call for help. 4. Resident #2 was admitted to the facility on 6/14/16, with diagnoses which included quadriplegia, DM, acute respiratory failure, seizures and altered mental status. Resident #2's Initial MDS assessment, dated 6/21/16, documented Resident #2 had mild depression, no cognitive impairment, and required extensive assistance of 2 staff members for all transfers, extensive assistance of 1 staff member for hygiene, dressing and eating.	F 246		

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F 246	Continued From page 72 On 7/11/16 at 2:37 pm - 3:50 pm, Resident #2 was observed laying in his bed with his call light out of reach. The call light was on his pillow behind his head. On 7/12/15 from 8:35 am - 10:35 pm, Resident #2 was observed laying down in his bed with his call light out of reach. The call light was on his pillow behind his head. The call light was moved within reach at 10:35 am. On 7/13/16 at 8:36 am, Resident #2 stated he could not always reach his call light but he did not want to complain. On 7/15/16 at 9:50 am, the ADON stated residents should have call lights so they can ask for help. On 7/15/16 at 10:19 am, CNA #1 stated Resident #2 often does not get his call light because the staff are too busy to help him.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure 1 of 27 sampled residents (Resident #9), with an ongoing program of activities relevant to	F 248	1. Resident #9 had Activity Assessment updated on 7/19/16 by Activity Director to capture current activity interest. Activity care plan was reviewed and revised to	8/12/16

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F 248	Continued From page 73 the resident's life and interests, which included computer use and outside activities. The deficient practice created the potential for psychosocial harm when Resident #9 expressed feelings of boredom and frustration. Findings include: Resident #9 was quadriplegic and had total loss of the use of all four limbs and torso. He required the assistance of 2 staff for all activities of daily living. Resident #9's annual MDS assessment, dated 6/16/16, noted that his cognitive skills for daily decision making were not impaired and he was alert & oriented. Assessment of his Preferences for Customary Routine Activities indicated that it was very important for him to do favorite activities and go outside in good weather. During interview with Resident #9 on 7/12/16 at 9:05 a.m. he stated, "I am bored to death. I would like to go outside. They do not have enough staff to take me outside. I feel bad about asking for my TV to be changed. Activities do not provide activities in room. I would like to get on the computer. I have family who are traveling overseas. I would like to be able to get on Facebook. This is where they are sharing their travel. I have a grandson who is a pistol. They share a lot about what he is doing on Facebook. I would like to be able to research some things. I have asked but nothing ever comes of it. " During interview with the Activity Director on 7/14/16 at 4:30 p.m. she stated, "He gets room visits several times a week. We visit with him quite often." When queried about the types of activities she stated, "My girls chart them."	F 248	reflect current interest. LSW assessed Resident #9 related to psychosocial outcome on 7/17/16 and again on 8/12/16; no negative findings indicated. On 8/11/16, Activity Director spoke with Resident #9□s son, who has access to adaptive equipment previously supplied by the Veteran□s Administration (VA), and Resident□s son agreed to bring the adaptive computer equipment to the facility. Resident #9 was notified and informed that the VA will be notified once the adaptive computer equipment is at the facility to provide assistance with set up. Resident #9 was in agreement to this plan to meet his preferred activity needs. Resident #9 discharged from the facility on 8/16/16 prior to his son bringing the equipment to the facility. 2. An audit of Residents□ Activity Assessments was conducted on 7/22/16 by Activity Director to validate Residents□ individual activity care plan reflects current activity interest and activity evaluation is current. 3. Root Cause Analysis by the IDT concluded that Resident #9□s current preferences were not reflected in current activity care plan. Activity Director and assistants were educated by Registered Nurse on the requirements of the regulation to provide individualized activity programs/care plans based on Resident Activity Assessment on 7/22/16.	

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F 248	Continued From page 74 Observation throughout the survey found that activity aides did not enter Resident #9's room. Only CNAs and licensed nurses, entered Resident #9's room. Resident #9's record included Activity Evaluations dated 12/28/15, 3/22/16, and 6/15/16. Each of them indicated that Resident #9 preferred to participate in scheduled activities in the morning and afternoon in his own room, in the day/activities room, inside the facility, off the unit and outside facility. Documentation that Resident #9 received activities of any type, anywhere, was lacking.	F 248	4. Beginning the week of 8/15/16, the Social Services Director will conduct five (5) resident interviews weekly to validate that individualized activity program meets the respective resident□s current activity preferences. Interviews will be conducted weekly for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee monthly for three months for further recommendations. The Administrator is responsible monitoring and compliance.	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a homelike environment was provided for resident living and common spaces. This was true for 14 of 14 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #14, #15, #16, #17) sampled residents who currently resided in the facility, residents using the facility's dining room, or hallways, and 1 of 12 (#26) residents sampled who no longer resided in the facility. The deficient practice created the potential for harm if resident's experienced	F 252	F252 1. Condiment caddies were cleaned by the Regional and facility Dietary Managers on 7/14/16. Room 105 was cleaned by housekeeping supervisor on 7/25/16. Resident #2 was assessed by licensed nurse on 7/16/16 in regards to personal care needs being met; no additional findings indicated. Room 101 was cleaned by housekeeping	8/12/16

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F 252	Continued From page 75 embarrassment about the odor in the facility, the cluttered hallways and the lack of cleanliness of items used during dining. Findings include: 1. Condiment caddies, located on the tables in the Royal Fork dining room, were observed to be soiled with sticky, gummy, accumulated food/beverage residue throughout the course of the survey. Ten of the 18 caddies were found in this condition. The caddies were made of a clear plastic and held packets of condiments such as sugar, sugar substitute, salt and pepper. Dates and times of observations were: 7/11/16 at 10:47 a.m., 7:11/16 at 2:35 p.m., 7/12/16 at 3:25 p.m., and 7/14/16 at 11:50 a.m. The Regional Dietary Manager and facility Dietary Manager observed the caddies on 7/14/16 at 11:50 a.m. with the surveyor and agreed they were soiled and needed to be cleaned. They stated dietary staff were responsible for this task and they would make sure the caddies would be cleaned right away. Resident #27's family member was interviewed on 7/13/16 at 8:15 a.m. He stated Resident #27 lived at the facility for about a month starting in mid-December 2015. Resident #27's family member stated he came to the facility regularly and was often present during meals and ate meals with his wife at least 10 times. He stated the condiment caddies were sticky and had not been washed in at least a month during Resident #27's stay. He said he brought it up to the Dietary Manager at the time. He stated, "They told me they just cleaned them a week ago." A Record of Concern, dated 1/19/16, had been	F 252	on 7/27/16 and room 114 on 7/22/16. Hall 200 was cleaned by housekeeping beginning on 7/21/16 with focus on 204, 207 & 211. Hoyer lifts were removed from the floor and designated storage areas was determined by the Administrator and Maintenance Director on 7/18/16. Tiles in hallways on 500 near theater, 300 and 500 merger and 200 hall near 207 and hall near the chapel entrance were replace by Regional and facility maintenance directors on 8/10/16. 2. Facility Dining areas were inspected by Regional Dietary Manager on 7/19/16; findings were corrected at that time as indicated. Facility wide observation was conducted by Regional Vice President and Housekeeping Supervisor on 8/10/16 for determination of source of odors; findings were addressed as indicated related to the specific cause. A facility wide observational inspection for home like environment was completed on 8/10/16 by Regional Maintenance Director related to the floors; additional findings will be corrected by 8/18/16. 3. Root Cause Analysis was conducted by IDT and determined that more focus was needed in regards to maintaining a home-like environment. The ADM/RNC/RVP reviewed the current process in the facility and amended the VIP (rounds tool) that is used by members of the IDT/facility management to make rounds in assigned areas to include monitoring for odors, cleanliness,	

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F 252	Continued From page 76 initiated by Resident #27's family member. One of the concerns identified was the cleanliness of the condiment holders. Corrective action included re-educating dietary employees on ensuring the cleanliness of equipment. 2. During the initial tour of the 100 unit on 7/11/16 at 10:15 a.m., there was a strong smell of urine and feces identified coming from room 105A and 105B. LPN #9 was interviewed on 7/11/16 at 10:30 a.m. She stated, "He (Resident #2) had a colostomy and a supra-pubic catheter." On 7/13/16 at 8:00 am, resident room 105 was observed to have a strong odor of feces and urine. On 7/14/16 at 5:00 a.m., a strong urine odor could be smelled on the 100 unit which covered rooms 101A to room 114B. 3. Resident Rooms: On 7/11/16 at 10:15 am, during the initial tour of the 200 unit, there was a strong odor of urine or feces identified coming from resident rooms 204, 207, 211, 217, and 221. On 7/11/16 at 10:45 am, CNA #24 stated: * The resident in 204B had a colostomy; * The resident in 207A had a catheter; * The resident in 207B had a colostomy; * The resident in 211A had a colostomy; * The resident in 211B had a catheter and colostomy;	F 252	items stored in halls, and floor tiles. The Meal Monitor program will provide additional monitoring. Facility staff were educated beginning on 7/28/16 and again on 8/10/16 in regards to requirement to provide a home like environment and how to report environmental concerns by the RNC and SDC. 4. Beginning the week of 8/15/16 the ADM will audit the VIP tools as well as the Meal Monitor tools weekly to validate that any concerns that are being identified are resolved and will monitor for trends. The weekly Resident Council meeting will continue until such time the residents decide to decrease frequency so that the ADM can monitor resident satisfaction. A report will be submitted to the QAPI committee monthly for three months for follow up and recommendations. The ADM is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 252	Continued From page 77 * The resident in 217A had a colostomy; * The resident in 221 had incontinent episodes during the night. On 7/13/16 at 4:30 pm, a strong odor of urine and feces could be smelled in the 200 unit which coved rooms 201A to 221B. On 7/14/16 at 5:05 am, a strong odor of urine could be smelled in the 200 unit which coved rooms 201A to 221B. On 7/14/16 at 8:26 am, during the environmental tour, a strong odor of urine could be smelled from room 221's bathroom. 4. Hallways On 7/11/16 at 2:47 pm, a Hoyer lift and a sit-to-stand were parked in the 100 and 200 unit hallways next to residents' rooms 105, 109 and 207. On 7/11/16 at 3:01 pm, the hallways in the 500's hall near the theater; between the 300 and 500 hallway merger; and in the 200 hallway near room 207 and near the chapel entrance, had stains on the floor or the floor was cracking and splitting. On 7/12/16 at 8:10 am, a Hoyer lift and a sit-to-stand were parked in the hallways near rooms 105 and 210. On 7/13/16 at 8:00 am, a sit-to-stand and a Hoyer lift were parked in the hallways near rooms 105 and 210.	F 252		

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F 252	Continued From page 78 On 7/14/16 at 5:05 am, a Hoyer lift and sit-to-stand were parked in the hallway near rooms 210 and 217. On 7/14/16 at 8:26 am, the Maintenance Director was informed of the issues related to the storage of the sit-to-stands and Hoyer lifts in the halls, the odor throughout the facility, and the stained and cracked floors. He stated the facility was working on the odor with changing out mattress and wheelchair pads. He stated the cracks in the floors were due to the seams of the building. He did agree that the odor and objects in the hallways was not homelike.	F 252		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY LANE REHABILITATION AND HEALTHCARE CENTER	2105 12TH AVENUE ROAD NAMPA, ID 83686

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F 279	Continued From page 79 This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, the facility failed to develop a comprehensive care plan with specific goals and approaches to distinguish between bowel and bladder incontinence for 1 of 27 sampled residents (Resident #4). This deficient practice had the potential to negatively impact the resident's sense of well-being, and her physical and emotional health. Findings include: During the initial tour of the facility on 7/11/16 at 10:00 a.m., LPN #9 stated Resident #4 was incontinent of urine, needed total assistance from staff with toileting, and used a bed pan. On 7/11/16 at 4:00 p.m. CNA #5 stated, "We always put her on the bed pan to toilet her. She is always, usually wet, and she will let us know if she needs to go. She is always incontinent and will ask for the bed pan." Review of the undated Face Sheet indicated Resident #4's admitting diagnoses included fracture of the lower end of the femur, dementia, functional urinary incontinence, and chronic kidney disease stage 3. Review of the 1/5/16 Bladder Evaluation indicated, "Hx (history) of incontinence per H&P (history and physical)." Resident #4's MDS assessment, dated 1/12/15, stated Resident #4, "Requires assistance with ADLs related to impaired mobility...she is able to make needs known. She is incontinent of B&B	F 279	F279 1. Resident #4 was assessed by licensed nurse on 7/16/16 related to toileting needs with no additional findings indicated. Resident #4 was assessed by Regional CRS on 8/10/16 related to incontinence/use of bed pan and preferences in care; care plan and care card were updated to reflect resident current status. 2. An audit was initiated by Regional CRS on 8/10/16 of current residents in the facility to ensure bowel and bladder assessments were current and to validate appropriateness of a bowel and/or bladder program and to ensure that care plans and care cards were updated to reflect resident□s current status; findings were corrected as indicated. 3. Root Cause Analysis was conducted by the IDT and determined that changes in resident status was not being communicated to the IDT so that care plans and care cards could be updated and residents evaluated for change in status. Resident #4 has a BIMs of 4 and usually will say she needs to use the bed pan after she has already used it, and was incontinent. Care plan was not updated to reflect the resident□s incontinent status and lack of control of bladder and need to check the resident for hygiene needs. Nursing staff were educated by RNC and SDC beginning on 8/10/16 on	

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	135094		07/19/2016

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F 279	Continued From page 80 (bowel and bladder) and is unaware of urge." An undated Care Plan documented Resident #4 "Is always incontinent of urine." The Care Plan did not include indication of the use of a bed pan. However, an additional undated Care Plan noted Resident #4 "Is at risk for alteration in bowel pattern related to history of constipation and diverticulitis." This Care Plan indicated, "Provide bed pan for bowel movements." There was no indication of the use of a bed pan related to Resident #4's urinary incontinence. A 7/11/16 In-service Training document included, "Resident is able to tell you when she needs to toilet. Please offer bed pan...She needs to be as continent as possible." During an interview on 7/12/16 at 3:45 p.m., the DON stated, "Usually the admitting nurse would be the one doing the bowel and bladder assessment and based on the assessment, if the resident is incontinent of urine, then there should be a care plan developed under urinary incontinence if they are using a bed pan or not." During an interview on 7/12/16 at 4:00 p.m., the Regional Nurse Consultant stated, "The admitting nurse does the initial bowel and bladder assessment upon admission. Once that assessment was done, then the next step would be to develop a care plan. It would be the nurse and IDT who ensures that it is done. I do see on her (Resident #4's) care plan to provide a bed pan for bowel movements only. I don't see it care planned under urinary incontinence specifically." During observations on 7/13/16 from 8:15 a.m. to	F 279	communicating change in resident status and alerting IDT when the care card does not currently reflect resident status. 4. Beginning the week of 8/15/16 the MDS Coordinator/designee will audit five residents clinical records and include review with C.N.A.s, weekly to ensure the bowel and bladder assessments are current, and care plans and care cards are reflective of current resident status. These weekly reviews will be conducted for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee monthly for three months for follow up and recommendations. The DON is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 81 11:32 a.m. (a total of 3 hours and 15 minutes) Resident #4 sat on a blue Hoyer sling in her wheelchair in the main dining room, eating breakfast, then again in her room still seated on the blue Hoyer sling in her wheelchair. During this time, Resident #4 had a strong smell of urine and no staff was observed to ask her if she needed to use the restroom, or offer to assist her with using the bed pan. During an interview on 7/13/16 at 9:30 a.m., CNA #9 stated, "We are supposed to be offering her a bed pan, but I was not aware of a bed pan prior to this morning. I worked with her last week on Tuesday and Wednesday and I was not made aware of her using a bed pan. She is a heavy wetter." During an interview on 7/13/16 at 10:05 a.m., CNA#10 stated, "I have never given her a bed pan. I've never known her to ask for one. I'm not sure if she has ever had a bed pan or not. She is very incontinent and is usually, always wet." During an interview on 7/13/16 at 10:30 a.m., LPN #4 stated, "She is continent. Most of the time she lets us know when she needs to go to the bathroom and she uses a bed pan." During an observations on 7/13/16 at 10:50 a.m. Resident #4 sat in her wheelchair on a blue Hoyer sling with a strong urine odor. During an interview with Resident #4 at that time, she was asked if any staff had offered the bed pan to her or offered to toilet her after breakfast this morning. Resident #4 stated, "No, I've been sitting here in my chair this whole time and I would really like to lie down."	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 82 During an interview on 7/13/16 at 11:45 a.m., the ADON stated, "I would assume that once the bladder evaluation was done and if the MDS indicated the resident was incontinent of urine and requires a bed pan, then that should be on the care plan under urinary incontinence but I'm not seeing it here under urinary incontinence." During an interview on 7/14/16 at 5:00 a.m., CNA #22 stated, "She (Resident #4) uses a bed pan and she doesn't know when she has to go so we have to change her a lot because she is incontinent." Resident #4's care plan did not clearly identify the type of assistance she needed to meet her bowel and bladder elimination needs.	F 279		
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 periodically reviewed and revised by a team of	F 280		8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 83 qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to update and revise care plan interventions for 2 of 27 sampled residents (Residents #6 and #7) who were dependent on staff for all or some cares. This resulted in care plans that did not accurately reflect residents' needs and created the potential for harm due to lack of care or to receive services against their wishes. Findings include: 1. Resident #6 was admitted to the facility on 5/1/14 with diagnoses which included RA, dysphagia, muscle weakness, joint pain, osteoarthritis, spinal stenosis and chronic pain. Resident #6's quarterly MDS assessment, dated 6/22/16, documented she had no cognitive impairment with minimal signs of depression. The MDS documented she was totally dependent on staff for eating due to a feeding tube. The MDS documented Resident #6 was able perform the task of transfers, dressing and ambulation with staff supervision. Resident #6's July Physician Order Review documented: * Jevity 1.5 at 65 mL/hr for 12 hours, with 150 mL of water flushes QID. (Resident #6 was to receive her medications through her PEG Tube.)	F 280	F280 1. Resident #6 was assessed by the Registered Nurse on 8/10/16 and comprehensive care plan/care card were reviewed by the Regional CRS on 8/8/16 to ensure care plan reflected current status; revisions were made as indicated. Resident #7 was assessed by the Registered Nurse on 7/16/16 and comprehensive care plan/care card were reviewed by the Regional CRS on 8/12/16 to ensure care plan reflected current status; revisions were made as indicated. 2. An audit of assessments for current residents of the facility was completed on 8/10/16 by Registered Nurses. Comprehensive care plans/care cards were reviewed and updated to reflect current status for current residents of the facility on 8/10/16 by Regional CRSs; findings were corrected as indicated. 3. Root Cause Analysis conducted by the IDT determined that nursing evaluations and comprehensive care plans/care cards did not reflect residents current status with resident change of condition and preferences. The care plan was not revised at that time and the care plan had a typographical error indicating the right gluteus versus the left gluteus that was being treated for	

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	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 84 * Resident #6 received a Modified Pureed diet with small portions beginning 6/24/16. (Resident #6 wanted off of the tube feeding and the facility was trying to transition her onto solid food food.) Resident #6's July 2016 Tube Feeding Record Sheet documented Jevity 1.5 at 65 mL/hr for 12 hours and to start at 7:00 pm. The sheet documented staff were to give 150 mL water flushes QID and to document that the head of the bed was elevated. Resident #6's Tube feeding Care Plan, dated 5/22/14, documented she was at risk for complications related to dysphagia and GERD. Interventions included: *Resident #6 was to lie down on either side or on her back for PO intake. *Staff was to flush the PEG tub before and after medications per order. *Staff was to encourage head of bed elevation. *Staff was to monitor her gastric tube intake every shift. On 7/12/16 at 8:36 am, Resident #6's bed was flat and she was lying on her back hooked up to the tube feeding pump. She stated she was lying flat without the head of the bed elevated because when the bed was elevated it hurt her back. Resident #6 stated staff had asked her to elevate the head of her bed and she stated she had slept flat on her back and did not want to change. She made no mention of staff educating her on the	F 280	Resident #7. The MDS Coordinator will coordinate with the DON/IDT to schedule quarterly evaluations to be conducted by licensed nursing staff and comprehensive care plans/care cards to be reviewed and updated on a quarterly basis. The nursing staff were educated beginning on 8/10/16 by the SDC/RNC regarding the requirement of regulation including the resident□s right to participate in care plan process and make choices regarding care and on communicating resident specific care request to the IDT. 4. Beginning the week of 8/15/16, the MDS Coordinator will conduct an audit weekly of MDS assessments due for the week, to ensure quarterly nursing assessments are current and care plans/care cards reflect resident□s current status. The weekly audit will be conducted for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee monthly for three months for further recommendations. The DON is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY LANE REHABILITATION AND HEALTHCARE CENTER	2105 12TH AVENUE ROAD NAMPA, ID 83686

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F 280	Continued From page 85 risk factors of lying flat while the tube feeding was running. Resident #6's care plan did not address her preference of laying flat through the administration of the tube feeding due to pain. On 7/13/16 at 8:39 am, Resident #6's bed was flat and she was lying on her back hooked up to the tube feeding pump. The tube feeding had run from 8:30 pm till 8:30 am. Resident #6 stated she had slept on her back through the night. On 7/13/16 at 5:45 pm, the ADON stated that since Resident #6 was refusing to elevate the head of her bed the care plan should not include reference to elevating the head of the bed. Resident #6's care plan was not updated to address her preference for receiving tube feedings while lying on her back, or interventions to enable her to do so with the head of the bed elevated. 2. Resident #7's admission nursing note dated 5/24/16, described the presence of a stage 2 pressure ulcer on his left gluteus (buttock). Resident #7 was observed on 7/12/16 at 2:30 p.m., during perineal care. A healing stage 2 pressure ulcer was noted on his left gluteus. The Weekly Pressure Ulcer form, dated 7/8/16, outlined the treatment for the pressure ulcer on his left gluteus. Resident #7's Physician's Orders, dated 5/24/16, instructed staff to cleanse his left gluteus with normal saline, pat dry and cover every 1 to 7	F 280		

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	135094		07/19/2016

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F 280	Continued From page 86 days. However, Resident #7's Admission Care Plan, dated 5/24/16, provided interventions that outlined care and treatment for Resident #7's right gluteus. During an interview with the facility's Treatment Nurse, Director of Nursing and Regional Nurse Consultant, on 7/12/16 at 2:50 p.m., they all confirmed the care plan incorrectly identified the location of Resident #7's pressure ulcer and that the care plan should have been revised.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure medications were not initialed as given on the Medication Administration Record prior to administration of the medication, and that pharmacy requisitions were complete. This was true for 2 of 5 residents (#29 and #30) observed during the Medication Pass and 1 of 1 (#26) Random Resident. This failed practice had the potential for harm if residents were documented as having received medications they either refused or were not given and when resident did not received their medication as ordered. Findings include: 1. On 7/11/16 at 3:45 pm, LN #7 was observed pre-initialing Resident #29's MAR after she put the Sennosides, Carbidopa, Ropinirole in the	F 281	F281 1. Licensed nurses were educated beginning on 7/28/16 by MDS regarding initialing Medication Administration Records after administration of medications. Resident #26 was discharged from the facility 10/1/15; no further corrective action indicated. 2. Medication Pass observations were conducted by SDC/RNC/Registered Nurses/contracted pharmacy services beginning on 7/19/16 to ensure that licensed nurses were initialing MARs after administration of medications. Contract pharmacy services conducted additional audits of orders and medication administrations with review of MARs	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

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F 281	Continued From page 87 medication cup, and prior to its actual administration. On 7/11/16 at 4:00 pm, LN #2 said she initialed the MAR after she placed the medication into the medication cup and would circle her initial if the resident refused to take the medication. She also said, "That's how I'm used to doing it." 2. On 7/12/16 at 8:45 am, LN #2 was observed to pre-initialing Resident #30's MAR after she placed the Sertraline, Omeprazole, ASA, Metoclopramide, Methimazole and Tramadol into the medication cup, and prior to its actual administration. On 7/12/16 at 9:05 am, LN #2 said she had initialed Resident #30's MAR before giving the medications to the resident and would circle her initial if Resident #30 refused to take the medications. 3. Resident #26 was admitted to the facility on 8/24/15 for rehabilitation after a surgical repair of a fractured hip. Resident #26's 8/24/15 admission orders included an order for Norco 5/325 mg, two tablets PO every 4 hours PRN for pain. Resident #26's Nurse's Notes documented: *8/26/15 at 1:00 pm, "...Family asked to fax [Physician's Name] for decrease in Norco and add an intermediate pain med. Awaiting response." A SNF Communication addressed to Resident #26's physician documented:	F 281	beginning 7/25/16; additional findings were corrected as indicated. 3. The IDT conducted Root Cause Analysis and revealed that licensed nurses were not following facility protocol for initialing MAR after medication pass administration and that Resident #26□s pain medication orders were not clarified or rewritten to include to administer Tramadol before Norco, but was added to the existing order. Licensed nurses were re-educated beginning on 8/10/16 by the SDC in regards to ensuring parameters for pain medications and insuring orders are complete or obtaining clarification. Licensed nurses were educated to follow five (5) rights of medication administration and initialing MAR after medication is administered. 4. Beginning the week of 8/15/16 the DON/SDC/designee will conduct three (3) medication pass observations weekly to ensure MARs are not initialed until after medication is administered and review new pain medication orders as a part of the morning clinical meeting process to ensure pain medication orders contain parameters. Audits will be completed weekly for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee monthly for three months for further recommendations. The DON is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 88 * 8/26/15, "Res family requesting pain medications stronger than Tylenol but not as strong as Norco? May we have an order from either Tramadol or Ultracept please. Also may we have an order change from Norco 5/325 mg 2 tabs PO Q4 PRN to 5/325 1 tablet PO Q4 as 2 tabs appears to be too much..." * 9/4/16, "Pt was recently prescribed Tramadol 50 mg...Our pharmacy will not fill the order because no quantity was noted..." Resident #26's 8/26/15 Physician's Order included an order,"Change Norco 5/325 mg to 1 tablet PO every 4 hours PRN and add Tramadol 50 mg 1 tablet PO every 4 hours PRN." Resident #26's August, September and October 2015 MARs documented an order, dated 8/26/15, for "Norco 5/325 mg take by mouth every 4 hours PRN and Ultram 50 mg take by mouth every 4 hours PRN for pain." The September and October MARs included a handwritten note,"Please use Ultram [Tramadol] before Norco PRN for pain." Resident #26's MARs documented the following information: * 8/27/15 at 7:15 pm, Norco was administered. * 8/28/15 at 3:00 pm and 11:30 pm, Norco was administered. * 8/30/15 at 12:01 am and 5:30 am, Norco was administered. * 9/2/15 at 12:00 am and 9:30 am, Norco was administered. * 9/3/15 Norco was given twice, once at an undetermined time, and at 4:20 am.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY LANE REHABILITATION AND HEALTHCARE CENTER	2105 12TH AVENUE ROAD NAMPA, ID 83686

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F 281	Continued From page 89 * 9/5/15 and from then on, Ultram 50 mg one tablet every four hours PRN for pain was administered to Resident #26. On 7/13/16 at 4:30 pm LN #2 was asked about the 9 day delay for Resident #26 to received the Tramadol. LN #2 said they had a lot of new graduate nurses during that time and if the order was incomplete the pharmacy would not deliver the medication. LN #2 also said the nurse on duty should have noticed the Tramadol was not being administered and called the pharmacy to find out why the medication was not delivered. LN #2 said the nurse who received the order for Resident #26 should have clarified the order with the physician as to when to give the Norco and when to give the Tramadol. Resident #26 did not receive the ordered Tramadol until 9/5/15. The nurses continued to give her Norco for pain even though her MAR documented, "Use Ultram before Norco."	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation; staff, resident, and family interview; review of I&As, and record review, it	F 309	F309 1. Resident #11 discharged from the	8/12/16

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	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 90 was determined the facility failed to ensure care and services necessary for residents to achieve their highest practicable physical, emotional, and psychosocial wellbeing. This was true for 5 of 27 sampled residents (#1, #2, #11, #15, and #22). As a result: a) Resident #11 was harmed when the facility failed to identify, treat, and monitor significant changes in his condition, which culminated in his hospitalization and subsequent death 2 days later. Resident #11 was also harmed when facility failed to secure his urinary catheter resulting in it being pulled out frequently, causing damage to penis and urinary tract. b) Resident #15 was harmed when he experienced pain for which he was not assessed and treated, and became tearful, expressing concern that facility staff did not listen to him. c) Resident #2 had the potential for harm when his pain was not assessed for needing pre-medication prior to wound care and needing a scheduled pain medication, given his high PRN usage and could have experienced uncontrolled pain. d) Resident #22 had the potential for harm when the facility failed to provide a helmet replacement due to the resident's craniotomy and she could have experienced further head injury. e) Resident #1 had the potential for harm when the facility failed to follow physician orders by not drawing blood to be sent out for iron and ferritin levels to be checked. Findings include: 1. Resident #11 was admitted to the facility on 10/15/15; diagnoses included paraplegia,	F 309	facility on 1/21/16; no further corrective measures indicated. Resident #15 was assessed by licensed nurse on 8/8/16 and pain evaluation was conducted. Comprehensive care plan was reviewed and revised to reflect current status. Resident #2 was discharged from the facility on 8/2/16; no further corrective actions indicated. Resident #1□s laboratory test orders were reviewed and MD notified on 7/20/16; orders received. (This sentence was duplicated on the 2567.) Resident #22 was discharged from the facility on 5/15/16; no further corrective actions indicated. 2. An audit was completed on 8/10/16 of current residents□ medical records by RNC/Registered Nurses to ensure pain evaluations were current; findings were corrected as indicated and comprehensive care plans were updated to reflect current status. An audit was completed on 8/5/16 of laboratory test orders for current residents to ensure results were obtained and provider notified; findings were corrected as indicated. 3. Root Cause Analysis was conducted by the IDT determined that MARs did not provide an opportunity for licensed nurses to document pain assessment and that there was not a tracking system in place to reconcile laboratory test results. Current residents□ MARs were updated to reflect pain evaluation every	

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F 309	Continued From page 91 neuromuscular dysfunction of bladder, dysphagia, chronic kidney disease, pressure ulcers, history of urinary tract infections, and respiratory failure. Resident #11 had a catheter, was on a ventilator, and had a tracheostomy. He resided in the facility until he was transferred to the hospital on 1/21/16, where he died two days later. a. Resident #11 had a long history of catheter use with the condition of his penis being compromised. His catheter was not adequately secured and was pulled out during his stay. The NP initiated orders on 2 different occasions to ensure Resident #11's catheter was secured; however, there was evidence his catheter was not consistently secured. The progression was as follows: Resident #11's 10/22/15 MDS assessment documented, "Long history of indwelling catheter use. Per the H&P...he has erosion from the tip of his penis which necessitated an alternate insertion site for the catheter. It is now placed in an opening under his penis, through his scrotum and requires replacement q (every) 6-8 weeks using a guide wire. It is done by a urologist at off-site appointments." The Urologic Institute History and Physical, dated 10/29/15, indicated Resident #11 had a complex history as follows: "Pt (patient) apparently has developed ventral urethral meatal erosion secondary to a long-term indwelling Foley catheter. Foley catheter changes have been done on a q (every) 6-8-week basis and have required either surgery or have been done with a catheter over wire technique. Had a suprapubic	F 309	shift by the licensed nurse on 8/1/16 by Medical Records. A new laboratory test tracking procedure was put into place on 7/28/16 by Registered Nurse; IDT and nursing administration were educated on process. Licensed Nursing staff were educated by RNC beginning on 7/22/16 regarding pain assessments for residents who cannot verbalize pain. Clinical staff were educated by SDC and RNC beginning on 8/10/16 regarding assessing residents for signs/symptoms of pain, with focus on treatments. Licensed nurses were re-educated on new lab testing tracking tool and process. Laboratory tests and tracking log are being reconcile in the morning clinical meeting process by the IDT. C.N.As were educated by SDC/RNC to notify nurses with resident concerns/indications of pain. 4. Beginning the week of 8/15/16, the Unit Managers will conduct audits by assessing pain for five residents who receive treatments to ensure pain is being evaluated around treatments and that pain evaluations and medications are being documented on the MAR. The Unit Managers will audit laboratory test tracking weekly to ensure that laboratory test, results and notifications are being conducted. Audits will be conducted weekly for four weeks, monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee monthly for three months for further recommendations. The DON will be responsible for monitoring and	

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F 309	Continued From page 92 catheter at one time and this was discontinued because it kept getting pulled out." The plan was for suprapubic catheter if possible so catheter changes could be completed at the care facility. The 10/30/15 NP's Progress Note indicated Resident #11's Foley catheter had to be inserted at the base of his penis because of flaying of his penis from the Foley use. Resident #11 was scheduled for placement of the suprapubic catheter by urology. An 11/8/15 Nurse's Note documented the CNAs finding Resident #11's catheter out on rounds. The balloon was ruptured and Resident #11 denied pulling it out. An 11/9/15 NP's Progress Note indicated Resident #11's Foley catheter came out and he was sent to the emergency department; however, the emergency department was unable to reinsert the Foley. Urology was called and recommended the catheter be left out which was done. Resident #11 was voiding some urine. An 11/11/15 NP's Progress Note indicated the urologist had to replace the catheter using a guide wire. The note documented, "We sent him to the ER over the weekend and they were unable to replace it. They contacted urology and were told to leave the catheter out as long as he was voiding yesterday when I saw him his abdomen is quite distended and painful with palpation and I was concerned that he was retaining urine. I sent him to the emergency department for further evaluation...Resident #11's Foley was replaced at the surgical center. It was not secured to his thigh so I told the staff that I	F 309	compliance. Date of Compliance: 8/12/16	

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F 309	Continued From page 93 wanted it secured to his thigh to try to prevent any further episodes of it coming out." A telephone order was written on this date as follows: "Make sure Foley is secured to his thigh." A 12/18/15 NP's Progress Note documented "S/P (status post) emergency room visit/neurogenic bladder with urinary catheter in place as previously mentioned he pulled out his suprapubic catheter and was sent to the emergency department to have it replaced. It was replaced and is now sutured in place. I told the staff that I wanted that catheter secured to his abdomen as all times. He continues to have a Foley catheter inserted that is plugged and he does have a follow up with urology scheduled." A second telephone order was written on this date as follows: "Please make sure suprapubic cath (catheter) is secured to his abd (abdomen) at all times." A 12/29/15 "Physician's Progress Note documented Resident #11 was present for a suprapubic exchange. His catheter was changed on this date. A 12/30/15 NP's Progress Note documented Resident #11 was complaining of pain around the suprapubic catheter site. Documentation indicated cream that was indicated was in use and the catheter was not secured as follows: "There was some type of whitish cream around the catheter that I removed. I asked the staff not to place any cream around that area. The catheter was not appropriately secured. I asked the staff to be sure and have his gastrostomy tube and his suprapubic catheter secured with a	F 309		

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F 309	Continued From page 94 device called a stat lock. I also demonstrated how to properly use it to the nurse." The NP was interviewed on 7/14/16 at 2:40 p.m. and stated he did not remember the specifics regarding Resident #11's catheter; however, if he documented the catheter was not secured, then it was not. The NP further stated, "It (catheter) might not come out if it was secured." Nurse #8, the charge nurse, was interviewed on 7/14/16 at 5:40 a.m. and stated it was standard nursing practice to ensure catheters were secured and it was unusual to see a physician's order for this. b. Resident #11 experienced a change in condition prior to his hospitalization on 1/21/16. There was a lack of following physician's orders for tube feeding administration, free water administration, as well as, monitoring urinary output over a 3-week period prior to 1/21/16. In the timeframe immediately preceding Resident #11's hospitalization, there was evidence he experienced a change in condition that was not identified or monitored by facility staff. The progression was as follows: On 10/21/15 the Medical Nutrition Assessment was completed. Resident #11's admission weight was 176.8 lbs. The tube feeding rate was increased from 55 to 75 cc an hour based on the dietitian's recommendation on this date. The revised tube feeding regimen provided a daily total of 1847 cc fluid daily. Resident #11 was allowed ice chips and ice cream orally and no other food or beverages. Resident #11's tube feeding orders remained unchanged through	F 309		

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F 309	Continued From page 95 date of transfer to the hospital on 1/21/16. A 10/23/15 Social Service Progress Note indicated Resident #11 was alert and able to communicate needs and preferences with a goal of weaning from the ventilator and returning to the group home where he had resided. During the course of his stay he had a number of medical issues such as his catheter coming out, Gastrostomy tube (G-tube) becoming clogged, tracheostomy coming out, having a urinary tract infection, and sustaining significant weight loss. Cross refer to F327 and F325 for details. Nurse's notes for the week preceding hospitalization documented: * On 1/15/16 at 12:00 noon Resident #11 was documented as being alert, in bed, with the tube feeding being administered, and antibiotic being applied to his right eye. * On 1/15/16 at 9:50 p.m., Resident #11's G-tube was documented as being clogged with nursing being unable to get it unclogged. He was sent to the hospital and returned with the issue resolved and the tube feeding running. * On 1/16/16 at 6:20 p.m., Resident #11's right eye was documented as being swollen with medications being given as ordered. * There were no notes on 1/17/16. * On 1/18/15 at 8:00 a.m., Resident #11 was documented as being alert and confused. Tube feeding was administered per orders, Foley intact, and continuation of antibiotic for his eye. A note at 10:30 p.m. documented tube feeding running without problems, the Foley catheter was leaking, respirations were even and unlabored.	F 309		

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F 309	Continued From page 96 Resident #11 was documented with clear speech and his needs being anticipated. * On 1/19/16 the only Nurse's Note was a Nutrition at Risk (NAR) note, written at 12:30 p.m., that documented a weight of 160 lbs with no new medications or labs being available. * There were no Nurse's Notes for a 2-day period preceding Resident #11's hospitalization, 1/19/16 at 12:30 p.m. until a note on 1/21/16 at 4:35 p.m. * A 1/21/16 Nurse's Note at 4:25 p.m., documented Resident #11 being sent to the emergency department to be evaluated for a stroke. Vital signs were oxygen saturation at 84% with an increase to 98%, heart rate 44-113, blood sugar 181, blood pressure 96/70 with Resident #11 having slurred speech. A note later that day at 10:00 p.m. documented, "No ice chips or water should be left in pt (patient's) room." * On 1/21/16 in the NP's Progress Note Resident #11 was documented with altered mental status, decreased oxygen saturation in the 80s and somnolence. He was hospitalized on this date. Resident #11 was hospitalized on 1/21/16 due to a change in mental status. The ED Physician Note at 2:50 p.m. documented, "He has quite poor hygiene, primarily oral hygiene...Oral mucosa is significantly dry with brownish crusting over tongue and oral mucosa. He is edentulous. Tongue is significantly dry with a layer of brownish crusting." The note further documented an elevated sodium lab of 190 (137-145 normal range), BUN 140 (9-20 normal range), and creatinine 2.5 (.6-1.25 normal range). Clinical impressions were, "1. Altered level of consciousness, 2. Intracranial mass, 3. Dehydration, 4. Hypernatremia (high sodium)." The note stated, "Severe dehydration and	F 309		

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F 309	Continued From page 97 rehydration high risk for cerebral edema." Resident #11 passed away on 1/23/16 in the hospital. According to the 2/5/16 hospital Discharge Summary admitting diagnoses included severe dehydration, severe hypernatremia, acute kidney injury, and acute urinary tract infection with a suprapubic catheter related. The cause of Resident #11's death was documented in full, "1. Intracranial mass, possible olfactory neuroblastoma or other malignancy of the brain. 2. Urinary tract infection, possibly secondary to suprapubic catheter with gram negative rods. 3. Gram positive cocci bacteremia, unclear source. 4. Severe hypernatremia with dehydration 5. Acute encephalopathy, possibly secondary to dyselectrolytemia [an electolyte disorder] and infection. 6. Acute kidney injury." Review of Resident #11's Tube Feeding Record for January 2016, indicated he was not provided with tube feeding and water flushes per physician's orders. There were 5 shifts, between 1/13/16 and 1/21/16, in which tube feeding administration was not signed off by nursing as being completed. There were 2 shifts on 1/14/16 and 1/17/16 in which the flush of 200 ccs was not documented as having been administered. The order for flushing the G-tube with 30-60 ccs of fluid was not documented as having been completed on night shift for the 8 days prior to Resident #11's hospitalization (from 1/12/16-1/20/16). Review of the MARs demonstrated Resident #11's output was not adequately monitored in the facility prior to his hospitalization. For the month	F 309		

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F 309	Continued From page 98 of January 2016 (through am shift on 1/21/16), catheter output was not documented for 11 out of 62 shifts. Resident #11's total output per day was not totaled for any of the days in January 2016. Of the days in which output was documented for all 3 shifts (12 days out of 21 days total), Resident #11's output averaged 1104 cc per day (per the surveyor ' s calculations). Review of Resident #11's output records for the month of October 2015, showed an average output of 1670 cc per day, demonstrating decreased urinary output, not identified by the facility, prior to Resident #11's hospitalization. Resident #11's POA was interviewed on 7/12/16 at 9:40 a.m. and stated he had cared for Resident #11 for 12 years prior to Resident #11's admission to the facility. He stated Resident #11 was not provided adequate fluids and he was severely dehydrated when he went to the hospital on 1/21/16. The POA also stated Resident #11 had a large growth at his right eye that the facility did not address adequately or timely. The POA stated Resident #11's cognition had already begun to deteriorate at the time the care plan meeting was held 1/13/16. The POA stated Resident #11 became increasingly incoherent over the last month of his life and indicated Resident #11 had been basically alert and oriented previously. The POA stated Resident #11 was very thirsty and often asked for ice chips, which he had been allowed to have previously when he was on the ventilator. The POA stated he observed Resident #11 with a dry mouth and with cracked dry lips in the week preceding his hospitalization. The POA stated, "He died at the hospital. The doctor said he didn't know how he (the resident) could get so	F 309		

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F 309	Continued From page 99 dehydrated. His electrolytes were through the roof. It was like he had been in the desert for weeks. Nobody bothered giving him fluids." 2. Resident #15 was admitted to the facility on 4/20/15, with diagnoses which included dementia, suprapubic catheter, fall with fracture, and chronic kidney disease stage III. Resident #15's quarterly MDS assessment, dated 7/8/16, documented he had a mild cognitive impairment with signs of moderate depression and no behaviors. The MDS documented he received scheduled pain medications and no PRN pain medications. The MDS documented that Resident #15 was usually understood when he communicated, but had difficulty with some words or finishing thoughts. Resident #15's Pain Care Plan, dated 4/2/15, documented he was at risk for pain related to muscle weakness, history of UTI's and bladder spasms. Interventions included: *Staff was to offer him non-pharmacological relief to include massage, repositioning, music, relaxation, and diversion. *Staff was to assess for pain each shift. *Staff was to observe him for non-verbal signs and symptoms of chronic pain. Resident #15's Hydration Care Plan, dated 3/8/16, documented he was at risk for dehydration related to alterations in cognition and dementia. Interventions Included:	F 309		

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F 309	Continued From page 100 *Staff were to offer him fluids within his diet parameters, with med passes as ordered, and PRN. *Staff was to assess Resident #15 for signs and symptoms of dehydration. Resdient #15's last Pain Evaluation, dated 6/15/16, documented his non-verbal signs of pain included: * grimacing * frowning * tearing * crying/whimpering * rocking, * rubbing body parts, * increased hand/finger movement. Resident #15's July Physician Orders included: * 37.5/325 mg Ultracet twice daily for pain. * 650 mg Tylenol every 4 hours as needed for pain. * 37.5/325 to75/650 mg Ultracet every 6 hours as needed for pain. Resident #15's May MAR indicated he was not given the scheduled pain medications 5 times. Four of the 5 times the medications were not given, the reason was not documented. The May MAR showed Resident #15's pain was not assessed during 1 shift. Resident #15's June MAR he was not given the scheduled pain medications as ordered 1 time	F 309		

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F 309	Continued From page 101 and the reason the medications were not administered, was not documented. The June MAR showed Resident #15's pain was not assessed during 4 shifts. Resident #15's July MAR up to 7/13/16, showed that on 1 occasion his pain medications were not given and the reason was not documented. The July MAR showed Resident #15's pain was not assessed for 2 shifts and no PRN pain medications were administered. On 7/13/16 at 4:30 pm, Resident #15 was in his room sitting in his wheelchair about 2 and half feet from the bed. He had his head bent over and he was tearful. He was holding on to his right wrist and was rubbing it. He started to rock back slightly in his chair. The call light was on his bed out of his reach. Resident #15's water cup was on a dresser at the foot of his bed out of his reach and he smelled of urine. He was asked how he was doing and Resident #15 stated "not good." When asked "why not," Resident #15 stated he did not know what he did to deserve this, he had lived a good life, raised his kids, made good money, and now he was here. As Resident #15 was talking it was observed his mouth had a white crusty looking film around it and he kept licking his lips and his mouth had a thick looking mucus in it. During the interview Resident #15 stated "I am so needing fluids can you help?" Resident #15 expressed pain all over his body, as well, and stated that he smelled bad. Since his call light was not in his reach, the surveyor noticed a CNA in the hall and CNA #16 came in the room. Resident #15 started to talk to CNA #16, however, she interrupted him and asked if he was thirsty. He stated "yes I am so	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

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F 309	Continued From page 102 needing fluids." She gave him a drink of water, then returned the water cup back to the dresser at the foot of the bed, out of Resident #15's reach. Resident #15 thanked her for the water and continued to talk. CNA #16 interrupted him and stated "Do you want to call your son in a bit that always cheers you up." He stated yes he would like that but he smelled bad. CNA #16 stated she would be back in a bit to get him to dinner. Resident #15 was still tearful and stated he did not want to go to dinner. She left the room before he could finish talking and he could tell her he hurt. The surveyor asked Resident #15, "who can you tell about your pain?" and he stated he tried to tell her [CNA #16]. The surveyor told Resident #15 he should try again to talk with CNA #16 about his pain when she came back. Toward the end of the interview, CNA #16 returned to Resident #15's room and and started talking to him again and told him she was going to put him to bed since he did not want to go to dinner and she would get him a dinner tray. CNA#16 did not notice Resident #15's non-verbal signs of pain and did not wait for him to communicate his needs. 7/14/16 at 9:48 am, the ADON stated the facility documented pain assessments once per shift. She stated if a resident had pain at other times it would be on the PRN pain medication administration sheet. Issues were discussed with ADON related Resident #15's difficulty communicating and that is was observed that staff did not assess him for pain during the above observation/interview, when Resident #15 was tearful, held onto and rubbed his wrist, had his head bent over, and was rocking in his chair. She stated there was not a place on the MAR for	F 309		

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F 309	Continued From page 103 random pain checks for residents who had dementia or could not communicate their pain needs well. The staff was to watch for non-verbal signs of pain and tell an RN who could then administer PRN pain medications. 3. Resident #2 was admitted to the facility on 6/14/16 with diagnoses which included functional quadriplegia, neurogenic bladder, chronic pain, left above the knee amputation, DM, acute respiratory failure, seizures and unstageable pressure sore to the right ankle. Resident #2's Initial MDS assessment, dated 6/21/16, documented Resident #2 had no cognitive impairment and mild depression. The MDS documented he received PRN and scheduled pain medications. It documented Resident #2 was admitted with a un-stage pressure ulcer no location was specified. Resident #2's July Physician Orders Review documented: * 650 mg of Tylenol every 4 hours as needed for pain, beginning 4/26/16. * 5-10mg of Oxycodone every 4 hours as needed for pain, beginning 6/14/16. Resident #2's orders did not include a routinely scheduled pain medication. Resident #2's hospital H&P, dated 4/24/16, documented he had received PRN Tylenol and Oxycodone as ordered above, for pain and also had a scheduled pain medication of 25 mcg Fentanyl patch which was changed every three	F 309		

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F 309	Continued From page 104 days. The H&P documented Resident #2 had a reaction to the Fentanyl patch and it was discontinued. Resident #2's MAR from 6/14/16 to 7/12/16, documented PRN Oxycodone was administered 15 times and Tylenol PRN was administered one time for pain. Resident #2's Pain Management Flowsheet from June 2016 documented an additional 4 doses of Oxycodone administered 6/16/16 at 4:00 am, 6/20/16 at 3:00 pm, 6/21/16 at 8:00 pm, and 6/22/16 at 2:45 pm. The administrations were not documented on the MAR. Resident #2 was administered Oxycodone PRN 19 times in 28 days [6/14/16 to 7/12/16]. Resident #2's average pain rating from the June 2016 Flowsheet was 7.78 on a scale of 1-10, with 10 being the worst. On 6/14/16, Resident #2 Nurses' Notes documented he complained of neck pain. On 6/16/16, Resident #2's Nurses' Notes documented he complained of pain. On 6/17/16, Resident #2's MD progress note documented he had chronic pain and used Tylenol and oxycodone when necessary. On 6/27/16, Resident #2's Nurses' Notes documented he complained of pain after a shower. On 6/30/16, Resident #2's Nurses' Notes documented he complained of pain in his back. On 7/14/16 at 10:38 am, Resident #2 was	F 309		

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F 309	Continued From page 105 observed during a dressing change to his heal wound. Resident #2 was sitting up slightly in bed and the dressing change started. There was no observation of pre-medication offered to Resident #2. While positioning Resident #2 to work on his multiple skin issues, the wound nurse started to move the bed position and move Resident #2. Resident #2 closed his eyes, started grimacing and made a hissing sound. The dressing change and skin assessment continued. On 7/15/16 at 9:50 am, the ADON stated that residents get assessed once a shift for pain. The facility could not provide documentation that pre-medication was offered prior to wound care. In addition, the facility could not provide documentation that Resident #2's chronic pain had been addressed in regards to his frequent use of PRN pain medication as a sign he needed a scheduled pain medication. 4. Resident #1's clinical record documented a Diagnosis and Assessment document, dated 6/30/16 at 1:15 p.m., which noted Resident #1 had a past medical history of chronic kidney disease and abnormal laboratory values. Resident #1's Physician's Orders included an order to obtain an iron and ferritin level for the month of June 2016. Documentation on the Diagnosis and Assessment form included a notation by Resident #1's Physician that stated, "I had ordered an iron and Ferritin level that I do not see." On 7/14/16 at 11:15 a.m., the Regional Nurse Consultant confirmed the laboratory had not	F 309		

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F 309	Continued From page 106 been made aware of the Physician's order and the laboratory tests were not drawn. During a phone interview on 7/15/16 at 11:30 a.m., with the facility's Nurse Practitioner, he stated that staff often failed to ensure labs were drawn. He stated he does not know why this had been occurring. 7. Resident #22 was admitted to the facility on 10/29/15 in comatose state with a history of hemorrhagic stroke and craniotomy on 9/21/15, where part of her brain was removed. Resident #22's skullcap was not replaced. Resident #22's MDS Assessment, dated 11/14/15, documented, she was totally dependent on staff for all of her ADLS. Review of Resident #22's Nurse's Notes documented: *10/29/15 , "...resident skull bone flap out. Order for helmet for OOB [out of bed]..." *4/26/16 at 6:00 am, "...hoyer transfer [with] helmet on..." Resident #22's Social Services Progress Note, dated 10/30/15, documented the resident was to wear a helmet when she was out of bed. Resident #22's October and November 2015 MAR had no documentation of her using a helmet when she was OOB. A Resident Care Conference, dated 1/21/16, documented "Nursing will get, ask for an order for a helmet to be used when going to the shower." Resident #22's Physician Order, dated 1/27/16,	F 309		

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F 309	Continued From page 107 documented "Ok for Helmet when OOB." Resident #22's February 2016 MAR documented an order, dated 1/27/16, she was to use a helmet when she was OOB. Resident #22's NP's Progress Note, dated 2/8/16, documented Resident #22's family member had called that morning and had some concerns about Resident 22's rashes on her arms, skin damage to her heels, and skin breakdown on her buttocks. The family member also inquired about a helmet to be used when Resident #22 was out of bed because she was missing part of her skull. The NP's Progress Notes also documented he had already ordered a helmet to be used by Resident #22 when she was up and out of bed. On 7/14/16 at 9:50 am, the Wound Nurse said Resident #22 had a helmet but she cannot remember when it was ordered or when Resident #22 started using it. She said it was used whenever Resident #22 was out of bed for her shower. There was no documentation found on the Resident #22's clinical record that she was provided with a helmet when she was out of bed, until 1/27/16 when it was ordered by the NP. 7. Resident #1's clinical record documented a Diagnosis and Assessment document, dated 6/30/16 at 1:15 p.m., which noted Resident #1 had a past medical history of chronic kidney disease and abnormal laboratory values. Resident #1's Physician's Orders included an	F 309		

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F 309	Continued From page 108 order to obtain an iron and ferritin level for the month of June 2016. Documentation on the Diagnosis and Assessment form included a notation by Resident #1's Physician that stated, "I had ordered an iron and Ferritin level that I do not see." On 7/14/16 at 11:15 a.m., the Regional Nurse Consultant confirmed the laboratory had not been made aware of the Physician's order and the laboratory tests were not drawn. During a phone interview on 7/15/16 at 11:30 a.m., with the facility's Nurse Practitioner, he stated that staff often failed to ensure labs were drawn. He stated he does not know why this had been occurring.	F 309		
F 312 SS=G	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, and resident family interview, the facility failed to provide assistance with ADLs for 6 of 27 sampled residents (#6, #7, #8, #11, #25, and #26) who required staff assistance for all or some of their ADLs. Resident #11 was harmed when he did not receive oral care and his mouth contained a brownish crust when he was admitted to the hospital. Resident #25 was harmed when her hair became so matted and	F 312	F312 1. Resident #11 was discharged from the facility on 1/21/16; no further corrective action indicated. Resident #25 was assessed by licensed nurse on 7/16/16 and LSW on 7/17/16. Per resident statement, Resident #25 stated she requested her hair be cut short after returning from the hospital. On 7/16/16 resident appeared well groomed	8/12/16

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F 312	Continued From page 109 tangled from the lack of assistance with grooming that she had to have her head shaved. Residents #6 and #8 had the potential for psychosocial harm when they were not provided with grooming or hygiene to meet their needs and were observed unkempt, odorous and soiled which could lead to feeling a loss of self-worth. Residents #26 and #7 were at risk of harm when they did not receive bathing or oral hygiene care consistent with their needs. Findings include: 1. Resident #11 was admitted to the facility on 10/15/15; diagnoses included paraplegia, neuromuscular dysfunction of bladder, dysphagia, and respiratory failure. Resident #11 had a urinary catheter, was on a ventilator, and had a tracheostomy. He was transferred to the hospital on 1/21/16. The 10/22/15 admission MDS assessment indicated Resident #11 usually made himself understood and usually understood others. The assessment documented he was totally dependent on staff for eating and required the assistance of one staff. He was documented as having a swallowing disorder and receiving nutrition via a feeding tube. The ADL care area assessment (CAA) indicated Resident #11 was dependent for all ADLs due to limited mobility of his arms and legs. Resident #11's care plan, dated 12/30/15, identified the problem of requiring staff assistance to maintain personal hygiene due to paraplegia and contractures. The goal was, "Will be clean, dry, odor free and dressed appropriately for season, place and time of day through review date." Pertinent care plan	F 312	and was assessed as having her care needs met. Resident #6□s was assessed by RNC on 7/16/16 related to personal care needs and provided toileting and grooming assistance with no negative findings indicated. Resident #6 was reassessed on 8/10/16 by the Regional CRS regarding incontinence and pain; care plan was reviewed and revised to reflect current status. Resident #6 was assessed by LSW on 7/17/16 regarding her psychosocial outcome; no negative finding noted. Resident #8 was discharged from the facility on 7/25/16; no further corrective action indicated. Resident #26 was discharged from the facility on 10/1/15; no further corrective action indicated. Resident #7 was assessed by licensed nurse on 7/16/16 for oral care needs; resident appeared well groomed and oral care needs had been met. 2. Regional/members of IDT/facility licensed nurses performed an audit by assessing the needs of current residents of the facility beginning on 7/16/16 to determine if resident specific care needs were performed; findings addressed as indicated. 3. Root Cause Analysis was conducted by IDT and determined that direct care staff did not follow resident care plan/care card for provision of care needs and that changes in resident specific care needs were not being communicated to IDT so that care plan and care card could be	

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F 312	Continued From page 110 approaches were, "I am dependent on one person for oral care ...Provide oral care at least 2x (twice) shift (added 1/18/16). " Record review demonstrated concerns with Resident #11's oral hygiene, as follows: * A 1/11/16 Speech Therapist Progress note indicated a concern with oral care, "Patient/care giver training - Education re: risks of aspiration and PNA (pneumonia) with poor oral care. " * The 1/13/16 Resident Care Conference form included, "Family Input: Oral care concerns ..." * A 1/19/16 Speech Therapist Progress note included, "Oral care continues to be a challenge. Initiation of staff education re: necessity of completing oral care up to 4x (4 times) a day, along with, how oral care should be completed." Resident #11 was hospitalized on 1/21/16 due to a change in mental status. The ED Physician Note, documented at 2:50 p.m., stated "He has quite poor hygiene, primarily oral hygiene...Oral mucosa is significantly dry with brownish crusting over tongue and oral mucosa. He is edentulous. Tongue is significantly dry with a layer of brownish crusting." Resident #11's POA was interviewed on 7/12/16 at 9:40 a.m. The POA stated Resident #11's mouth was dry and he was not provided with adequate oral care. Concerns regarding his oral hygiene were raised at the care plan meeting held on 1/13/16. The SLP was interviewed on 7/14/16 at 10:10	F 312	revised. Miscommunication between respiratory therapy and direct care staff was identified. Beginning on 7/15/16 the Respiratory Manager educated respiratory staff on providing oral care twice a day and as indicated. Facility staff were educated by RNC beginning 7/16/16 regarding ensuring resident care needs are met in timely manner, following care plan and care card for care provisions and reporting changes in resident care needs to the IDT so that care plan and care card can be updated to reflect changes in resident care needs. Members of IDT/facility Registered Nurses began making daily rounds to observe for provision of resident care and the VIP tool was updated to assist in monitoring for those needs being met on 8/12/16. Beginning on 8/10/16 the SDC educated the facility clinical staff on ensuring that resident care needs are being provided per the care plan and care card and that refusals are communicated to licensed nurses. The ADM/designee will meet with Resident Council weekly, until Resident Council determines to decrease frequency, to discuss any outstanding concerns regarding care. 4. Beginning the week of 8/15/16 the finding of the VIP tool used in daily rounds by the IDT/Registered Nurses will be reviewed in morning clinical meeting. The ADM will audit VIP tool five times weekly and will report findings to the QAPI	

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F 312	Continued From page 111 a.m. and stated Resident #11 had increased salivary secretions which resulted in him having a lot of, "gunk in his mouth." She stated he had dry lips and had increased needs for oral care. She stated she instructed staff how to provide oral care as he was at risk for aspiration due to the contents in his mouth. CNA #13 was interviewed on 7/13/16 at 3:15 p.m., and stated the respiratory therapist did oral care once per shift and the CNAs did it in between. CNA #1 was interviewed on 7/15/16 at 10:10 a.m. and stated there was not enough staff to take care of the residents. She stated there were a number of instances when she came on her shift and found Resident #11 without oral hygiene having been provided. She stated, "He never got oral care done." 2. Resident #25 was readmitted to the facility on 3/22/16 with diagnoses that included paraplegia and respiratory failure. Resident #25's 5/5/16 Quarterly MDS assessment documented she was cognitively intact, had minimal depression, displayed physical behavioral symptoms 1-3 days of the previous 7 days, and was dependent on two staff for bed mobility and personal hygiene. On 7/15/16 at 10:10 a.m., CNA #1 was interviewed and stated there was not enough staff to take care of the residents. She said there were several female residents whose hair did not get brushed that resulted in severe tangling and matting. CNA #1 stated Resident 25's hair was so	F 312	committee monthly for three months for further recommendations. The ADM is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 312	Continued From page 112 matted, her head had to be shaved. Resident #25 was interviewed on 7/15/16 at 11:15 a.m. She was lying in bed in a hospital gown. Her hair was short, approximately 1/2 inch long. Resident #25 was on a ventilator with a trach in place. The respiratory therapist came into the room and provided treatment that would enable her to talk and then left the room. Resident #25's mouth was dry with a white substance around her lips and a foul odor emanated when she spoke. She had difficulty speaking. When asked if she was provided oral care and baths, she said, "No." When asked if staff brushed her hair, she said they did not and stated her hair was tangled and matted prior to it being cut. 3. Resident #6 was admitted to the facility on 5/1/14, with diagnoses which included RA, dysphagia, muscle weakness, joint pain, osteoarthritis, malnutrition, and chronic pain. Resident #6's quarterly MDS assessment, dated 6/22/16, documented she had no cognitive impairment with minimal signs of depression. The MDS documented she was totally dependent on staff for eating due to a feeding tube. The MDS documented Resident #6 was able perform the task of transfers, dressing and ambulation with staff supervision. Resident #6's ADL Care Plan, dated 5/1/14, documented she required supervision while performing ADL's but may require some staff assistance with grooming, hygiene, oral care, dressing, toileting, and bathing related to weakness and RA. Interventions included:	F 312		

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F 312	Continued From page 113 Resident #6's Care Plan did not address how often she would like to receive a bath or shower; address her grooming preferences; and her clothing preferences. Resident #6's June 2016 ADL Records documented Resident #6 refused a shower on 6/26/16. The facility could not provide documentation regarding the refusal or of attempts to reapproach and encourage her to take a shower. On 7/13/16 at 5:45 pm, the ADON stated they did not document reapproaches when showers were refused, however, staff were to reapproach and to look in the nursing notes. The nursing notes did not include documentation of reapproach or shower refusal. On 7/15/16 at 10:19 am, CNA #1 stated Resident #6 got ignored often by staff and had to wait for extended periods of time before getting help. She stated Resident #6 used to have really long hair and it had to be cut because Resident #6 could not brush it out by herself, and it kept getting tangled. CNA #1 stated if staff did not have time to do cares like grooming or showers they would document the resident refused. On 7/15/16 at 12:35 pm, Resident #6 stated she previously had long hair and it got tangled often and had to be cut. She stated she liked her haircut now because it was not heavy on her head or as much maintenance. The facility failed to ensure Resident #6 was appropriately assisted with bathing, grooming	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

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F 312	Continued From page 114 and personal hygeine. 4. Resident #8 was admitted to the facility on 12/23/14, with diagnoses which included hemiplegia of the left side, dysphagia following CVA, acute respiratory failure with a tracheostomy, and muscle weakness. Resident #8's Quarterly MDS assessment, dated 6/14/16, documented she had moderate cognitive impairment with mild depression, and required the assistance of 1 to 2 staff for all cares, except eating. The MDS documented Resident #8 rejected cares 1-3 days per week and was totally dependent on the assistance of two staff for toileting. Resident #8's ADL Care Plan, dated 4/25/14, documented she required staff assistance for all ADL's due to left hemiplegia. Interventions included: *Resident #8 was dependent on 1-2 staff members for extensive assistance with all cares. Resident #8's Care Plan did not address how often she would like to receive a bath or shower, her grooming preferences, and her clothing preferences. On 7/11/16 at 2:30 pm, Resident #8 was in her bed wearing a hospital gown. The gown was off of her left shoulder and her breast was exposed. On 7/11/16 at 3:40 pm, Resident #8 remained in her bed wearing a hospital gown. The gown was off of her left shoulder and her arm was almost out of the gown. CNA #8 entered the room and	F 312		

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F 312	Continued From page 115 helped her put her arm back in the gown. On 7/12/16 at 8:45 am, Resident #8 was wearing a hospital gown. The gown was coming off the shoulder and her breast was exposed. She attempted to lift up her gown and place it back on her shoulder. She was unable to complete this task herself and the gown remained off of her shoulder. On 7/12/16 at 4:25 pm, CNA #19 and CNA #20 stated the facility completed pericare three times a day for Resident #8. It was scheduled to be completed early in the morning, at about 2:45 or 3:00 pm, and after dinner. On 7/13/16 at 2:45 pm, CNA #19 stated Resident #8 was not going to get pericare at that time because she was in an activity. On 7/13/16 at 4:34 pm, the ADON stated residents should be checked on whenever staff had contact with them, or at a minimum of every two hours. This was to include all cares. The ADON stated staff should provide pericare whenever there was an episode of incontinence. On 7/13/16 at 5:56 pm, CNA #19 stated Resident #8 did not receive pericare in the afternoon after the activity because she was up in her chair and it was about time to eat dinner. Resident #8 last pericare was early in the morning at change of shift. On 7/15/16 at 10:19 am, CNA #1 stated Resident #8's cares got neglected often because the staff did not like going into her room. She stated Resident #8 did not reject cares if people treated	F 312		

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F 312	Continued From page 116 her like a person and talked to her first. If staff went into her room and started "whipping her around then she would get upset." CNA #1 stated if staff did not have time to do cares, like grooming or showers, they would document the resident refused. 5. Resident #26 was admitted to the facility on 8/24/16 for rehabilitation after a surgical repair of a fractured hip. Resident #26's admission MDS assessment, dated 8/31/16, documented she was cognitively intact with BIMS of 15, and required two person assistance for transfers and one person assistance for hygiene and bathing. The MDS documented she had impairment on one side of her lower extremity and had used wheelchair for mobility. The MDS also documented she did not reject of cares and it was very important for her to choose between tub bath, shower, bed bath, or sponge bath. Resident #26's Care Plan did not addressed how often she would receive a bath or shower. Resident #26's ADL Record for August 2015, documented she had refused her bath three times on 8/25/15 and the nurse was notified. Between 8/26/15 and 8/31/15, Resident #26 did not received a bath. There was no documentation in her ADL record that she refused her bath on those days. On 7/15/16 at 9:55 am, CNA #1 said Resident #26 had not refused her bath or shower but would like her bath or shower to be done in her own way and not be rushed, and staff would not	F 312		

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F 312	Continued From page 117 accommodate it. 6. Resident #7's clinical record documented diagnoses which included, but were not limited to, stroke, quadriplegia, respiratory failure, and ventilator dependent. His admission Minimum Data Set, dated 5/31/16, stated he required total assistance from staff for performance of personal hygiene. Resident #7's care plan, dated 5/24/16, documented he required assistance with oral care related to quadriplegia. During an observation of Resident #7 on 7/12/16 at 8:30 a.m., his lips and oral cavity were cracked and dry. During an interview on 7/12/16 at 9:15 a.m., with the manager of the respiratory therapy team, she stated her staff were responsible for oral care, as well as, the nurses.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to provide services to prevent the development of pressure	F 314	1. Resident #1 was evaluated by the Unit Manager on 7/22/16, plan of care was updated; pressure wounds to	8/12/16

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F 314	Continued From page 118 ulcers, promote healing of pressure ulcers and adhere to infection control measures designed to prevent cross contamination resulting in the development and worsening of avoidable pressure sores for 5 of 5 residents (#s 1, #2, #8, #10, and #22) with pressure ulcers. As a result: a) Resident #1 was harmed when he developed a Stage III pressure ulcer on his left heel and a Stage II pressure ulcer on his right heel. b) Resident #2 was harmed when a blister on his right heel worsened to an unstageable pressure ucler. c) Resident #22 was harmed when she developed multiple Stage II pressure ulcers on her coccyx and a blood blister on her left great toe. d) Residents #8 and #10 experienced the potential for harm when they were not turned or their skin was not monitored, placing them at risk for developing pressure ulcers. Findings include: 1. Resident #22 was admitted to the facility on 10/29/15 in a comatose state, with a trach, and required a ventilator. She was morbidly obese and had history hemorrhagic stroke and underwent a craniotomy on 9/21/15 where part of her brain was resected. Resident #22's skullcap was not replaced and the bone flap from her skull was implanted into her abdomen. Resident #22's 11/14/15 MDS Assessment documented the following regarding her status: * Totally dependent on staff and required extensive assistance of two persons for all her ADLs * Had an indwelling catheter	F 314	bilateral heels are now resolved. Resident #2 was discharged from the facility on 8/4/16; no further corrective actions indicated. Resident #8 was discharged from the facility on 7/25/16; no further corrective actions indicated. Resident #10 was discharged from the facility on 7/28/16; no further corrective actions indicated. Resident #22 was discharged from the facility on 5/15/16; no further corrective actions indicated. 2. Beginning on 7/20/16 a skin audit was conducted of residents by the Unit Manager and licensed nurses to ensure residents skin was intact or had necessary treatments for skin conditions in place; concerns were addressed at that time. 3. Root Cause Analysis conducted by the IDT determined that documentation of interventions and necessary changes to the plan of care for residents with compromised skin was not consistent, communication of changes to skin condition was not consistent when noted nor were the weekly body audits or weekly measurements consistently documented. Beginning on 7/28/16 clinical staff were educated on prevention of pressure ulcer program by the Unit Manager/RNC. Beginning on 8/10/16 the facility staff were educated on prevention of pressure ulcers, notifying licensed nurses of	

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F 314	Continued From page 119 * At risk of developing pressure ulcers * Did not pressure ulcer(s) at Stage 1 or higher * Had surgical wounds on her abdomen * Her skin and and ulcer treatment was, "pressure reducing device for bed." * On turning reposition program Resident #22's care plan documented: * Resident #22 was at risk for impaired skin integrity related to persistent vegetative state and lack of purposeful movement. * Skin Integrity Risk: High * Use lotion to ensure skin is well moisturized * Watch for skin tears or reddening of the skin * Ensure that direct care staff are aware of skin risk * Place resident on a pressure reducing cushion in wheelchair, if used. * Keep heels and other areas covered to reduce friction. * Monitor skin condition on a weekly basis and PRN with bath. * Do ROM with daily dressing to increase circulation. * Air mattress to bed to decrease risk of impaired skin integrity. Check function frequently. Resident #22's care plan did not document the need to float her heels or wear a protective boots. Resident #22's Weekly Non-Pressure Skin Report for her right buttock documented on 10/29/15, "excoriated R [right] buttock" and on 4/6/16, "healed" Resident #22's Weekly Non-Pressure Skin	F 314	change in skin condition and licensed nurses following up to ensure interventions are put into place and that the plan of care is updated to reflect current status. Licensed nurses were educated regarding completion and documenting weekly body audits. The treatment nurse was educated by the Unit Manager regarding ensuring weekly measurements are provided. 4. Beginning the week of 8/15/16 the DON/IDT will review three comprehensive care plans to ensure current care plans reflect education of risks associated with resident care choices that have potential risks. Weekly body audits and measurements of the wounds will be audited by the DON/designee during the weekly Persons at Risk (PAR) meeting. The Unit Managers will observe five (5) treatments each week to ensure care plan interventions are in place and being followed during the treatments. The reviews will be conducted weekly for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee monthly for three months for further recommendations. The DON is responsible for monitoring and compliance.	

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F 314	Continued From page 120 Report for her left buttock documented: *4/6/16, buttock was excoriated, measuring 0.3 cm x 0.7 cm x 0.1 cm *4/13/16, buttock was excoriated, measuring 1.2 cm x 0.8 cm x 0.1 cm *4/21/16, resolved There was no skin report on Resident #22's blood blister on her L great toe. Resident #22's Nurse's Notes documented the following: * 11/4/15 at 7:00 pm, "...Pt buttocks appears to be peeling possibly due to increased loose stool. Bacitracin applied with a non adherent dressing. Pt to be placed on side and buttock up off relieving pressure..." *11/6/15 at 11:15 am, "Checked area on coccyx. Applied Z Guard for protection. Order for Z Guard TID until healed..." *11/10/15 at 6:00 am, "...Resident has wound on coccyx area, wound nurse contacted to observe..." *1/8/16 at 2:00 pm, "Clean sacrum w/ NS. Apply there honey and sacral dressing [change] M-W-F." *1/10/16 at 3:30 am, "Resident shearing to coccyx covered with dressing..." *2/2/16 at 4:00 am, "...Silvasorb to open area on coccyx use optifreeze to cover...Get Res. off bottom every 2 hours. Do not pull her up in bed without lifting her bottom off bed because of	F 314		

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F 314	Continued From page 121 shearing. LPN to evaluate each time she is turned." *2/7/16 at 1:05 am, "...Wound to coccyx has 2 open areas to upper [cheeks]..." *2/8/16 at 3:00 pm, "Ok for Prevalon boots. When you turn her I want her completely off the open areas..." *2/21/16 at 10:00 pm, "...Res has new blood blister on L toe which is being monitored by wound nurse. Family stated they were not happy about this." *2/23/16 at 9:00 am, ...[family] concerned re; new blood blister on her L big toe and dsg to coccyx off since [after]shower ..." *2/26/16 at 11:00 am, "...NP on rounds today and viewed resident's bottom and requested we place a wedge pillow..." An NP Progress Note dated 2/8/16 documented, the Resident #22's family had called him and had some concerns about skin damage to Resident #22's heels and skin breakdown on her buttocks. The NP assessed Resident #22 to have "Buttocks stage I and 2 wounds- the skin on her buttocks is moist and a bit erythematous- she has 2 small circular stage II wounds on her buttocks cheeks. The wound nurse is following her routinely." The NP told the staff he wanted the resident off her buttocks routinely and to be repositioned from side to side every 2 hours. A Physician's orders documented the following: *11/6/15, "Z Guard to coccyx TID til healed"	F 314		

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F 314	Continued From page 122 *1/8/16, "Clean sacrum with NS. Apply thera honey and sacral dressing change M-W-F." *2/4/16, "Get off her bottom every Q hrs. Do not pull her up in bed without lifting her bottom off bed-shearing. Use Z Guard each time she is turned." *2/5/16, "Apply Optifoam AG and cover with ..." *2/8/16, "Ok for Prevalon boots" *2/26/16, "Place wedge pillow under her bottom" *2/29/16, "May [discontinue] Optifoam to buttocks. Continue Silvasorb gel to open areas on buttocks apply Q day and PRN..." On 7/14/16 at 9:50 am, the Wound Nurse said, Resident #22 required total care. She said the wound on Resident #22's buttocks were more moisture related. She also said Resident #22 was being repositioned every 2 hours and said she remembered a wedge pillow was ordered for her but because of her size, air could not easily circulate on her bottom area. On 7/15/16 at 9:55 am, CNA #1 said Resident #22 needed an extensive assistance of two persons and staff were unable to repositioned her every 2 hours as ordered, especially during the night. She also said there were not enough staff to meet the residents' needs, especially where Resident #22 was, where most residents required 2 persons assistance. Resident #22 developed blood blister on her L great toe and wounds on her buttocks while in the facility which included multiple Stage II and Stage I ulcers, as noted by the NP. Resident #22 was high risk for pressure ulcers upon admission	F 314		

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F 314	Continued From page 123 due to her persistent vegetative state and morbid obesity. The facility failed to ensure interventions sufficient to prevent Resident #22's pressure ulcers were implemented as stated in her care plan and initiated in a timely manner. 2. Resident #1, was admitted to the facility on 6/10/16. An Admission Body Audit showed he had no skin breakdown on either heel. The Norton Plus Pressure Ulcer Scale, completed on admission 6/10/16, documented a score of 10, indicating Resident #1 was at risk for the development of pressure ulcers. Resident #1's Weekly Body Audit sheets dated 6/10/16, 6/17/16 and 6/24/16, documented he remained free of skin breakdown on his heels. On 6/26/16, nurses' notes indicated the resident was sitting in his wheel chair for an extended period of time waiting for van transport to the wound clinic for treatment of a pressure ulcer on the coccyx. Upon return from his appointment, during the evening hours, a stage 3 pressure ulcer was noted on his left outer heel and a stage 2 pressure ulcer was noted on his right outer heel. During an interview with the treatment nurse on 7/14/16 at 10:00 a.m., she reported Resident #1 was admitted with a wound on his coccyx. The treatment nurse further stated the pressure of his feet on his wheel chair foot rests was the only rationale she knew of that could have contributed to the development of the two pressure ulcers on his heels. Observation of both heels on 7/14/16 at 12:00 p.m., noted he had bilateral heel booties and a	F 314		

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F 314	Continued From page 124 bed cradle on the bottom of the bed. The treatment nurse removed the heel booties, painted each wound with Betadine and placed the booties back on each foot/heel. Infection control practices of keeping the wound clean after painting with betadine was omitted. The bed covers were replaced over the bed cradle and the treatment nurse exited the room. Resident #1's record showed the facility failed to consistently measure the wound for signs of and evidence of improvement. 2. According to Resident #10's MDS assessment, dated 02/12/16, he was 66 years old. Resident #10 had a history of CVA with a diagnosis of chronic respiratory failure and had a tracheostomy. He was nonverbal and was able to nod his head to yes/no question inconsistently. He was rarely understood and sometimes was able to understand others. He remained dependent upon staff to anticipate and meet all of his needs. The ARNP's diagnosis and assessment in the Progress Notes, dated 06/21/16, documented, "Scrotum and buttocks [have] a candida infection - I will have staff use nystatin powder until it's resolved." An order for "Nystatin Powder to affected area BID X [twice a day for] 14 days " was written 6/21/16 on the Comprehensive Physician's Order Sheet. Resident #10's clinical record documented that he had a history of pressure ulcers on his buttocks. His skin was observed in the presence of the wound care nurse on 7/12/16 at 10:25 a.m. Resident #10 had excoriation from his coccyx to	F 314		

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F 314	Continued From page 125 the scrotum. There were 2 round opened areas approximately 0.5 centimeters on both sides of the inner buttocks. In addition, there was yeast-like substance from the coccyx to the scrotum. The wound care nurse indicated she was unaware of Resident #10's skin condition. She instructed CNAs #1 and #2 to put Dimethacone Skin Protectant on the area. Resident #10's clinical record lacked a care plan. Nurse's notes, CNA notes, turning schedules, weekly skin checks were also lacking in the clinical record from March 1 to July 1, 2016. 3. Resident #2 was readmitted to the facility on 6/14/16 with diagnoses which included functional quadriplegic, neurogenic bladder, chronic pain, Left AKA, DM, acute respiratory failure, seizures and an unstageable pressure ulcer to the right ankle. Resident #2's Initial MDS assessment, dated 6/21/16, documented Resident #2 had no cognitive impairment, mild depression, and required extensive assistance of 2 staff members for all transfers, extensive assistance of 1 staff member for hygiene, dressing and eating. The MDS documented Resident #2 was totally dependent on 1 staff member for locomotion on the unit and in his room and he was totally dependent on 2 staff members for bathing. The MDS documented Resident #2 had a colostomy and a suprapubic catheter. The MDS documented Resident #2 was admitted with an unstageable pressure ulcer no location was specified.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

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F 314	Continued From page 126 Resident #2's July Physician Orders Review documented: *Staff was to turn Resident #2 every 2 hours to offload the coccyx, beginning 6/16/16. *Staff were to perform weekly skin checks on Tuesday's, beginning 6/16/16. *Post-operative flap sitting regimen staff was to monitor for skin breakdown or redness. If Resident #2's skin showed signs of redness or breakdown, staff was instructed to put him on bed rest for a few days, beginning 4/26/16. * Staff was to cleanse Resident #2's right malleolus (ankle bone area) with a wound DE cleanser. Nursing was to use a felt donut, beginning 5/6/16. *Staff was to use an Prevalon boot to the right ankle and nursing were to remove the boot every shift and assess for signs and symptoms of skin breakdown, beginning 6/14/16. Resident #2's discontinued orders documented: *Staff was to use AFO suspension boot to the right foot and remove every shift and assess for signs and symptoms of skin breakdown, beginning 4/29/16 and discontinued 7/10/16. Resident #2's admit Weekly Body Audit, dated 6/14/16, documentation included: * 3.5 by 2.5 unstageable pressure sore to right malleolus;	F 314		

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F 314	Continued From page 127 * 3.5 by 2.8 intact fluid filled blister to the right heel; * Scar from a reconstructed sacral coccyx flap; * Suprapubic catheter; * Colostomy. Resident #2's Weekly Body Audit, dated 6/21/16, documented no new or worsening skin issues. Resident #2's Weekly Body Audit, dated 6/30/16, documented no worsening skin issues with a new abrasion to the calf which measured 5 cm by 1cm. Resident #2's Weekly Body Audit, dated 7/5/16, documented no new or worsening skin issues. The Weekly Body Audit's did not document new skin issues to the coccyx or worsening skin issues to the right heel. Resident #2's June 2016 MAR documentation for the skin to be assessed under the boot was incomplete for 7 shifts. The facility could not provide documentation that the skin was assessed during those shifts. The June MAR documentation for Resident #2's coccyx to be offloaded and for him to be turned every 2 hours was documented once per shift. The facility could not provide documentation that the 2 hour offloading of Resident #2's coccyx was completed. In addition, there were 7 shifts where the documentation was missing.	F 314		

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F 314	Continued From page 128 Resident #2's July 2016 MAR documentation for his skin to assessed under the boot was completed 7/1/16 through 7/11/16 and the documentation was missing during 1 shift. The July 2016 MAR documentation for Resident #2's coccyx to be offloaded and and for him to be turned every 2 hours was not documented on the MAR. The facility could not provide documentation that the 2 hour offloading of Resident #2's coccyx was being completed. On 6/17/16, Resident #2's MD progress note documented he had a history of a chronic wounds to his coccyx and sacral area which he got a flap repair in 2016. The note documented the wound was a stage 4 with complications of necrotizing fasciitis (flesh eating bacteria). On 6/18/16, Resident #2's Nurses' Notes documented he was using an orthotic boot. On 6/19/16, Resident #2's Nurses' Notes documented he was wearing a boot. On 6/20/16, Resident #2's Nurses' Notes documented it was reported to the treatment nurse that a preexisting blister on the right foot heel opened. 6/21/16, Resident #2's Nurses' Notes documented he had two unstageable wounds one to his right ankle and the other on his right heel. On 6/25/16, Resident #2's Nurses' Notes documented he was wearing a Prevalon boot on his right foot.	F 314		

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F 314	Continued From page 129 On 6/26/16, Resident #2's Nurses' Notes documented he was wearing a Prevalon boot on his right foot. On 6/27/16, Resident #2's Nurses' Notes documented sacral flap reconstruction without open areas. On 6/27/16, Resident #2's Nurses' Notes documented he was wearing a Prevalon boot on his right foot. On 7/11/16 at 2:37 pm through 3:50 pm, Resident #2 was observed lying in his bed. He was not moved or turned during the observation. On 7/11/16 CNA #24 stated Resident #2 had skin issues on his coccyx, and right leg. On 7/12/15 from 8:35 am through 12:30 pm, Resident #2 was observed lying in his bed without being moved or repositioned. On 7/12/16 at 3:30 pm, the Wound RN stated Resident #2 had pressure sores to his heel and ankle and that he did not have any skin issues on his coccyx. She stated she changed the dressing twice a week on his shower days which were Tuesdays and Thursdays. On 7/12/16 at 3:30 pm, Resident #2's pericare was observed and he was found to have a wound on his coccyx. There was no bandage on the coccyx. The wound bed was covered with a yellow cheesy yeast like substance. This substance indicated a sign of infection to the wound bed.	F 314		

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F 314	Continued From page 130 On 7/12/16 at 3:50 pm, the Wound RN and Regional RN #2 entered the room to determine the nature of the wound. The wound was measured to be 4 cm and the Wound RN described it, "like a slit." On 7/15/16 at 10:15 am, CNA #1 stated residents were lucky to get repositioned or turned once per shift and if the residents could not talk they were left from 4:00 pm - 1:00 am without being changed or repositioned. On 7/13/16 at 12:00 pm, the DON stated CNA's are responsible for a giving a report to the wound nurse after residents are showered. The wound nurse audits the reports and that is how new or worsening skin issues are brought to light. She stated in Resident #2's, case of the coccyx wound, no report or I&A was developed until 6/12/16. The facility could not provide documentation of the wound to the coccyx prior to 6/12/16. The DON stated the Wound RN would be able to tell when the wound started. The DON stated she thought moisture contributed to the development of the coccyx wound. She was not aware of residents not being turned. 4. Resident #8 was admitted to the facility on 12/23/14, with diagnoses which included hemiplegia of the left side and dysphagia following a CVA, acute respiratory failure with a tracheostomy, and muscle weakness. Resident #8's Quarterly MDS assessment, dated 6/14/16, documented she had moderate cognitive impairment with mild depression, and	F 314		

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F 314	Continued From page 131 required assistance of 1 to 2 staff members with all cares, except eating. The MDS documented Resident #8 would reject cares 1-3 days week and was totally dependent on 2 staff for toileting needs. Resident #8's July Physicians' Orders included: * Calazime/bagbalm to buttocks twice daily PRN for irritation, beginning on 12/23/14. * Nystatin powder to excoriated area twice daily PRN, beginning on 10/8/15. * Air Mattress to bed to decrease risk of impaired skin integrity, check function frequently, beginning on 12/23/14. Resident #8's Elimination Care Plan, dated 11/17/14, documented she was incontinent of bowel and bladder. Interventions included: * Staff was to observe skin daily for irritation and redness. * Staff was to provide pericare with each incontinence episode. * Staff was to check and change Resident #8 on rounds and PRN. Resident #8's Skin Care Plan, dated 4/25/14, documented she was at high risk of skin breakdown related to impaired mobility and history of CVA. Interventions included: *Staff was to provide turning and repositioning on rounds and PRN and check and change incontinent briefs. * Staff was to assess skin weekly and document.	F 314		

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F 314	Continued From page 132 Resident #8's ADL Care Plan, dated 4/25/14, documented she required staff assistance for all ADL's related to left hemiplegia and a history of CVA. Interventions stated Resident #8 was dependent on 1-2 staff members for extensive assistance with all cares. On 7/2/16 Resident #8's Weekly Body Audit documentation included 1 small red area on her buttock. The Nurses' Notes did not include documentation of follow up related to the red area on her buttocks until 7/11/16 at 9:45 pm. A copy of the 7/11/16 weekly body audit documentation was not provided. Resident #8's July 2016 MAR documentation included: *Weekly Body Audits to be done on Monday evenings. The MAR documentation on 7/11/16 was blank. * Calazime/Bagbalm to buttocks twice daily PRN for irritation, was ordered 12/23/14. The MAR documentation did not include administration of the cream 7/1/16-7/12/16. *Nystatin Powder to excoriated areas twice daily PRN, was ordered 10/8/15. The MAR documentation did not include administration of the powder 7/1/16-7/12/16. * Staff were to check the function of the air mattress frequently. Resident #8's records did not contain documentation of when the air mattress function	F 314		

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F 314	Continued From page 133 was checked. The documentation did not include a specific frequency of the air mattress checks and what the checks entailed. On 7/11/16 at 9:45 pm, Resident #8's Nurses' Note documented Resident #8 received a treatment to her left buttocks and she tolerated the procedure well. This was the first documentation after the 7/2/16 weekly body audit documented the irritation on Resident #8's left buttock. Resident #8's Skin Care Plan was not updated to reflect the changed skin condition of Resident #8's buttocks. On 7/11/16 at 3:27 pm, Resident #8 was scheduled to get her incontinence briefs changed and staff exited her room at 3:30 pm and told an RN in the hall that Resident #8 had hit one of them and they would not be doing pericare at this time; they would try and come back later. On 7/11/16 at 3:40 pm, Resident #8 told CNA #8 her incontinence briefs had been soiled and she wanted them off. CNA #8 loosened the briefs and told Resident #8 that she took care of it and left the incontinence briefs on. On 7/12/16 from 8:25 am through 10:46 am, Resident #8 was observed in her bed watching TV and was not repositioned or turned. On 7/12/16 at 4:25 pm, CNA #19 and CNA #20 stated the facility completed pericare three times a day for Resident #8. It was scheduled to be completed in the early mornings, at about 2:45 or 3:00 pm, and after dinner. On 7/13/16 at 2:45 pm CNA #19 stated Resident	F 314		

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F 314	Continued From page 134 #8 was not going to get pericare at this time because she was in an activity. On 7/13/16 at 5:56 pm CNA #19 stated Resident #8 did not receive pericare in the afternoon after the activity because she was up in her chair and it was about time to eat dinner. Resident #8 had not received pericare since early that morning. Resident #8 did not receive pericare or have her incontinent briefs changed, for approximately 8 hours. On 7/13/16 at 4:34 pm, the ADON stated residents should be checked on whenever staff had contact with them or at a minimum of every two hours. The staff should provide pericare whenever there is an episode of incontinence. She agreed that pericare and changing of incontinent briefs is important especially when residents are at increased risk of skin breakdown and if residents had limited mobility. On 7/15/16 at 10:19 am, CNA #1 stated Resident #8's cares got neglected often because the staff do not like going into her room. CNA #1 stated Resident #8 did not reject cares if people treated her like a person and talked to her first. If staff went into her room and started "whipping her around then she would get upset."	F 314		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		8/12/16

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F 315	Continued From page 135 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation; staff, resident, and family interview; and record review, it was determined the facility failed to ensure cares were provided for residents to be able to retain their highest practicable physical and psychosocial wellbeing in regards to their different toileting needs. This was true for 7 of 10 residents (#2, #4, #7, #8, #10, #13, and #15) sampled for decreased bladder control, UTI's, and indwelling urinary catheters. As a result: a) Resident #13 experienced psychosocial harm when the facility failed to offer him timely opportunities to use a urinal and he started to refuse medication, respiratory treatments, TF feedings and he stated "If I have to piss and shit on myself, I would rather be dead." b) Resident #10 was harmed when the facility failed to ensure that the resident received the appropriate care and services to maintain an indwelling catheter in proper working order; and provide sufficient medical information to the transferred treating facility and to prevent infections. c) Resident #8 was harmed when the facility failed to provide pericare on an as needed basis and provided it 3 times a day and she experienced frequent UTI's. d) Resident #2 and #15 had the potential to be harmed when the facility failed to ensure	F 315	F315 1. Resident #4 was assessed by RNC on 7/21/16 regarding bowel and bladder evaluation. Regional CRS on 8/10/16 related to incontinence/use of bed pan/pain and preferences in care; care plan and care card were updated to reflect current status. Resident #7 was assessed by Regional CRS on 8/10/16 on bowel and bladder status and needs; care plan was updated at that time to reflect current status. Resident #15 was assessed by Regional CRS on 8/10/16 on bowel and bladder status and needs; care plan was updated at that time to reflect current status. Resident #8 was discharged from the facility on 7/25/16; no further corrective action indicated. Resident #2 was discharged from the facility on 8/4/16; no further corrective action indicated. Resident #10 was discharged from the facility on 7/28/16; no further corrective action indicated. Resident #13 was discharged from the facility on 7/8/16; no further corrective action indicated.	

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F 315	Continued From page 136 residents with indwelling urinary catheters were provided appropriate care, and had the potential to cause harm, to include development of urinary tract infections. e) Resident #4 had the potential for harm when the facility failed to complete a bladder assessment evaluation form to assess her toileting needs and creating the potential psychosocially embarrassing incidents of incontinence. f) Resident #7 had the potential to be harmed when the facility failed to complete a bladder retraining program after his Foley Catheter was discontinued by the physician. This created the potential for harm if the residents' continence status declined, skin was compromised from prolonged exposure to urine, or the resident experienced psychosocially embarrassing incidents of incontinence. Findings include: 1. Resident #13, 28 years old, was admitted to the facility on 5/18/16 with diagnoses including chronic respiratory failure, neuromuscular dysfunction of the bladder, dysphagia and quadriplegia. Resident #13 used a ventilator, had a tracheostomy (trach), and was fed via gastrostomy feeding tube. The resident was discharged to the hospital on 6/11/16 due to blood in his trach and decreased oxygen saturations. Resident #13 was readmitted to the facility on 6/17/16. The resident was again discharged to the hospital on 7/8/16 for a diagnosis of refusing respiratory care and the inability to meet Resident #13's needs (per physician's order on 7/8/16). The resident's closed record was reviewed.	F 315	2. Beginning on 8/1/16 an audit of bowel and bladder status was completed for current residents by regional and facility licensed nurses. Beginning on 8/1/16 the Regional CRS conducted an audit on care plans and status of bowel and bladder was updated at that time. 3. A Root Cause Analysis was conducted by the IDT and determined that staff did not respond to call lights in a timely manner, residents who are on the vent unit may take two staff members to meet care needs and may take more time to provide that care. An additional CNA was assigned to the vent unit. A generic form was being utilized for monitoring of intake and output versus being completed per physician orders. Assessments were not thoroughly documented as completed and there was no documentation regarding bladder training. Beginning on 7/16/16 clinical staff were educated by RNC/DON regarding the requirements of F315, responding to call lights and providing care in a timely manner, following the care plan for toileting needs, following physician orders, documenting changing of catheters and completion of assessments. Beginning on 8/10/16 clinical staff were educated on ensuring timely response to residents toileting needs, notifying the nurse if there is a difference in resident toileting pattern, change in status of urine, complaint of pain or discomfort with urination, encouraging fluids and keeping water within reach	

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F 315	Continued From page 137 a. Record Review A 9/24/15 Psychiatric Consultation conducted prior to Resident #13's admission to the facility, demonstrated his desire to be admitted to the facility. His chief complaint was, "I want to live at (name of facility)." Resident #13 was documented with a history of quadriplegia and ventilator dependence secondary to a motor vehicle accident several years earlier. Resident #13 had been living with his mother who could no longer care for him and he had been admitted to the hospital. The resident stated the facility was one of the only places that could take him due to his medical status and needs. Resident #13's mother was his guardian since he was 18 and he now wanted to make his own decisions. The resident was documented as having a good understanding of his medical illness. His mental status was documented as not having suicidal or homicidal thoughts, no hallucinations or delusions, reporting his mood as good and his affect being full and appropriate. Short and long term memory appeared to be intact with insight and judgment being good. The admission Bladder Evaluation, dated 5/18/16, indicated Resident #13 had a diagnosis of neurogenic bladder, had perception of the need to void, and required extensive assistance with toileting. The resident used a urinal and was alert and oriented. Resident #13 had urge incontinence and had 1 incontinent episode per week. Some sections of the form were incomplete/blank: recent surgery, onset of incontinence, duration of incontinence, catheter, pattern of fluid intake, skin status, types of	F 315	unless otherwise contraindicated. 4. Beginning the week of 8/15/16 the Unit Managers will conduct weekly audits to confirm residents who are incontinent or who have a catheter, that their toileting needs are being met timely by observation and interview, that physician orders are being followed for intake and output, that care of catheters is being documented and assessments are completed timely. Audits will be conducted for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee monthly for three months for further recommendations. The DON is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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	135094		07/19/2016

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F 315	Continued From page 138 programs, and ability to participate in program. The box for "Unable to participate in program" was checked with the reason of "quadriplegia with neurogenic bladder" documented. Resident #13 was documented as having a voiding pattern of every 2 hours; however, there was no evidence the resident's voiding patterns had been assessed. Voiding records were not found in his closed record. The care plan, dated 6/13/16, indicated Resident #13 required staff assistance with all activities of daily living (ADLs) related to incomplete quadriplegia and impaired mobility. Although, the Bladder Evaluation, dated 5/18/16 indicated the resident had the perception of the need to void and had only 1 incontinent episode per week, the care plan read, elimination: I am incontinent of bowel and bladder d/t (due to) neurogenic bowel and bladder." The care plan goal did not address keeping the resident continent to the extent possible and instead read in full, "Will remain free of urinary tract infection through next review 8/31/16." Care plan approaches did not include providing the urinal, toileting the resident, or indicating how much assistance was needed. What was to be provided (toileting or wearing an incontinent brief with checking and changing) in regards to incontinence was not identified. Care plan approaches read in full, "Bowel care protocol per facility policy, -Monitor and report to charge nurse any change in color of urine, increased odor, or c/o (complaints of) pain, -Administer bowel care meds (medications) as ordered by my physician, -Administer medication for bladder spasms as	F 315		

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F 315	Continued From page 139 ordered by physician, -Notify physician of the presence of fever, urine with dark color, odor, change in volume, or if no voiding within 8 hour period." Review of Nurse's Notes demonstrated Resident #13 was initially compliant with cares following his 5/18/16 admission to the facility. However, Resident #13's behavior deteriorated during his stay. He refused his tube feeding and water flushes, stating this was because he was not provided with toileting assistance in order to remain continent. Eventually, he refused most care including respiratory therapy. The progression was as follows: -5/18/16, 8:00 p.m., "Pt (patient) able to use restroom for bowel and bladder with times of incontinence. Pt declines a need for Attends (incontinent brief) at this time." -5/19/16, 2:10 p.m., "Very Pleasant and excited to be back." -5/20/16, 6:35 p.m., "Res (resident) has neurogenic bladder and is able to use toilet for urine and bowel. Res has periods of urinary incontinence." -5/22/16, 5:00 a.m., "Cont (continent) of B & B (bowel and bladder), all fluids and nutrition and meds (medications) given through Mickey tube button. Res (resident) tolerates well. Has 2 Cal (tube feeding formula) for bolus with water tolerates well. Pleasant and cooperative with cares." -5/23/16, 7:38 p.m., "Res pleasant ... No issues noted." -5/24/16, no time documented, "NPO (nothing by mouth) nutrition via tube feeding. Tolerating well." -5/26/16, 10:15 p.m., "Feeding and water given	F 315		

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F 315	Continued From page 140 as ordered. Res had no c/o (complaints of) pain or SOB (shortness of breath). RT (Respiratory therapist) at bedside for all resp (respiratory)/vent/trach needs. No issues noted." -5/28/16, 3:20 p.m., "Resident alert oriented, challenging with staff and cares. Resident angry about bolus feeding this am and noon attempting to pull Mickey tube appliance from body." -5/29/16, 4:40 a.m., "Resident was explained implications that can arise from him refusing his feeding and H20 (water). Resident stated 'You guys don't listen!' Resident did allow pm meds to be given and allowed PEG tube to be flushed. Resident stated he will not take his feedings and H20 because he is not toileted quickly enough and does not like to have accidents." -5/30/16, 6:00 p.m., "Pt refusing 2 Cal nutrition." -5/30/16, 8:00 p.m., "Res is frustrated. He is unable to control his bladder. Res stated that is why he has been refusing water and 2 Cal" -6/1/16, 1:00 p.m., "Resident is alert and oriented, able to make his needs known...He is able to be continent of B & B but tends to need someone right as he is pushing the call light...He says he doesn't like being incontinent and afraid if he eats he will be." -6/3/16, 10:00 p.m., "Negative mood and affect. Pt refused nursing cares, meds, tx (treatment), 2 Cal and H20." -6/5/16, 3:00 p.m., "Res cont (continues) to refuse bolus feedings, H20, medications per RT has refused trach cares." -6/8/16, 2:25 a.m., "Resident has been compliant with cares this evening. Resident continues to be upset. He feels as though the CNAs on evening shift are not taking care of him properly...Resident continent of b/b (bowel and bladder)."	F 315		

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F 315	Continued From page 141 -6/10/16, 11:00 p.m., "Pt is continent of bladder and asks to use urinal." Resident #13 was sent to the hospital on 6/11/16 due to the ventilator alarming due to blood in his trach. Resident #13 was readmitted to the facility on 6/17/16 following a hospital stay of 6 days. Following his readmission, no refusals were noted for 6 days. After 6 days the following was documented: -6/23/16, 4:00 p.m., "Res declined bolus. Upset with CNA when she cleaned him in bathroom." -6/29/16, 4:00 p.m., "Refused 1600 (4:00 p.m.) meds and bolus." -6/30/16, 6:30 p.m., "Resident has refused all medications and feedings today." -6/30/16, no time documented, "Resident has refused all meds, food, & fluids stating that he will not be eating or anything else until CNAs & other staff answer his light with not longer than (illegible number) min (minutes) from time it goes on, because he does not want to have an accident. I proceeded to inform him I'd be there to help & he said no not till everyone does this. I educated him on the issues this would cause like dehydration & he said that he was willing to risk this. This stance did not change throughout the shift." -7/1/16, 2:30 a.m., "Res has refused all cares and PEG flush of 315 cc." -7/1/16, 11:00 p.m., "Pt c/o constantly being incont (incontinent) of urine due to slow response of CNA...Mother reported pt sat in urine for over 45 minutes w/o (without) anyone answering call light. When talking with mother I informed her it	F 315		

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F 315	Continued From page 142 had only been 25 minutes since I had been in and there was no mention of needing to be changed when asked." -7/2/16, 1:00 p.m., "Pt refused Two Cal today et (and) meds." -7/3/16, 2:00 p.m., "Pt continuing to R (refuse) all meds & nutrition." -7/3/16, 7:10 p.m., "(Guardian) states pt is intentionally making himself sick so he can go to the hospital. Pt is upset he has not been discharged to group home yet." -7/4/16, 12:30 a.m., "Called to room by RT (respiratory therapist) who expressed concern that res was becoming dehydrated." -7/4/16, 3:00 p.m., "He refused all meds and fluids including feeding." -7/6/16, 1:00 a.m., "Contd (continues) to refuse most nrs (nursing) cares." -7/6/16, 10:10 a.m., "New order per NP (nurse practitioner) - send to ER non emergent dx (diagnosis) dehydration. Pt sent non emergent at approximately 1030 (10:30 a.m.)." Resident #13 was transferred to the hospital on 7/6/11 at 11:00 a.m. The "Interact, Review of Acute Care Transfer" form stated the hospital's diagnosis was aspiration pneumonia. Contributing factors were refusing medication, feeding, and water. b. Family Interview Resident #13's family member was interviewed on 7/15/16 at 1:30 p.m. She stated she had been Resident #13's caregiver previously and had removed him from the facility a couple of years ago due to poor care. She stated the care had deteriorated since then and was worse now. The	F 315		

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F 315	Continued From page 143 family member stated the current plan was for the resident to transition into a group home where he could live more independently since he was a young adult and wanted to exercise his independence as much as possible and live with people closer to his own age. His recent admission to the facility was intended to be of short duration while everything was put into place for his new living situation. Resident #13's family member stated, "The care is substandard. They are terribly understaffed." The family member stated the resident refused to allow his tube feeding and water flushes to be administered because staff would not toilet him resulting in him soiling himself. The family member stated "He told me, 'If I have to piss and shit on myself, I would rather be dead.' He does pretty well with his bladder (remaining continent) if he is toileted. I timed it; he waited 51 minutes for someone to respond (to his call light) while I was there and not just once. (Resident #13) is stubborn. He never liked to be messy since he was a small child. I have been in tears a lot of times to see him that way (soiled with urine and feces). Wheelchair cushions cost a lot of money. Someone has to pay for it (a new cushion) if it becomes ruined (due to incontinence)." c. Resident #13's guardian was interviewed on 7/15/16 at 9:45 a.m. She stated the resident was medically complex and acted younger than his 28 years. She stated, He does not have much control (over things in his life) but he can say 'No.' She verified Resident #13 got very irritated and upset and as a result refused cares. Resident 13's guardian stated, "They were short staffed and slower than ideal." Resident #13's	F 315		

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F 315	Continued From page 144 guardian stated the resident refused tube feeding and water flushes because staff did not toilet him quickly enough. She verified Resident #13 knew when he needed to use the toilet and was incontinent if staff did not toilet him timely. She stated there were 2 incidents when she visited Resident #13 when he waited 25 minutes for the call light and stated, "We timed it." d. Staff Interview CNA #1 was interviewed on 7/15/16 at 10:10 a.m. She stated Resident #13 was not toileted, in part due to short staffing. CNA #1 stated the resident knew when he needed to use the urinal and put his call light on. She stated he could be continent if he was toileted timely. CNA #1 stated "It is a lot of work to toilet him and it takes 2 people. He could use the urinal. He was not toileted; it was easier to change him (after he had been incontinent) than toilet him." Nurse #5 was interviewed on 7/15/16 at 9:15 a.m. and stated she cared for Resident #13 a total of 3 times. She stated the first 2 times she did not have any issues with him; he allowed all care and did not refuse anything. She stated she answered his light and he told her it was not that way when other nurses were working. Nurse #5 stated the last time she cared for Resident #13 he refused his tube feeding, medications and respiratory care because he stated his call light was not answered quickly enough. Nurse #5 stated Resident #13 could remain continent if staff could toilet him quickly. 2. Resident #10's was re-admitted to the facility on 11/21/14. He had a history of intracranial	F 315		

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F 315	Continued From page 145 hemorrhage with significant neurological deficits due to uncontrolled hypertension and CVA (cerebral vascular accident). His annual MDS dated 2/12/16, documented he was severely cognitively impaired, nonverbal and unable to make himself understood. He was unable to move all 4 extremities and was totally dependent upon staff for activities of daily living. He had a PEG [feeding tube] and a tracheostomy to facilitate mechanical ventilation. Resident #10 had a suprapubic catheter. Review of the ARNP Progress Note, dated 2/17/16, documented, " Day staff told me the night shift changed his suprapubic catheter and when they came on duty they found suprapubic catheter out and blood on his thighs. . .His suprapubic catheter is out and a Foley catheter has been placed thru [through] his urethra. . . I tried to reinsert the suprapubic catheter but the stoma has closed and I was unsuccessful." The ARNP diagnosis and assessment included, "Neurogenic bladder with a displaced suprapubic catheter- is unclear to me how his suprapubic Catheter became displaced. I doubt seriously that he pulled it out. The stoma had closed and I was unable to replace a suprapubic catheter. We have been able to replace a Foley catheter thorough his urethra and I will leave that in place. I will not send him out to urology to have the suprapubic catheter replaced unless we have trouble with his Foley catheter." Resident #10's clinical record lacked nurse's notes, and intake/output notes, from March 2016 to July 2016. A care plan for any period of time was lacking. A request was made of the medical	F 315		

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F 315	Continued From page 146 records director to provide the clinical records for the missing months on 7/12/16 at 10:00 a.m, 7/13/16 at 8:35 a.m. and 3:30 p.m., 7/14/16 at 7:05 p.m., and 7/15/16 at 11:15 a.m. The records were never provided. An H&P documented by the emergency room physician, dated 3/28/16, stated Resident #10 was admitted to a hospital with "chronic indwelling Foley catheter in place...The Foley catheter allegedly was changed out on the 17th of this month. The patient apparently has not been having any urinary output unclear for what period of time...The staff at the facility could not get an IV [intravenous] fluid and due to concern of dehydration, he was sent to the Emergency Department. The Foley catheter was removed with purulent drainage and then replaced, draining 1000 mL out... The patient's white cell count was 26,000 [4,500-10,000 white blood cells per microliter (mcL)]..." The emergency physician's Assessment and Plan included "severe sepsis, meeting criteria with fever of 38.4 Celsius [101.12 Fahrenheit], heart rate 128, respiratory rate 20...With urinary tract infection and possible pneumonia in a patient who has chronic trach [tracheostomy] and indwelling Foley catheter which was obstructed..." In addition, the emergency room physician documented, "Medical record. [The facility] at this point is refusing to send over complete medical record which would include the last dosing and timing of the medications because it is their new policy. I requested to speak to the supervisor as this puts the patient at high medical risk for	F 315		

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F 315	Continued From page 147 medical error...Anticipate patient will be in the hospital greater than 2 midnights due to the severity of his illness, wait for culture results...The patient is in the step-down unit as he has high potential of becoming hemodynamically unstable." 3. Resident #8 was admitted to the facility on 12/23/14, with diagnoses which included hemiplegia of the left side anddysphagia following a CVA, acute respiratory failure with a tracheostomy, and muscle weakness. Resident #8's Quarterly MDS assessment, dated 6/14/16, documented moderate cognitive impairment with mild depression, and that Resident #8 required 1-2 staff assistance with all cares, except eating. The MDS documented Resident #8 rejected cares 1-3 days a week and was totally dependent on assistance from 2 staff for toileting. The MDS documented a bladder retraining trial had not been completed. Resident #8's Elimination Care Plan, dated 11/17/14, documented she was incontinent of bowel and bladder. Interventions included: *Staff was to observe skin daily for irritation and redness. *Staff was to provide pericare with each incontinence episode. *Staff was to check and change Resident #8 on rounds and PRN. Resident #8's UTI Care Plan, dated 5/11/16 and 7/11/16, documented she had a UTI. Interventions included:	F 315		

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F 315	Continued From page 148 *Staff was to administer antibiotics as ordered. * Staff was to observe urine for odor, color, and sediment. * Staff was to report if Resident #8 had changes in her voiding patterns. A June UTI Care Plan was not provided for review. Resident #8's May 2016 MAR included: *Cipro 500 mg PO BID for 10 days to treat a UTI, beginning on 5/9/16 and discontinuing on 5/11/16. * Macrobid 100 mg PO BID for 1 week to treat a UTI, beginning on 5/11/16 and discontinuing on 5/18/16. Resident #8's June 2016 MAR included: * Omnicef 300 mg by mouth twice a day for 10 days to treat a UTI, beginning on 6/13/16 and discontinuing 6/22/16. The MAR had two holes in the administration of this medication, on 6/14/16 at 8:00 am and 6/18/16 at 8:00 pm. The documentation on the MAR did not include a reason the medication was not provided. The NN documentation did not provide a reason the medication was not provided. Resident #8's July 2016 MAR included: Omnicef 300 mg by mouth twice a day for 10 days to treat a UTI, beginning on 7/7/16 and scheduled to end 7/14/16. Resident #8's Urinalysis results from 6/6/16 and 6/10/16 document she had trace ketones, blood	F 315		

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F 315	Continued From page 149 and protein in her urine, was positive for nitrites in her urine, and had bacteria in her urine. Resident #8's Urinalysis result from 7/6/16 documented she had blood in her urine and was positive for nitrites, and had bacteria in her urine. Resident #8's Bladder Evaluation, dated 4/18/16, documented no bladder retraining program was trialed as she was unable to follow a program. Resident #8's Bowel Retraining Evaluation, dated 4/18/16, documented she was unable to participate due to confusion. On 7/11/16 at 3:27 pm, Resident #8 was scheduled to get her incontinence briefs changed and staff existed her room at 3:30 pm and told an RN in the hall that Resident #8 had hit one of them and they would not be doing pericare at this time they would try and come back later. On 7/11/16 at 3:40 pm Resident #8 stated to CNA #8 her incontinence briefs had been soiled and she wanted them off. CNA #8 loosened the briefs and told Resident #8 that she took care of it and left the incontinence briefs on. On 7/12/16 at 4:25 pm, CNA #19 and CNA #20 stated the facility completed peri care three times a day for Resident #8. It was scheduled to be completed in the early mornings, at about 2:45 or 3:00 pm, and after dinner. On 7/13/16 at 2:45 pm CNA #19 stated Resident #8 was not going to get pericare at this time because she was in an activity.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 150 On 7/13/16 at 5:56 pm CNA #19 stated Resident #8 did not receive peri care in the afternoon after the activity because she was up in her chair and it was about time to eat dinner. On 7/13/16 at 4:34 pm the ADON stated residents should be checked on whenever you have contact with them or at a minimum of every two hours. The staff should provide pericare whenever there is an episode of incontinence. She stated the staff should not rely on change of shifts to check the residents which was three times a day. The ADON agreed that if a resident was not changed and pericare not completed, it may increase their risk of UTI's. On 7/15/16 at 10:19 am CNA #1 stated Resident #8's cares get neglected often because the staff do not like going into her room. She stated Resident #8 did not reject cares if people treated her like a person and talked to her first. If staff went into her room and started "whipping her around then she would get upset." 4. Resident #2 was admitted to the facility on 6/14/16 with diagnoses which included functional quadriplegic, neurogenic bladder, chronic pain, Left AKA, DM, acute respiratory failure, seizures and un-stage pressure sore to the right ankle. Resident #2's Initial MDS assessment, dated 6/21/16, Resident #2 had a colostomy and a suprapubic catheter. Resident #2's Suprapubic Catheter Care Plan documented he was at risk for alterated elimination, interventions included:	F 315		

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	135094		07/19/2016

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F 315	Continued From page 151 * Staff were to encourage good fluid intake each shift. *Staff were to provide pericare as needed. * Staff were to provide suprapubic care as ordered. Resident #2's July Physician Orders Review documented: * Foley Catheter to be changed every month and PRN for neurogenic bladder, beginning 6/14/16. Resident #2's MAR from 6/18/16 to 6/30/16, documentation included: * Staff was to assure patency to the gravity bag drain every shift. The MAR indicated that on 16 occasions the assessment of patency was not completed. * Staff was to check catheter output every shift. The MAR indicated that on 21 occasions the catheter output was not done. *Staff was to assure catheter care and catheter strap was in place every shift. The MAR indicated that on 15 occassion there was no documentation that staff assured the catheter was secured and appropriate catheter care was completed. Resident #2's MAR from 7/1/16 to 7/12/16, documentation included: * Staff was to assure patency to the gravity bag drain every shift.	F 315		

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	135094		07/19/2016

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F 315	Continued From page 152 * Staff was to check catheter output every shift. The MAR indicated that on 3 occasions the catheter output was not done. *Staff was to assure catheter care and catheter strap was in place every shift. On 7/13/16 at 12:00 pm, the DON stated she would look for the documentaion of catheter care and if it was somewhere in the clinicial record. On 7/14/15 at 3:45 pm, the DON was unable to find if the documentation for the catheter care. 5. Resident #15 was admitted to the facility on 4/20/15 with diagnoses which included dementia, suprapubic catheter, and chronic kidney disease stage III. Resident #15 quarterly MDS assessment, dated 7/8/16, documented he had a mild cognitive impairment and no behaviors. The MDS documented he had a Suprapubic Catheter. Resident #15's Elimination Care Plan, dated 4/2/15, documented he was at risk for alterations of bladder function related to him requiring a suprapubic catheter for his neurogenic bladder. (Resident #15 did not have a separate catheter care plan.) Interventions included: * Staff members were to encourage fluid intake. * Staff members were to flush his catheter with NS PRN for occlusion.	F 315		

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F 315	Continued From page 153 * Staff was to change his catheter and drainage bag per policy or as ordered by the MD. There was no physician order for changing the drainage bag and no policy was provided. * Staff was to empty his urinary bag every shift, upon rounds, and PRN and record the urine output per facility protocol. Resident #15's July Physician Orders included: * Foley Catheter to be changed every month and PRN for neurogenic bladder, beginning 4/20/15. * Staff may flush his foley with NS PRN if occluded, beginning 11/16/15. Resident #15's Bladder Evaluation, dated 2/28/16, documented his average fluid intake was 1000 mL for 24 hours. In addition, it documented his average fluid output was 4-5000 mL per 24 hours. Resident #15's May 2016 MAR documentation included: * Staff was to assure patency to the gravity bag drain every shift. The MAR indicated there were nine occasions where the patency of the catheter was not completed. * Staff was to check catheter output every shift. The MAR indicated that staff failed to document urinary output on 11 occassions. *Staff was to assure catheter care and catheter strap was in place every shift. The MAR indicted that staff failed to ensure the catheter was secure	F 315		

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	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 154 and catheter care was completed on 11 holes occassions. Resident #15's June 2016 MAR documentation included: * Staff was to assure patency to the gravity bag drain every shift. The MAR indicated there were four occasions where the patency of the catheter was not completed. * Staff was to check catheter output every shift. The MAR indicated that staff failed to document urinary output on 15 occassions. *Staff was to assure catheter care and catheter strap was in place every shift. The MAR indicted that staff failed to ensure the catheter was secure and catheter care was completed on 5 occassions. Resident #15's July 2016 MAR documentation included: * Staff was to assure patency to the gravity bag drain every shift. The MAR indicated there were two occasions where the patency of the catheter was not completed. * Staff was to check catheter output every shift. The MAR indicated that staff failed to document urinary output on 1 occassion. *Staff was to assure catheter care and catheter strap was in place every shift. The MAR indicted that staff failed to ensure the catheter was secure and catheter care was completed on 1 occassion.	F 315		

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	135094		07/19/2016

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F 315	Continued From page 155 7/14/16 at 9:48 am the ADON stated she would have to look for the missing documentation but to check in the nurses notes. The nurses' notes did not contain documentation of the missing information. 6. Resident #4's admitting diagnoses included functional urinary incontinence, and chronic kidney disease stage 3. The 1/5/16 admission Bladder Evaluation indicated, "Hx (history) of incontinence per H&P." The Bladder Evaluation included a section on the form which indicated, "Evaluation for Bladder Program Potential. Able to participate in program. Evaluation period: 1/5/16 to 1/8/16." The 1/12/16 admission MDS Care Area Assessment (CAA) for "ADL/ Functional/ Rehabilitation" indicated Resident #4, "Requires assistance with ADLs related to impaired mobility...she is able to make needs known. She is incontinent of B&B (bowel and bladder) and is unaware of urge." Review of an undated Care Plan indicated Resident #4 "Is always incontinent of urine." On 7/12/16 at 3:45 p.m. during interview, the DON stated, "I'm not sure what system is in place for bowel and bladder assessments yet. I haven't looked at it yet and haven't gone through this form (referring to the "Bladder Evaluation" form). Usually the admitting nurse would be the one doing the bowel and bladder assessment at the time if admission. In the first three hours of admission, they may not know things (related to	F 315		

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F 315	Continued From page 156 incontinence of the resident) right away, but I would expect they (staff) still need to get the information on the form." On 7/12/16 at 4:00 p.m. during interview, the Regional Nurse Consultant stated, "The admitting nurse does the initial bowel and bladder assessment upon admission to see if the resident is a candidate for a bowel and bladder program. I would have to find out what took place from 1/5/16 to 1/8/16 as was indicated on the bladder evaluation." On 7/15/16 at 2:50 p.m. during a second interview regarding a bowel and bladder training program for Resident #4, the Regional Nurse Consultant stated, "I spoke with to the nurse regarding the bowel and bladder evaluation form and she indicated she did fill out the information for those three days (1/5/16 to 1/8/16). When I spoke to the nurse, she said she could not find it anywhere in the chart. So we could not find any documentation of a bowel and bladder training program that was done for those three days." 7. Resident #7's clinical record indicated he was admitted to the facility with a Foley Catheter on 5/24/16. Physician's Orders, dated 5/26/16, stated staff were to initiate bladder training for removal of the Foley Catheter. On 6/1/16, Resident #7's physician wrote the following order, "What happened to the Bladder Training I ordered- Did it get done-if not see 5/26/16 order."	F 315		

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	135094		07/19/2016

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F 315	Continued From page 157 A Nurse's Note, dated 6/9/16, included, "D/C Foley Catheter to begin bladder training." During an interview with the Regional Nurse Consultant on 7/13/16 at 10:00 a.m. she stated the Nurse's Note dated 6/9/16 was incorrect since bladder training should occur prior to removal of the catheter by clamping and releasing of the catheter. She further stated she was unable to locate a facility policy or procedure for staff to follow related to how to perform bladder training.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced	F 322		8/12/16

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F 322	Continued From page 158 by: Based on observation, interview and record review, the facility failed to ensure that 1 of 2 sampled residents (#6) with gastric feeding tubes (G-tube) were provided care and services to: a) Avoid dehydration and b) Ensure the residents were not lying flat in bed during and immediately after administration of a feeding (Resident #6). The deficient practice created the potential for residents to experience dehyration, aspiration, or choking. Findings include: Resident #6 was admitted to the facility on 5/1/14 with diagnoses which included RA, dysphagia, muscle weakness, joint pain, osteoarthritis, malnutrition, spinal stenosis and chronic pain. Resident #6's quarterly MDS assessment, dated 6/22/16, documented she had no cognitive impairment with minimal signs of depression. The MDS documented she was totally dependent on staff for eating due to a feeding tube. Resident #6's July Physician Order Review documented: * Jevity 1.5 at 65 mL/hr for 12 hours, with 150 mL of water flushes QID, beginning on 7/5/16. (Resident #6 was to receive her medications through her PEG Tube.) * Staff were to change the G-tube every three months and PRN, beginning 4/14/15. * Staff was to flush the PEG tube before and after medication administration with 30 - 60 mL of water, beginning 5/28/14.	F 322	1. Resident #6 was assessed by RNC on 7/16/16 related to personal care needs and provided toileting and grooming assistance with no negative findings indicated. Resident #6 was reassessed on 8/10/16 by the Regional CRS regarding incontinence and pain; care plan was reviewed and revised to reflect current status and preferences. Resident #6 was assessed by LSW on 7/17/16 regarding her psychosocial outcome; no negative findings indicated. Resident #6 was assessed by the Registered Dietician on 7/16/16 with no significant findings indicated; care plan was reviewed and revised by IDT to reflect current status. Resident #6 was provided education on risks of preference to lie flat in the bed during administration of enteral feeding and on her right of choice on 7/21/16 by RNC and care plan was reviewed and revised to reflect preferences and risk. 2. Beginning on 7/16/16 current residents of the facility receiving enteral feedings were reviewed by the RNC and no further residents were deemed at risk of preferring to lie flat during administration of tube feeding. 3. Root Cause Analysis conducted by the IDT determined that the clinical record did not reflect documentation of education with Resident #6 risks associated with preference of lying flat in bed during the administration of enteral feeding. Beginning on 8/10/16 the SDC	

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	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 322	Continued From page 159 *Resident #6 received a Modified Pureed diet with small portions beginning 6/24/16. (Resident #6 wanted off of the TF and the facility was trying to transition her onto solid foods.) Resident #6's July 1st through July 12th am shift, Tube Feeding Record Sheet for 2016, documented she received Jevity 1.5 at 65 mL/hr for 12 hours and to start at 7:00 pm. The sheet documented staff were to give 150 mL water flushes QID and to document that the head of the bed was elevated. * Jevity 1.5 at 65 mL/hr for 12 hours was documented during NOC, am, and pm shifts. This was initialed off administered all shifts * Staff was to provide water flushes of 150 mL QID and was instructed to record the amount of the water flushes. The documentation was signed off at 12:00 am, 6:00am, 12:00 pm, and 6:00 pm, as completed. The documentation did not include the amount of water flushed. * Staff was to ensure Resident #6's head of bed was elevated to 30 degrees and it was documented during night, am, and pm shifts. The documentation was initialed for all shifts as completed. * Staff was to check for residuals and placement during night, am and pm shifts. The staff were instructed to hold the TF if residuals were greater than 100 mL. The documentation was initialed for all shifts as completed, except one on 7/6/16. The documentation did not include how much residuals was identified.	F 322	educated facility clinical staff on Resident Rights and residents having the right to choose care or preferences in care that may have potential for risks. IDT was educated that education and documentation and care plan must be provided to reflect resident choice in care. Facility will ensure contracted dietary provider policy regarding Enteral Formulary which reflects a collaboration of Registered Dietician assessment and recommendations with resident specific physician orders related to enteral feedings and water flushes; contracted pharmacy provider policy regarding administration of medications via G-tube; and Lippencott Manual of Nursing Practice, 10th edition, Chapter 20, procedure guideline for Enteral Feeding. Facility staff were educated beginning on 7/28/16 regarding utilization of reference materials for specific policies. 4. Beginning the week of 8/15/16, the IDT will review three comprehensive care plans to ensure that current care plans reflect education of risks associated with resident care choices that have potential risks. The reviews will be conducted weekly for four weeks, then monthly for two months and quarterly thereafter. The MDS coordinator is responsible for monitoring and compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 322	Continued From page 160 *The staff was instructed to check Resident #6 once per shift, for formula tolerance during night, am, and pm shifts. The documentation did not address monitoring the resident while she was receiving the TF. *Staff was instructed to check breathing sounds during night, am, and pm shifts. There was no documentation Resident #6's breathing was monitored while she was receiving the TF. Resident #6's Tube Feeding Care Plan, dated 5/22/14, documented she was at risk for complications related to dysphagia and GERD. Interventions included: *Resident #6 was to lie down on either side or back for PO intake. *Staff was to flush the peg tube before and after medications per order. *Staff was to encourage head of bed elevation. *Staff was to monitor her gastric tube intake every shift. On 7/12/16 at 8:36 am, Resident #6's bed was flat and she was lying on her back hooked up to the tube feeding pump. The tube feeding was administered 8:00 pm to 8:00 am this day. She stated she was lying flat without the head of the bed elevated because when the bed was elevated it hurt her back. Resident #6 stated staff had asked her to elevate her bed and she stated she had slept on her back for years and did not want to change. She made no mention if staff had educated her on the risk factors of lying flat while the tube feeding was running. On 7/13/16 at 8:39 am Resident #6's bed was flat	F 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

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F 322	Continued From page 161 and she was lying on her back hooked up to the tube feeding pump. The tube feeding had run from 8:30 pm till 8:30 am. Resident #6 stated she had slept on head back last night. On 7/13/16 at 10:49 am LPN #4 unhooked the tube feeding and used a syringe to check for residuals and flushed the tube with 30 mL of water. Resident #6 still remained flat on the bed. LPN #4 went to start to put the medications in through the PEG tube and the surveyor asked if the head of the bed needed to elevated prior to administration of the medications. LPN #4 stopped, stated yes, and elevated the bed to 30 degrees. LPN #4 administered the medications and another 30 mL of fluids after the medication. Resident #6's records did not document or address the resident's preference of lying flat through the administration of the TF due to pain. In addition, it did not address the staff's attempts to educate her on the side effects of lying flat. Her records did not document how much water was given with the administration of her medications. The documentation did not include the amount of water flushed. On 7/13/16 at 5:45 pm the ADON stated that since Resident #6 was refusing to have the head of the bed elevated, the care plan it should not have been documented that the bed was elevated. The facility should have attempted to educate Resident #6 on the importance of the bed elevation and the risks of not doing it. Staff would then notify the MD of the issue, assess her for pain, and implement interventions, such as pre-medicating Resident #6, to ease her back pain at night. If the intervention did not work, a	F 322		

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F 322	Continued From page 162 written consent would be obtained from Resident #6 to show she declined to elevate the head of her bed. This process was not done. The facility provided a policy and procedures for G-tube management from the Lippincott Manual of Nursing Practice, 10th edition, Chapter 43: Care of the Sick or Hospitalized Child. This policy and procedure did not address nutrition support needs in a long term care setting. The policy did not include the type of pumps the facility used; facility standards on how the residents could receive the tube feeding (i.e. NOC, bolus, continuous); the facility's free water standards; the facility's standards for medication administration in a G-tube with fluid requirements; the facility's standard on how nursing staff was to assess proper placement of the tube and proper placement of the residents during tube feeding administration; how nursing staff was to assess residents tolerance to the tube feeding; how nursing staff was to check residuals; and how the facility documented the information above.	F 322		
F 323 SS=D	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:	F 323		8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

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F 323	Continued From page 163 Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure supervision to prevent accidents. This was true for 2 of 27 sampled residents (#9 and #19) sampled for supervision. The deficient practice created the potential for harm for Resident #9 when he sustained an injury while staff assisted him in his wheelchair, and for Resident #19 when he fell during a transfer due to lack of sufficient assistance. Findings include: 1. Resident #9 was quadriplegic and had total loss of the use of all four limbs and torso. He was totally dependent upon staff to ensure his safety. His current diagnoses included diabetes mellitus and ALS (amyotrophic lateral sclerosis - a degenerative disease that affects nerve cells in the brain, the spinal cord and causes muscle to waste away). His breathing muscles were affected and he required a ventilator to assist with breathing. An Incident/Accident Report for Resident #9, dated 5/16/16 at 6:00 p.m., documented "Patient was being wheeled into room. Door was swinging and swing back. Bumped left 2nd toe. Pt. has hx [history of] DM [diabetes mellitus] and poor peripheral circulation. Quadriplegic." The Investigation of Incident/Accident form stated, "Patient was on the way into his room to use urinal. Wheel chair was going in door swung back and bumped resident's toe. 5/17/16 left 2nd toenail treatment obtained. No s/s [signs/symptoms] infection will monitor till healed."	F 323	F323 1. Resident #9 was reassessed on 7/21/16 by Unit Manager related to 5/16/16 event; no further corrective actions indicated. Resident #19 discharged from facility on 5/13/16; no further corrective actions indicated. 2. An audit was conducted on 8/9/16 by RNC of the last 30 days of incidents to determine if there were further events related to staff carelessness; no further negative findings indicated. 3. Root Cause Analysis by IDT determined that based on staff statements indicated that door to resident room swung toward the resident□s wheelchair as staff was assisting Resident #9 into the room, bumping Resident #9 on the toe and for Resident #19 staff member attempted mechanical lift transfer without assistance. Facility clinical staff were educated beginning on 8/10/16 regarding prevention of incidents and accidents. Nursing Staff were educated to follow transfer technique as per care plan and care card and during mechanical lift transfer with the assistance of a second staff member. Additional training on mechanical lift transfers with return demonstration was conducted by corporate staff beginning on 7/28/16. 4. Beginning the week of 8/15/16 the DON/SDC will conduct three observations of transfers to ensure staff are following care plan/care card during transfers. Observations will be conducted for four	

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F 323	Continued From page 164 Resident #9's annual MDS, dated 6/16/16, documented that he used a wheelchair for locomotion and required staff to propel the wheelchair. On 7/13/16 at 11:05 am, Resident #9 stated, "One of the aides almost broke my toe. I was in the wheelchair and the aide was in a hurry to get me to the room. She is the type who is always in a rush. Every room is on fire. She was pushing me into the room and pushed my left foot into the door jam. Accidents are going to happen, but this was a day they were short of help. I worry that someone is going to get hurt." 2. Resident #19 was admitted to the facility 6/26/08. His diagnoses included muscle weakness, joint contracture, gait abnormality and lack of coordination. His annual MDS, dated 2/9/16 documented he was unable to ambulate and his balance was stabilized only with staff assistance, used a wheelchair for mobility, and was severely cognitively impaired. Documentation in the Nurses Notes, dated 2/9/16 at 2:00 p.m., noted, "Rt [right] eye bruise 1 cm [centimeter] found on day shift." On 2/15/16 at 10:30 p.m., documentation in the Nurse's Notes stated, "At 2000 [8:00 p.m.] was notified per CNA that dry blood was noted to right geri sleeve. Upon removal of sleeve noted 2 skin tears 1 approx. [approximately] 1 3/4 in [inch] and the 2nd one approx. ¼ inch denied pain area was cleansed with wound cleaner. Non sting barrier applied...An environmental check was performed to resident's room, BR [bathroom], w/c and bedside table with no sharp edges noted to any	F 323	weeks, then monthly for two months and quarterly thereafter. A report will be submitted to QAPI Committee monthly for three months. The DON is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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	135094		07/19/2016

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F 323	Continued From page 165 areas. Resident does independently propel w/c using LE's [lower extremities] through facility yet resident was seen going to meal & returning from DR [dining room] to room after meal. DR table assessed no sharp edges noted to tables or entry ways." On 2/17/16 at 10:00 a.m., the IDT met to review the incident occurring on 2/15/16 at 10:00 p.m. and concluded "upon investigation, it is suspected that res [resident] bumped his arm on handrail or side rail." On 2/18/16 at 11:00 a.m., the IDT met to review the incident occurring on 2/9/16 at 8:00 a.m. and concluded "Upon investigation, it is suspected that Res bumped his eye on the SR [side rail]." Documentation in the Nurses Notes, dated 2/27/16 at 9:00 p.m., noted, "Res fell from w/c to floor while in bedroom, unwitnessed...Heard by this nurse. Minor skin tears on elbows bilaterally. Slight abrasion noted on forehead..Res stated he was leaning over trying to pick up a piece of candy from the ground." Review of the incident by the IDT on 3/2/16, documented, "Resident sitting in w/c in his room with wheels unlocked. He leaned down to pick up a piece of candy off the floor fell out of his w/c onto the floor." On 3/26/15 at 1:50 p.m., documentation in the Nurses Notes included, "Resident went to the social Easter egg hunt outside. Reached down to pick up a plastic egg and tumbled on the grass causing a superficial abrasion 1 cm by 0.25 cm... A Hoyer transfer by 2 assist for transfer from	F 323		

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F 323	Continued From page 166 grass to w/c, will continue to observe." A wedge cushion with Dysom [gel and foam] was applied as a preventative measure. An IDT review of the incident documented a referral was made to therapy services for wheelchair positioning. A Fall Risk Evaluation was conducted on 4/27/16, which indicated Resident #19 should be considered at "High Risk" for potential falls. On 4/2716 at 9:15 p.m., documentation in the Nurses Notes included, "Res is 2 A [assist] sit to stand for transfers, toileting." Documentation in the Nurses Notes, dated 5/7/16 at 1:35 p.m., noted "CNAs on day shift reported to this nurse that Resident was on floor." Interview with CNA #1 revealed the other CNA who was responsible for providing care and services to Resident #19, was not in the room when the incident occurred. She was in the adjacent room with CNA #1 and could hear what happened. CNA #1 stated, "[CNA #22] tried to transfer Resident #19 alone using a sit to stand lift and dropped him. He was a 2 person transfer and she tried to do it alone. I told the nurse and the DON but nothing was done about it because [CNA #22] was cool with the DON." The facility policy, Safe Lifting and Movement of Residents, stated "The use of a mechanical lift with residents requires the assistance of 2 staff members at all times." During interview with the ADON on 7/14/16 at 8:00 a.m., she was queried regarding policies and procedures for investigation of injuries of unknown origin and resident to resident abuse. She stated, "Forms are completed." When	F 323		

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F 323	Continued From page 167 queried regarding forms specifically for the incidents with Resident #19 she stated, "I do not know anything about [Resident #19's] fall or bruises, but I will look for completed investigation report. The ADON did not provide an investigation report of injuries of unknown origin, falls, or resident to resident abuse for Resident #19.	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 observations, record review, resident, staff, and family/decision maker interview, it was determined the facility failed to ensure 3 of 27 sampled residents (#3, #8, and #11) received nutritional interventions to prevent unplanned weight loss. As a result: a) Resident #11 was harmed when his tube feeding regimen was not adjusted and he experienced a severe unplanned weight loss. b) Resident #3 was harmed when she experienced a severe unplanned weight loss without implementation or revision of nutritional interventions. c) Resident #8 had the potential for	F 325	F325 1. Resident #3 was re-assessed by Regional Registered Dietician on 7/16/16; further recommendations were given. Resident #8 was discharged from the facility on 7/25/16; no further corrective action indicated. Resident #11 was discharged from the facility 1/21/16; no further corrective action indicated. 2. An audit was conducted by the Regional Registered Dietician completed	8/12/16

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F 325	Continued From page 168 harm when assistance was not provided at meals per her care plan. Findings include: 1. Resident #11 was admitted to the facility on 10/15/15: diagnoses included paraplegia, neuromuscular dysfunction of bladder, dysphagia, chronic kidney disease, pressure ulcers, history of urinary tract infections, constipation and respiratory failure. The resident had a catheter, was on a ventilator and had a tracheostomy. A Social Service Progress Note, dated 10/23/15, indicated Resident #11 was alert and able to communicate needs and preferences with a goal of weaning from the ventilator and returning to the group home where he previously resided. The resident was transferred to the hospital on 1/21/16; he died two days later. Resident #11's closed record was reviewed. a. Record Review The admission MDS assessment, dated 10/22/15, indicated Resident #11 usually made himself understood and usually understood others. He was totally dependent on staff for eating. It was documented Resident #11 had a swallowing disorder and received nutrition via a gastrostomy feeding tube. A Nutrition at Risk (NAR) note, dated 10/20/15, documented his weight of 210 pounds (lbs) in the hospital prior to admission. The assessment indicated Resident #11 had 2 stage 2 pressure ulcers and 1 stage 4 pressure ulcer, all present at time of admission. The stage 4 pressure ulcer was 4.0 cm by 2.6 cm in length and 0.3 cm in depth. The nutrition care area assessment in full read, "Resident is at	F 325	on 7/26/16 of further residents at risk for weight loss; findings addressed as indicated. 3. Root Cause Analysis conducted by IDT determined interventions were not being implement in a varied, timely manner for those residents with risk for weight loss. Registered Dietician provided further education with facility Registered Dietician on 7/21/16 regarding implementation of interventions for at risk residents. Facility clinical staff were educated beginning 8/10/16 by RNC and SDC regarding reading and following meal ticket and reporting inconsistencies, documenting meals, snacks and fluids on meal intake form, offering alternative or substitute for residents who do not eat at least 50% of meal offered, notifying licensed nurse of intake less than 50%, maintaining fluids in reach of resident unless there is a restriction, following care plan/care card for restrictions/therapeutic diet. 4. Beginning the week of 8/15/16, the DON/ADON will attend weekly nutritional risk review with Registered Dietician to review residents at risk for weight loss for additional clinical support for four weeks, then monthly for two months and quarterly thereafter. Meal tickets will be monitored by Meal Monitor designee and reviewed by ADM/designee weekly. A report will be submitted to QAPI monthly for three months for further recommendations. The DON is	

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F 325	Continued From page 169 nutritional risk due to respiratory failure, hypothyroid, trach and sacral wound. He is on a tube fed diet and is being followed by the RD." The feeding tube care area assessment documented use of a gastrostomy (G-tube) tube for all calories, nutrition and fluids. According to the initial physician's orders, Resident #11 was prescribed tube feeding formula via a G-tube; the only items allowed orally were ice chips and ice cream. Although he was allowed to have ice cream, there was a lack of documentation in nursing, dietary or meal intake records to demonstrate the resident was provided ice cream (except one entry on 11/11/15 in nurse's notes) during his stay. Resident #11's care plan with an onset date of 10/15/15, read in its entirety: "Dietary: Resident is at nutritional risk due to respiratory failure, trach, hypothyroid and sacral wound." The goal was "Resident will not have a weight change greater than 5% in 30 days or 7.5% in 90 days." Interventions were, "Provide a tube fed diet, Weekly weights, RD [Registered Dietitian] to follow PRN." The care plan was developed prior to Resident #11's nutritional assessment being completed by the dietitian. The care plan was not revised at any time during the resident's 3 month stay even though he did not achieve the goals and, in fact, experienced a 5% weight loss within a month and greater than a 7.5% weight loss in 90 days. Resident #11's significant weight loss was not identified on the care plan. On 10/16/15, a physician's order was written for speech or nutrition to see Resident #11. There was a delay of 6 days from the order and his	F 325	responsible for monitoring and compliance. Date of Compliance: 8/12/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 170 admission until the initial nutritional assessment was completed by the RD on 10/21/15. On 10/21/15, the Medical Nutrition Assessment was completed. Resident #11 was not weighed upon admission; his initial weight was taken on 10/20/15 (5 days after admission); he weighed 176.8 pounds and his height was documented as 62 inches (equivalent to 5'2" tall). There was a lack of evaluation of Resident #11's weight of 176.8 lbs compared to the documented hospital weight of 210 lbs. Resident #11 was initially prescribed Promote with Fiber at a rate of 55 cc per hour for a period of 20 hours per day continuously via a pump. According to the 10/21/15 Medical Nutrition Assessment, the tube feeding regimen provided a total of 1100 kcal (meeting 73% of the resident's needs), 69 grams (gm) protein, and a total of 1514 cc (cubic centimeters) of fluid (formula and water flushes combined). The RD determined Resident #11's tube feeding regimen was insufficient to meet his nutritional needs by 400 calories per day. Resident #11's daily nutritional needs were calculated by the RD as: 1500-1800 calories, 60-72 gm protein, and 1500-1800 cc fluids. The RD recommended an increase in the rate of Promote with Fiber from 55 cc to 75 cc an hour and the addition of Beneprotein twice daily and Juven twice daily for his wounds. According to the 10/21/15 Medical Nutrition Assessment, the revised tube feeding regimen provided 1500 calories, 93 gm protein, and 1847 cc fluids which met the resident's nutritional needs according to the RD's calculations. The RD calculated Resident #11's nutritional needs based on an adjusted body	F 325		

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F 325	Continued From page 171 weight of 132 lbs (60 kg) when he actually weighed 176.8 lbs. According to the Academy of Nutrition and Dietetics, Evidence Analysis Library, Adult Weight Management, dated 12/1/14, current nutrition protocol does not include use of an adjusted body weight for calculating nutritional needs except in limited and specific situations (critically ill overweight and obese patients when a hypocaloric and/or high-protein feeding has been prescribed or with people having amputations). According to the Academy of Nutrition and Dietetics, Evidence Analysis Library, Adult Weight Management, "There is no evidence that substituting adjusted or ideal weight results in improved accuracy. Many of the resting metabolic rate, or RMR, equations were developed using actual body weight. The use of adjusted body weight, or ABW, may underestimate or overestimate RMR in patients depending on their weight status ... Actual body weight is advocated when assessing energy, protein and fluid needs." Resident #11's nutritional needs were likely underestimated by using adjusted body weight rather than actual body weight as evidenced by Resident #11 experiencing a significant weight loss while his calculated nutritional needs indicated intake (tube feeding providing 1500 calories) was sufficient for weight maintenance. Resident #11's tube feeding orders remained unchanged through date of transfer to the hospital on 1/21/16. A 1/8/16 Nutrition at Risk (NAR) note indicated Resident #11 experienced a significant weight loss with a weight of 159.6 lbs being recorded on 1/4/16. This constituted a 5.67% weight loss in the past month and 9.62% weight loss since admission on 10/20/15. The weight loss occurred	F 325		

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	135094		07/19/2016

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F 325	Continued From page 172 during a 1 month period of time in which Resident #11 was not weighed. He was noted with a Weight Change Notification form signed by the physician on 1/13/16. The form included Resident #11's weights that demonstrated significant weight loss occurred. Interventions or actions to be taken were not identified. There was no information on the form regarding what would be done based on the weight loss even though there was a section on the form for documenting this information. Resident #11 and his POA expressed their joint interest in Resident #11's transition to oral intake of food and fluids after his trach came out on 12/9/15. The initiation of pureed diet trial was delayed and was not implemented according to the speech therapy plan: -A 12/29/15 Speech Therapy Plan of Care, indicated Resident #11 was to start working with speech therapy (ST) with a goal of pureed foods and thin liquids being safely consumed. Documentation indicated he had been wanting to eat/drink for several weeks. Swallowing difficulties were noted due to the trach and the trach being recently de-cannulated. -A 1/4/16 Speech Therapist Progress note indicated Resident #11's pureed diet had not been initiated. His positioning in bed was documented as being a challenge with an increased risk aspiration and lethargy being present. Caregiver education on proper positioning was given. -A 1/8/16 nurse practitioner Progress Note indicated Resident #11's family inquired whether	F 325		

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F 325	Continued From page 173 he would be able to begin to eat and drink. Documentation indicated the speech therapist was spoken to and a barium swallow was scheduled. On 1/8/16, a diet requisition form from speech therapy indicated a diet trial would be completed at lunch on 1/11, 1/12, and 1/13/16. -A 1/19/16, a NAR note documented Resident #11 was receiving 100% of nutrition via the feeding tube, he was being seen by speech therapy for possible initiation of oral feeding and for the potential discontinuance of the feeding tube. -On 1/19/15, a new speech therapy goal to complete oral care to reduce the risk of decline of oral debris was initiated. Resident #11 was determined to be unsafe for oral intake based on the barium swallow results. A recommendation for small ice chips via ½ teaspoon was written; the trial of pureed foods was discontinued. Resident #11 was to be allowed small amount of ice chips. On 1/21/16, in the nurse practitioner Progress Note Resident #11 was documented with altered mental status, decreased oxygen saturation in the 80s and somnolence. He was hospitalized on this date and passed away in the hospital 2 days later. Review of the tube feeding records showed the tube feeding was not consistently signed off during the week prior to Resident 11's hospitalization. Review of the Tube Feeding Record for January 2016 showed the tube feeding administration was not signed off by nursing as being completed for 5 shifts between	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 174 1/13/16 and 1/21/16. On 7/14/16 at 10:50 a.m., the RD was asked for weight records for Resident #11 outside of what was documented in the medical record; none were provided. The care plan directed staff to obtain weekly weights. Resident #11 resided in the facility a total of 13 weeks; he was weighed 7 times. Review of Resident #11's weights documented in Nutrition Services Progress Notes showed the following progression: -210 lbs hospital (no specific date documented) -176.8 lbs 10/20/15 -174.4 lbs 10/26/15 -170 lbs 11/16/15 -171 lbs 11/30/15 -169.4 lbs 12/7/15 -166.8 lb 12/15/15 -161.8 lbs 12/25/15 -159.8 lbs 1/4/16 -160 lbs 1/16/16 b. Staff Interviews- -CNA #13 was interviewed on 7/13/16 and stated residents were to be weighed upon admission and on shower days. Weights were entered into a weight book kept at the nurse's station. -The RD was interviewed on 7/14/15 at 10:50 a.m. and stated she assessed new residents within 3 to 7 days after admission. If a resident was on tube feeding, she assessed them sooner, within 3 days if she was aware of their admission. The dietitian stated she used adjusted body weight if a resident was obese. She stated Resident #11 had wounds, issues with a clogged	F 325		

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	135094		07/19/2016

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F 325	Continued From page 175 feeding tube, and was in and out of the hospital several times during his stay. The RD verified significant weight loss occurred and that Resident #11's family was interested in Resident #11 progressing to oral intake. The RD stated that speech therapy had the final say on diet textures. If a resident was interested in a diet upgrade, the typical procedure was to do a 3-day diet trial. 2. Resident #3 was admitted to the facility on 2/18/16 and was readmitted on 5/25/16, with multiple diagnoses including acute and chronic respiratory failure with hypoxia, pneumonia, dependence on respirator, and malnutrition. Resident #3's Admission MDS assessment, dated 2/25/16, documented moderate cognitive impairment with BIMS of 10, and she required set-up only for eating with no difficulty in swallowing. Her admit weight was 129 lbs. Resident #3's care plan documented a problem, dated 2/18/16, "Resident is at nutritional risk due to respiratory failure, pneumonia, trachea/ventilator, COPD, DVT, anemia, anxiety..." Approaches to this problem included "Provide regular diet, resident is independent with eating and making food choices, RD to follow PRN, monthly weights, resident eats in her room per choice." Resident #3's care plan was revised on 6/21/16 for staff to give 2 oz of 2 cal QID with medication pass and one can of Ensure TID with meals, and on 7/7/16 it was noted Resident #11 preferred to have ice cream with her Ensure.	F 325		

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F 325	Continued From page 176 Resident #3's Care Plan did not address what staff were to do when she refused her meals or when she consumed less than 25% of her meal. Resident #3's 2/18/16 Physician's orders documented: *Regular diet, yogurt with meds *Ensure with meals Resident #3's Nutrition at Risk Progress Notes documented: *3/29/16 at 12:00 pm, weight 123.2 decrease of 6.6 lbs since admission. See RD note. Excoriation state 1 buttocks...Continue Plan Of Care (POC), NAR in 1 week. *4/5/16 at 1:45 pm, "Review of resident's current status since last NAR. See RD notes. wt on 3/28 124.4 lbs, [increase] 1.2 lbs since last NAR. O 3/28 skin: admitted [with] buttocks wound. Now healed. Cont POC, D/C from NAR/PAR." *4/12/16 at 12:00 pm, "weight 120.2, intake 20-40% of meals. Nursing reports pt [picking at meals. Daily weights x 3, 2 Cal 2 oz [with] med pass recommended by dietary..." *4/26/16 at 12:30 pm, "weight 116.4 no changes, PO intake varies. See RD note. No new meds, labs reviewed by RD. Cont POC. Next NAR 1 week." Meal intake records documented: *February 2016, 34% of the time, the resident ate 25% or less of her meals *March 2016, 63% of the time the resident ate 25% or less of her meals *April 2016, 71% of the time the resident ate 25%	F 325		

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F 325	Continued From page 177 or less of her meals *May 2016, 72% of the time the resident ate 25% or less of her meals The Meal Intake record showed Resident #3's intake was decreasing from February to May and did not document that she was offered a substitution for meals when less than 25% was consumed. Nutrition Services Progress Notes included: *3/29/16, "Resident #3's PO 32/24/57 with 783 cc fluid and to continue POC, regular diet, Ensure 1 can TID with meals and NAR in one week." *4/5/16, "wt 3/28 - 124.4 lbs increase 1.2 lbs since NAR. PO 25/25/42 with 2 refusals. Skin 3/25- skin buttocks/healed...Cont POC, D/C NAR." *4/12/16, "...Rec daily wts x 3 days to verify any changes. Cont regular diet, Ensure TID, MVI. 1+ pitting edema...Begin two Cal 2 oz BID with med pass. Cont POC..." Resident #3's daily weights documented: *4/14/16- 121.2 *5/15/16- 118.2 *4/16/16- 123.4 *4/26/16, "...[-] 13.1 lbs since admission. Cont regular diet, Ensure with meals, yogurt, cont MVI...wt loss probably [secondary] to [decrease] edema. Cont two cal 2 oz BID [with] med pass. Pt [with] mental decline, PO and supplement intake is variable." *5/10/16, "...since admission shows significant wt	F 325		

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F 325	Continued From page 178 [decrease] at 1 month and [at] 75 days...Cont regular diet with yogurt [at] meals, Ensure 1 can TID with meals. Remeron started 4/8/16 ...Folic Acid, Cont 2 Cal 2 oz BID [with] med pass, MVI..." Resident #3's Functional Maintenance Program-Caregiver Instructions from the ST documented the following: * Resident #3 to received one can of Ensure during breakfast, lunch and dinner and staff were to open the can of Ensure and pour it into a glass with ice and a straw, and to instruct the resident to finish it during the meal. * Staff were to give Resident #3 one can of Ensure either chocolate or strawberry flavor in a glass with ice and a straw at 10:00 am, 2:00 pm and 7:00 pm and to instruct her to consume the Ensure within 15 minutes. Staff should check back in 15 minutes to insure it is gone. ST also commented Resident #3 often complained of feeling full, and for staff to encourage her to finish all presented Ensures. On 7/13/16 at 8:30 am, Resident #3 was observed inside her room and on her overbed table were 1 unopened can of Ensure vanilla flavor, a chocolate drink with ice (resident said it was Ensure), and an opened yogurt container which was still full. Resident #3 said she was full and preferred to eat inside her room. On 7/13/16 at 6:50 pm, Resident #3 was observed in her room and said she just eaten her dinner. On her overbed table were a glass full of	F 325		

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F 325	Continued From page 179 chocolate Ensure with ice, yogurt container still full, and 2 cans of unopened Ensure one vanilla and one chocolate flavor. Resident #3 said the staff gave her 6 Ensure a day and she couldn't drink them all. On 7/15/16 at 9:10 am, the RD with the CDM said part of the problem with Resident #3 was she did not like to eat that much and she just wanted to have Ensure. When asked how sure they were Resident #3 was consuming her Ensure, the RD said she believed the ST gave Resident #3 a journal to record what she was taking in. When the RD showed the journal to the surveyor she said "I will be honest with you. There's nothing in here." When asked why other interventions were not considered for Resident #3 when her intake was 25% or less, the RD said Resident #3's wounds were healing, and it didn't mean she was not getting enough nutrition." When asked how they monitored Resident's #3's supplement intake, the RD did not answer. CDM looked at Resident #3's Meal Intake and said "Resident only ate 25% of her breakfast and refuses her lunch a lot. I got your point this is not good. It looks like they only give Ensure because that is what the resident wants." Resident #3 experienced a significant weight loss of 12.6 pounds (10.07 percent) in two months, with no documentation additional interventions were implemented or considered. Her POC was not revised or reviewed when the desired result was not achieved. Her care plan was not updated or individualized when she was consuming only 25% or less of her meal. 3. Resident #8 was admitted to the facility on 12/23/14, with diagnoses which included	F 325		

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F 325	Continued From page 180 hemiplegia of the left side and dysphagia following a CVA, acute respiratory failure with a tracheostomy, and muscle weakness. Resident #8's Quarterly MDS assessment, dated 6/14/16, documented moderate cognitive impairment with mild depression, and required assistance of 1-2 staff with all cares, except eating. The care plan did not address Resident #8 changes in her ability to self-feed. On 6/29/16 Resident #8's Therapy Referral and Screening Form documented: * From nursing, the "Change in ability to feed self" was checked and * "Difficulty transferring hand to mouth" was written out. * In addition, from the Therapist, "decreased intake, increased refusals at meals, difficulty with self-feeding regarding increased assist/cues" was written. On 7/1/16 in Resident #8's July Physician Orders documented she needed OT for ADL retraining. In addition, it documented Resident #8 needed work on her positioning and needed adaptive equipment for eating. On 7/1/16 in Resident #8's Nurses' Notes, documented she had new orders for OT to see her for positioning and adaptive equipment for eating. Resident #8's OT note, dated 7/6/16, documented the OT was following Resident #8 in regards to a decline in ADL's of self-feeding. The	F 325		

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F 325	Continued From page 181 note indicated she had increased refusals for self-feeding. The Initial Assessment portion of the notes documented Resident #8's current level of ADL Self Care, Self-Feeding was at moderate assistance which the note defined as Resident #8 required 26-75% assist with meals. This section documented Resident #8 required cues and redirection for safety on multiple occasions during the evaluation; she completed up to 50% of normal active and passive range of motion; and she had a severe impairment in her motor control. In addition, the OT's goal for improvement, in regards to Resident #8's self-feeding deficit, was documented as: [Resident #8] would require minimal assistance, defined as 1-25% assist, to help her self-feed at least 25% of her meal utilizing adaptive equipment as needed. The date the goal was to be met and evaluated on was 7/20/16. Resident #8's ADL Meal Intake Record documented: *In April 2016, 31% of the time, Resident #8 consumed between 25-50% of her meals. Resident #8 refused 1 meal. *In May 2016, 32.2% of the time, Resident #8 consumed 25 - 50% of her meals. Resident #8 refused zero meals. (The May ADL copy was of very poor quality.) *In June 2016, 39.3% of the time, Resident #8 either refused or consumed 25 - 50% of her meals. Resident #8 refused 6 meals.	F 325		

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F 325	Continued From page 182 *July 1st - July 11th 2016, 51.5% of the time, Resident #8 either refused or consumed 25 - 50% of her meals. Resident #8 refused 4 meals. On Resident #8's morning breakfast ticket, dated 7/13/16, documented she was impulsive and required supervision for all PO intake. On 7/13/16 at 8:19 am through 8:26 am, Resident #8 was sitting in her bed with her meal tray in front of her. She appeared asleep and had not touched her meal. Resident #8 was holding onto a Sippy cup and it was tipped over onto her lap. There was no aide to help her eat or supervise Resident #8. On 7/13/16 at 8:26 am, Resident #8 was woken up and her tray was taken away. The ADON stated she would look into why the meal ticket stated she required supervision and what the supervision should look like. She believed it just meant they had to look in on her as they passed by the room. The ADON made me a copy of the breakfast ticket. On 7/15/16 at 8:16 am, Resident #8 was calling out "Hello, Hello, Hello" continuously until 8:20 am. It was observed her call light was above her left shoulder on the outside of the pillow and out of her reach. She had her meal tray in front of her and the food was whole and not cut up. She was observed trying to get the food to her mouth and the food kept falling off of her fork. On 7/15/16 at 8:20 am, CNA #2 walked into Resident #8's room and asked her what she needed. Resident #8 pointed to her tray and CNA#2 asked if she needed help with it and she	F 325		

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F 325	Continued From page 183 stated "yes." On 7/15/16 at 9:50 am, the ADON stated respiratory therapists told her Resident #8 was safe to eat from a respiratory perspective. The ADON was shown the nursing Therapy Referral and Screening Form requesting OT services and the OT note. The OT note documented Resident #8 required moderate assistance with self-feeding issues at the present time. She stated she would look into it. On 7/15/16 at 10:19 am, CNA #1 stated Resident #8's cares got neglected often because the staff did not like going into her room.	F 325		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, medical provider, and POA interview, it was determined the facility failed ensure 4 of 27 sampled residents (#2, #8, #11, #15) were provided with sufficient fluids to maintain hydration. Residents were observed with dry mouths; they complained of being thirsty and asked for water. a) Resident #11 was harmed when he was not provided feeding tube formula and free water per MD order, and became severely dehydrated. b) Residents #2, #8, and #15 had potential for harm when they were not provided with fluids and/or assistance to	F 327	F327 1. Resident #11 was discharged from the facility on 1/21/16; no further corrective actions indicated. Resident #2 was discharged from the facility on 8/4/16; no further corrective actions indicated. Resident #8 was discharged from the facility on 7/25/16; no further corrective actions indicated. Resident #15 was evaluated by Regional Registered Dietician related to dehydration risk on 7/21/16; care plan	8/12/16

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F 327	Continued From page 184 consume them, complained of thirst, and were observed with dry mouths. Findings include: 1. Resident #11 was admitted to the facility on 10/15/15: diagnoses included paraplegia, neuromuscular dysfunction of bladder, dysphagia, chronic kidney disease, pressure ulcers, history of urinary tract infections, constipation and respiratory failure. He had a catheter, was on a ventilator and had a tracheostomy. A Social Service Progress Note, dated 10/23/15, indicated Resident #11 was alert and able to communicate needs and preferences with a goal of weaning from the ventilator and returning to the group home where he previously resided. Resident #11 was transferred to the hospital on 1/21/16; he died two days later. Resident #11's closed record was reviewed. a. Record Review Resident #11 was at risk for dehydration due to history of urinary tract infections, constipation with prescription of 2 daily medications (Miralax 17 grams and Senna 8.6 grams) and issues with the feeding tube becoming clogged/resident not receiving full feeding and flushes. The course of the resident's 3-month stay was as follows: The admission MDS, dated 10/22/15, documented Resident #11 usually made himself understood and usually understood others. He was totally dependent on staff for eating. The assessment documented Resident #11 had a swallowing disorder and received nutrition via a	F 327	was reviewed and revised as indicated by IDT. 2. An audit was conducted by the Regional Registered Dietician completed on 7/26/16 of further residents at risk for dehydration; findings addressed as indicated. 3. Root Cause Analysis conducted by IDT determined documentation of intake of fluids was not consistent by the facility staff. Education was initiated with facility staff on 7/16/16 regarding requirement of F327 by ADM, RNC, DON and SDC. Facility clinical staff was educated beginning on 8/10/16 regarding keeping fluids within reach unless restricted, monitoring for signs/symptoms of dehydration and reporting to licensed nurse, offering oral care at least twice daily, offering chap stick and communicating resident specific care needs to licensed nurses who will communicate change in resident care needs to the IDT via the 24 hour report. 4. Beginning the week of 8/15/16, members of the IDT will monitor resident care needs being met, fluids within reach unless restricted during VIP rounds five times weekly for four weeks, then monthly for two months and quarterly thereafter. Medical Records/designee will audit 25% of MAR/TAR/ADLs records weekly for four weeks, monthly for two months and quarterly thereafter to review for documentation of fluid intake. A report of findings will be submitted to QAPI Committee monthly for three months. The	

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F 327	Continued From page 185 feeding tube. The ADL Care Area Assessment (CAA) indicated Resident #11 was dependent for all ADLs due to limited mobility of his arms and legs. The communication CAA indicated Resident #11 spoke both Spanish and English; however, his ability to was hampered by the trach and ventilator. The nutrition care area assessment in full read, "Resident is at nutritional risk due to respiratory failure, hypothyroidism, trach and sacral wound. He is on a tube fed diet and is being followed by the RD." The feeding tube care area assessment documented use of a gastric tube (G-tube) for all calories, nutrition and fluids. The dehydration care area assessment documented in full, "Care plan addressing potential for dehydration or fluid imbalance will be addressed in Tube Feeding care plan 10/28/15." Resident #11's causal risk factors for dehydration were not identified or thoroughly assessed. According to the initial physician's orders, Resident #11 was prescribed tube feeding formula via a G-tube; the only items allowed orally were ice chips and ice cream. There was a lack of documentation in nursing, dietary or meal intake records to demonstrate he was provided ice cream (one entry only on 11/11/15) during his stay. On 10/21/15, the Medical Nutrition Assessment was completed. Resident #11's weight was 176.8 lbs. He was prescribed Promote with Fiber at a rate of 55 cc per hour for a period of 20 hours per	F 327	DON is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 327	Continued From page 186 day continuously via a pump. The tube feeding formula provided 914 cc of water and Resident #11 had an order for 600 cc of water (free water at 150 cc four times a day) for a total of 1514 cc a day. In addition, staff were to flush the tube with 30-60 cc of water before and after medications were administered. Resident #11's fluid needs were calculated as being between 1500-1800 cc day (using an adjusted body weight of 60 kg and factor of 25-30). Due to the tube feeding regimen not meeting Resident #11's needs, the tube feeding rate was increased to 75 cc an hour based on the dietitian's recommendation. The revised tube feeding regimen provided 1247 cc of water and the free water of 600 cc daily remained the same for a daily total of 1847 cc daily. Resident #11's tube feeding orders remained unchanged through date of his transfer to the hospital on 1/21/16. On 11/23/15 Resident #11 was diagnosed with a UTI and was prescribed Levaquin antibiotic for 10 days. Resident #11 was admitted to the hospital on 12/9/15 after his trach was found no longer in place. The 12/9/15 hospital H&P documented, "The patient felt sleepy and thirsty and asking for ice water with chips even though the patient has a history of dysphagia, has a PEG tube for tube feed." On 12/21/15, Resident #11 transitioned from his room on the ventilator unit to a room on the rehabilitation hall due to successful de-cannulation. His trach had been pulled out and the decision was made not to replace it. Resident #11 was breathing adequately without	F 327		

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	135094		07/19/2016

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F 327	Continued From page 187 the ventilator. A 12/29/15 Speech Therapy Plan of Care indicated Resident #11 was to start working with speech therapy with a goal of pureed foods and thin liquids being safely consumed. Documentation indicated he had been wanting to eat/drink for several weeks. Swallowing difficulties were noted due to the trach and the trach being recently de-cannulated. A 1/4/16 Speech Therapist Progress note indicated Resident #11's pureed diet had not been initiated. His positioning in bed was documented as being a challenge with an increased risk aspiration and lethargy being present. Caregiver education on proper positioning was given. A 1/7/16 nurse practitioner Progress Note indicated Resident #11's feeding tube was clogged. A 1/8/16 nurse practitioner Progress Note indicated Resident #11's family inquired whether he would be able to begin to eat and drink. Documentation indicated the speech therapist was spoken to and a barium swallow was scheduled. On 1/8/16 a diet requisition form from speech therapy indicated a diet trial would be completed at lunch on 1/11/16, 1/12/16, and 1/13/16. A 1/8/16 Nutrition at Risk (NAR) note indicated Resident #11 experienced a significant weight loss with a weight of 159.6 lbs being recorded on 1/4/16. This constituted a 5.67% weight loss in the past month and 9.62% weight loss since	F 327		

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F 327	Continued From page 188 admission on 10/20/15. The issue of the feeding tube clogging was documented. There was no evidence Resident #11's fluid balance was evaluated in light of the weight loss. On 1/13/16, the Resident Care Conference notes indicated nursing, dietary, activities, and family were present for the meeting. The family was documented as expressing concerns with Resident #11's fluid restriction. A 1/15/16 Nurse's Note, documented Resident #11's feeding tube being clogged with nursing being unable to get it unclogged. The NP was notified and an order obtained to send Resident #11 to the emergency department to have it changed. A 1/19/16 NAR note documented Resident #11 was receiving 100% of nutrition via the feeding tube, he was being seen by speech therapy for possible initiation of oral feeding and for the potential discontinuance of the feeding tube. On 1/19/15 a new speech therapy goal to complete oral care to reduce the risk of decline of oral debris was initiated. Resident #11 was determined to be unsafe for oral intake based on the barium swallow results. A recommendation for small ice chips via ½ teaspoon was written; the trial of pureed foods was discontinued. Resident #11 was to be allowed small amount of ice chips. There were no nurse's notes for a 2-day period preceding Resident #11's hospitalization (1/19/16 at 12:30 p.m. until a note 1/21/16 at 4:35 p. m).	F 327		

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F 327	Continued From page 189 A 1/21/16 Nurse's Note at 4:25 p.m., documented Resident #11 was sent to the emergency department to be evaluated for a stroke. A note later that day at 10:00 p.m. documented, "No ice chips or water should be left in pt (patient's) room." There was no evidence Resident #11's hydration status was evaluated. On 1/21/16 in the nurse practitioner Progress Note, Resident #11 was documented with altered mental status, decreased oxygen saturation in the 80s and somnolence. He was hospitalized on this date. Resident #11 was hospitalized on 1/21/16 due to a change in mental status. Review of the ED Physician Note, documented at 2:50 p.m. on that date, indicated, "He has quite poor hygiene, primarily oral hygiene ... Oral mucosa is significantly dry with brownish crusting over tongue and oral mucosa. He is edentulous. Tongue is significantly dry with a layer of brownish crusting." The note further documented an elevated sodium lab of 190 (137-145 normal range), BUN 140 (9-20 normal range), and creatinine 2.5 (.6-1.25 normal range). Clinical impressions were, "1. Altered level of consciousness, 2. Intracranial mass, 3. Dehydration, 4. hypernatremia (high sodium)." The note stated, "Severe dehydration and rehydration high risk for cerebral edema." Resident #11 passed away on 1/23/16 in the hospital. According to the 2/5/16 hospital Discharge Summary, admitting diagnoses included severe dehydration, severe hypernatremia, acute kidney injury, and acute urinary tract infection with a suprapubic catheter	F 327		

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F 327	Continued From page 190 related. Resident #11's cause of death was documented in full, "1. Intracranial mass, possible olfactory neuroblastoma or other malignancy of the brain. 2. Urinary tract infection, possibly secondary to suprapubic catheter with gram negative rods. 3. Gram positive cocci bacteremia, unclear source. 4. Severe hypernatremia with dehydration 5. Acute encephalopathy, possibly secondary to dyselectrolytemia (electrolyte disorder) and infection. 6. Acute kidney injury." Review of the Tube Feeding Record for January 2016 indicated Resident #11 was not provided with tube feeding and water flushes per physician's orders. There were 5 shifts, between 1/13/16 and 1/21/16, in which tube feeding administration was not signed off by nursing as completed. There were 2 shifts on the 14th and 17th in which the flush of 200 cc was not documented as having been administered. The order for flushing the G-tube with 30-60 cc of fluid was not documented as having been completed on the night shift for the 8 days prior to Resident #11's hospitalization (from 1/12/16- 1/20/16). Review of the MARs demonstrated Resident #11's output was not adequately monitored in the facility prior to his hospitalization. For the month of January 2016, catheter output was not documented for 11 out of 62 shifts (through am shift on 1/21/16). Resident #11's total output per day was not totaled for any of the days in January 2016. Of the days in which output was documented for all 3 shifts (12 days out of 21 days total), Resident #11's output averaged 1104 cc per day (per the surveyor's calculations).	F 327		

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F 327	Continued From page 191 Review of Resident #11's output records for the month of October 2015 showed an average output of 1670 cc per day, demonstrating decreased urinary output, not identified by the facility, prior to Resident #11's hospitalization. b. Interview with POA Resident #11's POA was interviewed on 7/12/16 at 9:40 a.m. and stated he had cared for Resident #11 for 12 years prior to his admission to the facility. He stated Resident #11 was not provided adequate fluids and he was severely dehydrated when he went to the hospital on 1/21/16. The POA relayed the series of events. The POA stated Resident #11's cognition had already begun to deteriorate at the time the care plan meeting was held 1/13/16. The POA stated Resident #11 became increasingly incoherent over the last month of his life and indicated he had been basically alert and oriented previously. The POA stated Resident #11 was very thirsty and often asked for ice chips, which he had been allowed to have previously when he was on the ventilator. The POA stated he observed Resident #11 with a dry mouth and with cracked dry lips in the week preceding his hospitalization. The POA stated once Resident #11 moved to a different room following his trach coming out and the discontinuance from the ventilator, he was no longer allowed ice chips. The POA stated the facility was afraid he would aspirate. During the care plan meeting (1/13/16) the POA stated he expressed his desire that Resident #11 be allowed to have ice chips and that he be allowed to eat and drink. The POA stated Resident #11 was denied fluids, ice chips and food. The POA stated, "He died at the hospital. The doctor said	F 327		

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F 327	Continued From page 192 he didn't know how he (the resident) could get so dehydrated. His electrolytes were through the roof. It was like he had been in the desert for weeks. Nobody bothered giving him fluids." c. Staff Interview Staff interviews showed Resident #11 was thirsty, he was denied ice chips and fluids, and no one knew who was responsible for monitoring urinary output: -CNA #13 was interviewed on 7/13/16 at 3:15 p.m., and stated she remembered Resident #11 requested ice chips. CNA #13 stated, "His urine had a lot of sediment; he had low urine output. He wanted ice chips, but he was NPO. We were not able to give them (ice chips) due to the (physician's) order. - Nurse #8, was interviewed on 7/14/16 at 5:40 a.m., and was asked about monitoring output for residents who had catheters. He stated output was recorded per shift for all residents who had catheters. When asked who totaled and monitored the daily output records, he stated, "I don't know who reviews it. The nurse practitioner looks at the MAR. I don't know who in nursing is responsible." When asked about documenting tube feeding administration and free water administration, he stated it was all recorded in the MAR. -The Speech Language Pathologist (SLP) was interviewed on 7/14/16 at 10:10 a.m., and stated Resident #11 had a lot of "gunk in his mouth" and he had dry lips. -Nurse #5 was interviewed on 7/14/16 at 2:20	F 327		

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F 327	Continued From page 193 p.m. and stated she remembered being able to give Resident #11 ice chips and then not being able to. She stated, "He got ice chips for a while. At the end I could not let him have them (ice chips). I felt bad." Nurse #5 verified Resident #11 asked repeatedly for ice chips. -The NP was interviewed on 7/14/16 at 2:40 p.m. and stated nursing was responsible for monitoring urine output and it was their responsibility to let him know of anything abnormal. He stated he did not remember any specific hydration concerns related to Resident #11. -CNA #1 was interviewed on 7/15/16 at 10:10 a.m., and stated, "He (Resident #11) asked for ice chips constantly." CNA #1 stated she was told by the nurses not to give Resident #11 ice chips. 2. Resident #2 was admitted to the facility on 6/14/16 with diagnoses which included quadriplegic, DM, acute respiratory failure, seizures and altered mental status. Resident #2's Initial MDS assessment, dated 6/21/16, documented Resident #2 had no cognitive impairment. Resident #2's Dehydration Care Plan, dated 5/25/15, documented he was at potential risk for dehydration related to quadriplegia and the inability to obtain water independently. Interventions included: *Staff was to assess his hydration status daily. *Staff was to encourage and offer him fluids with meals, upon rounds, with med pass, and PRN.	F 327		

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F 327	Continued From page 194 Resident #2's medical record did not contain documentation of how or when the staff assessed his hydration status. On 7/11/16 at 2:37 pm through 3:50 pm, Resident #2 was observed laying in his bed with his call light out of reach. The call light was on his pillow behind his head. Resident #2's water cup was on a table about 3 feet from the bed. Staff were not observed to encourage him to drink. On 7/12/15 from 8:35 am through 12:30 pm, Resident #2 was observed laying in his bed. Resident #2's water cup was on the bedside table about 3 feet from him from 8:35 am until his lunch arrived. Staff were not observed to encourage him to drink. On 7/15/16 at 9:50 am, the ADON stated residents should have call lights so they can ask for help. The ADON agreed that residents should have fluids available and get help if they need it. 3. Resident #8 was admitted to the facility on 12/23/14, with diagnoses which included hemiplegia of the left side and dysphagia following CVA, acute respiratory failure with a tracheostomy, and muscle weakness. Resident #8's UTI Care Plan, dated 5/11/16 and 7/11/16, documented she had a UTI. Interventions included stated staff were to encourage adequate fluid intake and they were to offer fluids at frequent intervals. On 7/14/16 at 5:05 am, Resident #8 was observed in her bed and asleep. Her call light was on her pillow above her head on the left side	F 327		

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F 327	Continued From page 195 of her body, out of her reach. On 7/14/16 at 5:46 am Resident #8 was calling out "hello, hello, hello, Rocky." No call light was used to get staff assistance. On 7/14/16 at 5:51 am, a staff entered the room to assist Resident #8. Resident #8 stated she was thirsty and needed water. The staff member filled up her water mug and left the room. On 7/14/16 at 5:59 am, Resident #8 was observed to laying in bed. She had a water mug in front of her with a straw in it. She had white around her mouth, dry lips, and was licking her lips. Resident #8 kept picking up her cup and was attempting to get the straw to her mouth. She stated she was calling out for staff this morning because she could not reach her call light and she was thirsty. The call light was now on her chest by her right side. She stated "I need help I don't want to dribble on myself...Help me, why are you not helping me." She grabbed her mug and attempted to get it to her mouth again. She could not get it to her mouth and put it down. Resident #8 stated "Are you going to help or not." The surveyor asked her what she usually did to get help. She stated she used this and pointed to her light. She stated "You are not helping me...They never help me." Resident #8 was reminded to use her call light for help if she needed it. On 7/15/16 at 9:50 am, the ADON was notified of the above observations. The ADON stated Resident #8's call light should have been where she could reach it to call for help with drinking her water.	F 327		

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F 327	Continued From page 196 4. Resident #15 was admitted to the facility on 4/20/15 with diagnoses which included dementia, and chronic kidney disease stage III. Resident #15 quarterly MDS assessment, dated 7/8/16, documented he had a mild cognitive impairment and was usually understood usually he communicated, but he had difficulty with some words or finishing thoughts. Resident #15's Elimination Care Plan, dated 4/2/15, documented he was at risk for alterations of bladder function related to him requiring a suprapubic catheter for his neurogenic bladder. Interventions included that staff was to encourage fluids intake. Resident #15's Hydration Care Plan, dated 3/8/16, he was at risk for dehydration related to alterations in cognition and dementia. Interventions Included: *Staff was to offer him fluids within diet parameters, with med passes as ordered, and PRN. *Staff was to assess Resident #15 for signs and symptoms of dehydration. Resident #15's July Physician Orders documented staff was to provide 120 mL of water with med pass four times a day and they were to document the amount he drank. Resident #15's Bladder Evaluation, dated 2/28/16, documented his average fluid intake was 1000 mL for 24 hours. In addition, it	F 327		

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F 327	Continued From page 197 documented his average fluid output was 4-5000 mL per 24 hours. Resident #15's July MAR up to 7/13/16 failed to document the administration of the 120 mL water offered on two occasions. The MAR documentation did not identify why the water was not given. On 7/13/16 at 4:30 pm Resident #15 was in his room sitting in his wheelchair about 2 and 1/2 feet from the bed. He had his head bent over and he was tearful. The call light was on his bed out of his reach. The water cup was on a dresser at the foot of his bed out of his reach. As Resident #15 was talking it was observed his mouth had a white crusty looking film around it and he kept licking his lips and his mouth had a thick looking mucus in it. Resident #15 stated "I am so needing fluids can you help?" As his call light was not in his reach the surveyor noticed a CNA in the hall and CNA #16 came in the room. He started to talk to her but she interrupted him and asked are you thirsty. He stated "yes I am so needing fluids." She gave him a drink of water but returned the water cup back to the dresser at the foot of the bed, out of his reach. On 7/14/16 at 9:48 am, the ADON was informed of the observation and agreed residents should have fluids available where they can reach them and have call lights where they can call for help. On 7/15/16 at 10:19 am CNA #1 stated Resident #15 did not get his light to call for help often. She agreed if the call light was out of reach he could not ask for water if he needed it.	F 327		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		8/12/16

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F 329 SS=D	Continued From page 198 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure clear indication for duplicate medication therapies. This was true for 1 of 4 residents (#6) sampled for psychotropic medication use. The deficient practice created the potential for harm when Resident #6 was started on two hypnotic medications at the same time. Findings include:	F 329	F329 1. Resident #6□s clinical record was reviewed by contracted pharmacist on 7/20/16; no additional findings indicated. Resident #6□s clinical record was reviewed by RNC on 8/10/16 with additional supporting documentation noted by the primary provider and	

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F 329	Continued From page 199 Resident #6 was admitted to the facility on 5/1/14 with diagnoses which included RA, dysphagia , and possible underlying psychiatric disorder with agitation. Resident #6's annual MDS assessment, dated 6/22/16, documented she had no cognitive impairment with minimal signs of depression, and no reports of changes in her sleep patterns. Resident #6's quaterly MDS assessments dated 3/31/16 and 5/19/16 also documented no changes in her sleeping patterns. On 5/1/16, Resident #6's MAR began to document hours of sleep at night. Between 5/1/16 and 5/16/16, a Psycho-Pharmacological Record for Resident #6 she slept restfully between 6 and 7 hours per night. On 5/16/16, a phychiatrist's progress note documented Resident #6 reported difficulty sleeping at night. The progress note documented new order for Trazodone for sleep, and a recommendation to consider adding Rozerem. On 5/16/16, Resident #6's physician's orders documented Trazodone 50 mg each night after dinner, and Rozerem 8mg every day at bedtime. The physician did not document a rationale for Resident #6 to have two different medications started for sleep on the same date. On 5/16/16 in Resident #6's MD progress note documented she was started on trazodone to help her sleep per Resident #6's request and Rezerem for restorative sleep by a psychiatrist's	F 329	psychological provider indicated. Primary provider risk versus benefits documentation in June, 2016 as indication of why both medications were indicated for use. 2. An audit was conducted by contract pharmacy provider beginning on 7/25/16 regarding duplication of psychopharmacological therapy; no additional findings indicated. A review was conducted of residents with psychopharmacological therapy by the IDT, care plans, Gradual Dose Reductions (GDRs□), consents, behavior monitoring documents were reviewed and revised as indicated. 3. Root Cause Analysis was conducted by IDT and determined that primary provider for Resident #6 was not contacted to clarify orders for duplicate therapy from primary provider and psychological provider. Facility clinical staff were educated beginning on 8/10/16 by SDC regarding requirements of F329 and requirement of psychotropic medications having orders that include diagnosis and behavior monitoring. Nurses are to monitor behaviors, side effects and interventions and document on the behavior monitoring flow record. C.N.A.s are to communicate behaviors to the licensed nurses. 4. Beginning the week of 8/15/16 the IDT will review new orders for psychotropic medications in the morning clinical meeting, any indications of potential for duplicate therapy will be reported to the primary provider for further	

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	135094		07/19/2016

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F 329	Continued From page 200 order. On 7/13/16 at 5:45 pm, the ADON was asked to provide further documentation for justification of duplicate hypnotic therapy. No further information was provided.	F 329	clarification. Orders will be review weekly for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee. The DON is responsible for monitoring and compliance. Date of Compliance: 8/12/16	
F 353 SS=L	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation; resident, staff, resident group, and resident family interviews; facility policy and procedure review; resident record	F 353	1. On 7/17/16 the QAPI committee developed an orientation packet for agency staff to be reviewed prior to	8/12/16

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F 353	Continued From page 201 review; review of the facility's grievances; and review of the facility's Resident Council minutes; it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of residents. The failed practice placed the health and safety of The failed practice placed the health and safety of 21 of 27 sampled residents #s 1-10, 14-21, and 23-27)in Immediate Jeopardy of serious harm, impairment, or death, and had the potential to adversely affect the remaining residents receiving services and treatment at the facility when the facility failed to provide an adequate number of trained RN, LPN, and CNA staff on duty throughout the facility to provide care as planned and to ensure residents needs were met due to the high acuity level. The deficient practice also resulted in serious harm, injury, or death for 4 of 4 sampled residents (#s 11, 13, 21, and 22) no longer residing in the facility. Facility Administration was informed of the Immediate Jeopardy, and need to develop and implement an acceptable plan to remove the Immediacy, at 4:20 pm on 7/15/16. Findings Included: 1. Licensed Nurse and CNA staffing: The facility had a specialty unit for residents with ventilators and tracheostomies. At the time of entrance on July 18, 2016 the facility provided care to 7 residents with tracheostomies and 19 residents who were ventilator dependant. According to interviews with CNA #1 on 7/15/16 at 9:55 am and CNA #13 7/13/16 4:55 pm, all residents on ventilators required two person assist for repositioning and transfers, and many	F 353	assignment into the facility; agency assignment will be logged by SDC. On 7/16/16 the Respiratory Manager/designee began an orientation process for new/agency staff to complete training related to the care of residents on the vent/trach prior to taking an assignment on the vent/trach unit. Beginning on 8/1/16 the facility initiated an on-call schedule with nursing management personnel to provide additional coverage for staffing. Beginning on 8/1/16 the facility schedule was reviewed and revised by the QAPI committee and Regional Vice President to validate provision of adequate staff and 16 consecutive hours of Registered Nurse coverage. The Orianna Employment 2-11 policy was revised on 7/20/16 to reflect specialized care competencies being validated via return demonstration before being scheduled to work on the ventilator unit. 2. Beginning on 7/16/16 members of the IDT/facility management have conducted observations and interviews with residents and staff regarding sufficient staff for provision of resident care needs; observations and interviews indicate resident and staff satisfaction with provision of care as indicated by sufficient staffing. 3. Root Cause Analysis by the IDT revealed there was not an orientation process in place for agency staff prior to taking an assignment in the ventilator/trach unit and that staffing	

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F 353	Continued From page 202 of the residents with tracheostomies required two person assist for transfers. Per the CNAs, assisting the residents with ventilators required approximately 20 minutes, even if the minimal amount of care was provided, and required them to exercise extreme caution so as to protect the residents' airways as cares were provided. 2. Resident Group Interview: On 7/13/16 at 11:00 am, the resident group stated, "Please help us. We are suffering." The group reported many ongoing problems with the lack of care in the facility. There were 8 residents in group, all of whom expressed issues with the inadequate nursing staff. The Group report included: *They had to wait too long for call lights to be answered. The residents reported call light response times were either slow, or the call lights would be turned off without needs being addressed and staff would leave the room. They reported the staff would tell them "Just a minute" and that "minute" would turn into "an hour later." * Residents reported they would be in the bathroom, sitting on the toilet, but when they called for assistance nobody would come. One resident stated that within the past week s/he had to wait an hour to be helped off the toilet. * Two residents reported they had to press the call light multiple times to get what they needed. The CNA's entered their rooms and did not have the time to wait and see all the things a resident might need before leaving. When the residents pressed the call light again, "the staff got annoyed" with them and "yelled" at them for pressing the call light too much. One resident	F 353	numbers were not being monitored to ensure adequate staff for provision of timely care for residents. Facility staff were educated beginning on 7/16/16 regarding the requirements of F353 by the ADM/RNC/Registered Nurses. Beginning on 8/10/16 the SDC provided additional education with facility clinical staff on requirement of the facility to provide sufficient qualified staff to meet the needs of the residents in a timely manner. Beginning 8/12/16 the DON will review newly admitted residents acuity and review staffing needs with Staffing Clerk to ensure facility has sufficient qualified staff available. The DON/ADM and Staffing Clerk will review the CMS form 802 weekly against projected staffing for the coming week and make adjustments as indicated based on resident acuity. 4. Beginning the week of 8/15/16, members of the IDT/facility management will conduct on-going observations and interviews with residents and staff to validate provision of care for residents. Observations/interviews will be conducted five times weekly for four weeks, then monthly for two months and quarterly thereafter. Administrator/designee will continue to attend Resident Council meetings weekly until such time as Resident Council determines to decrease frequency of meetings to review and discuss findings.	

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F 353	Continued From page 203 stated, "It hurt my feelings." * The residents reported the ratio of residents to aides was not good. One resident reported s/he had waited up to 2 1/2 hours for assistance to get out of bed. The group stated the night shift or evening shift was the most understaffed. The residents reported the 300 and 500 halls have 1 CNA each to assist all the residents. If both aides were in one room assisting a resident, that left no one to help the others and "it felt awful." One resident reported nursing staff did not have "time for us or time to do their job," The residents reported the staff "rushed" them (the residents) out of bed but made the residents wait for nursing staff when the residents needed things. a. Resident #24 was admitted to the facility on 7/29/15 with diagnoses which include Alzheimer disease, anemia, A-fib, CAD, HTN, ESRD, and UTI. Resident #24's Quarterly MDS assessment, dated 6/17/16, documented he had a mild cognitive impairment, required extensive assistance of two people for all transfers and extensive assistance of one person for toilet use. On 7/14/16 at 5:05 am, Resident #24's room was on. At 5:08 am, CNA #21 entered Resident #24's room, turned off the call light, then left the room. On 7/14/16 at 5:12 am Resident #24 activated his call light. At 5:23 AM, CNA #21 entered the room, turned off the call light, and left. On 7/14/16 at 5:35 am, Resident #24 activated his call light. At 5:43 am, CNA #21 entered the room, turned off the call light, and left.	F 353	The QAPI committee will meet weekly to review findings of ongoing audits/interviews/resident council meetings until such time that compliance is sustained. The Regional Vice President/RNC or corporate staff will continue to support the facility on weekly basis for a period of time of no less than one quarter to ensure compliance with corrective measures. The RVP is responsible for ongoing monitoring and compliance.	

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F 353	Continued From page 204 On 7/14/16 at 5:43 am, CNA #21 stated Resident #24 had put his call light on several times asking for assistance to get up. CNA #21 stated she was the only CNA currently assigned to that hall. She stated she knew she should get Resident #24 up like he asked, but she could not because she had to give change of shift report to the oncoming CNA, and other residents were also activating their call lights. CNA #21 stated Resident #24 required two people to transfer him, and there was no one else to help with the transfer. CNA #21 said with only one CNA, "it is hard getting to all the call lights on time and doing what the residents request." On 7/14/16 at 5:44 am, Resident #24 again activated his call light. CNA #21 responded and told him, "You are going to have to wait a bit longer. I will get you up in bit." CNA #21 turned the call light off and left the room. On 7/14/16 at 5:58 am, Resident #24 activated his call light again. CNA #21 and a nurse entered the room to assist Resident #24 out of bed. b. Resident #8 was admitted to the facility on 12/23/14, with diagnoses which included dysphagia and hemiplegia of the left side following a CVA, acute respiratory failure with a tracheostomy, and muscle weakness. Resident #8's 4/25/14 ADL Care Plan documented she was dependent on 1-2 staff members for extensive assistance with all cares. On 2/24/16 at 7:50 pm, an I&A report documented Resident #8 was found on the floor	F 353		

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F 353	Continued From page 205 after attempting to reach her cheesy bread. The report documented this incident could have been prevented if Resident #8 had bed rails up, and that the facility was low staffed and needed more people. The Witness Accounts documented the following: * Resident #8's O2 monitor was alarming, and she was calling out for help. * CNA #13 stated there were only 2 aides on duty for 28 high acquity residents, and they were in another room assisting a resident off of the commode when the event occurred. The witness statement documented there were untrained ventilator aides called to assist on the ventilator unit when it was short staffed. * RN #10 stated Resident #8 was calling out "help, help" and stated she fell out of bed trying to reach her cheesy bread. The witness statement documented Resident #8 stated she pushed her call light and no one came to help. In addition, the statement documented a response to Resident #8's call light request had taken too long. The reason RN #10 gave was "short staffed." 4. Staff Interviews a. On 7/15/16 at 10:19 am CNA #1 stated the CNA's are instructed to leave residents who cannot talk and take care of the ones who can talk, if you are busy, due to the ones who can talk can report it. She stated residents are lucky to get turned and changed once per shift. CNA #1 stated "it sucks going home like this and leaving people like this." She reported over the last few months there had been shift cuts and staff were often sent home due to "low census." CNA #1	F 353		

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F 353	Continued From page 206 reported this happened mostly on evening and night shifts, and stated the 200 hall usually had two CNA's on staff, but it had recently been cut to one. b. Observation on 7/14/16 from 5:00 am to 5:45 am (a total of 45 minutes) a call light was on in room 217. No staff was observed on the 200 hall or to answer the call light during this time. On 7/14/16 at 5:00 am., LPN #7 stated that she was an agency nurse, and was the only nurse working the graveyard shift covering hall 100 and 200 halls. LPN #7 further stated, "I'm only one nurse to 46 people and it's hard for me to know everyone. It can be very stressful at times." On 7/14/16 at 5:10 am., CNA #22 stated, "I'm the only CNA working the 100 unit now for 23 residents." The CNA then stated, "There was a time they pulled the 300/500 (identified as the ventilator unit) CNA to float and work the 200 hall because the agency CNA who was assigned to the 200 hall didn't show up. So no one was able to come in. They had no choice to pull the aide off the 300/500 hall to come help the 200 hall. This happened on the graveyard shift about a month ago." c. During tour of the 500 hall on 7/14/16 at 5:10 am, one charge nurse was noted handling multiple tasks. The charge nurse was observed providing guidance to the CNA, LPN, and consulting with the Respiratory Therapist. On 7/14/16 at 5:30 am, the charge nurse, who wished to remain anonymous for fear of retaliation, stated "It is very busy back here. Up	F 353		

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F 353	Continued From page 207 until last week I had an additional License Practical Nurse but I reported him for sleeping on the job and he was fired. I asked administration when a new nurse would be hired and I was informed if I was able to work on this 500 hall with one nurse sleeping then there is no need to replace the nurse who was terminated." The charge nurse further stated, "A disaster is going to happen. There are residents on ventilators back here on the 500 hall. Two nurses can't manage this hall at night." 5. Also, refer to the following deficiencies as they relate to the facility's failure to ensure sufficient numbers of nursing staff: Refer to F224 as it relates to the facility's failure to ensure residents were free from neglect. This failure resulted in all residents in the facility being placed in immediate jeopardy of serious injury, impairment, or death. Refer to F246 as it relates to the facility's failure to ensure call lights were accessible to residents, and the facility's practice of removing call lights from residents for "excessive use" during periods of low staffing. Refer to F309 as it relates to the facility's failure to ensure changes in residents' medical conditions were monitored, or anticipated, and residents were assessed for pain. Residents were harmed as a result of this deficient practice. Refer to F312 as it relates to the facility's failure to provide assistance with oral care and grooming. Residents were harmed as a result of this deficient practice.	F 353		

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F 353	Continued From page 208 Refer to F314 as it relates to the facility's failure to prevent pressure ulcers from developing or worsening. Residents were harmed as a result of this deficient practice. Refer to F315 as it relates to the facility's failure to ensure care and services to maintain or restore urinary continence, or to maintain urinary catheters. Residents were harmed as a result of this deficient practice. Refer to F322 as it relates to the facility's failure to ensure care and services for feeding tube management. Refer to F323 as it relates to the facility's failure to supervise residents sufficiently to prevent accidents. Refer to F325 as it relates to the facility's failure to prevent unplanned weight loss. Residents were harmed as a result of this deficient practice. Refer to F327 as it relates to the facility's failure to ensure residents were adequately hydrated. Residents were harmed as a result of this deficient practice. 6. Leadership Interviews: On 7/13/16 at 3:50 pm, the DNS and Administrator stated they were aware of issues, but "could not change it overnight." The Administrator stated the facility had identified a staffing shortage, and had been utilizing agency nurses from four different agencies. The Administrator stated the RTs working would help	F 353		

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F 353	Continued From page 209 the residents and he counted them towards staffing needs. The DNS stated the facility had posted positions on multiple Internet employment sites. The DNS stated the facility had offered sign on bonuses for CNA, LPN and RN positions. On 7/14/15, the Administrator provided the RT job description. RT responsibilities included assisting residents with maintaining their respiratory function. The job description did not include: * RT staff was able to assist residents to the toilet, or assist residents change soiled attends and then perform pericare. * RT staff was able to assist residents with eating needs. * RT staff was able to transfer and reposition residents. On 7/15/16 at 9:00 am, the RVP stated he had been aware of the facility staffing shortages and the use of agency staff. The RVP stated he was aware the use of agency staff could be "problematic" in terms of consistency of care, but did not think there had been significant care outcomes for facility residents.	F 353		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced	F 363		8/12/16

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F 363	Continued From page 210 by: Based on observations, record review, review of Resident Meal Forum Meeting minutes, review of menus, and resident, family and staff interviews, the facility failed to ensure adequate menus were developed and followed for 5 of 8 residents in the group interview, 10 residents who attended Resident Meal Forum meetings, and for all 9 residents who received pureed diets. Menus lacked variety, portions were small, and the Menu Nutrient Analysis report did not match the menus used for meal preparation and service. Foods were not prepared in accordance with the Diet Guide Sheets. This created the potential for dissatisfaction and weight loss. Findings include: 1. The group interview was held on 7/13/16 at 11:05 a.m. with 8 residents in attendance. Five residents expressed concerns with the menu. Issues included small portions, repetition, lack of fresh seasonal produce, and too much canned or frozen vegetables. Residents' comments included: -Four residents stated there was too much chicken served. One resident squawked like a chicken after making this comment. -Several residents stated peas, green beans, and carrots were served too often. -One resident reported canned and frozen fruits and vegetables were served instead of seasonal fresh produce. -One resident reported fresh fruit was never listed or served from the regular menu. -Three residents reported portions were small. One resident stated, "For breakfast, I was served a small piece of corn bread, one egg and one piece of bacon. My 2-year old could eat more	F 363	F363 1. The menus were reviewed by the Regional Registered Dietician and presented to the Resident Council/Meal Forum by Dietary Manager beginning on 7/20/16 for review and approval. The Regional Dietary Manager provided education with facility Dietary Manager regarding following of menus and recipes. 2. Beginning on 7/20/16 Facility Residents were interviewed by Regional Dietary staff regarding preferences; resident specific diet plans were reviewed and revised as indicated. An audit was conducted by Regional Dietary Manager beginning on 7/20/16 regarding pureed diets and recipes and dietary staff was educated on following diet recipes by Regional Dietary Manager beginning on 7/24/16. 3. Root Cause Analysis conducted by the IDT determined that facility cook was not following recipes and facility Dietary Manager needed additional education regarding amending menus per resident preference. Facility Dietary Manager was provided a new tool per the Regional Dietary Manager for documenting follow up to Resident Meal Forum/Resident Council meeting concerns. Facility staff were educated beginning 8/10/16 by the RNC and SDC regarding the requirement of F363, following posted menu, following resident diet/preferences per meal ticket, reporting changes in preferences or discrepancies in meal ticket, alternatives and substitutions.	

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	135094		07/19/2016

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F 363	Continued From page 211 than that." Another resident reported being served a, "small triangle of ham." 2. Minutes from the Resident Meal Forum Meetings were reviewed from January 2016 through May 2016. No meetings were held in June or July (as of the survey). Resident Meal Forum Minutes included the following comments: a. 1/21/16 Minutes "They would like more Jello desserts." b. 4/18/16 Minutes * "Discussed the rollout of the next menu series. Shooting for May 1st." * "Verified current menu that they would still like to see in the new menu, i.e. soup, instead of vegies with grilled cheese sandwiches, omelets, yogurt and cottage cheese breakfasts." * "Substitute some hamburger meals with hot dog meals." * "Some are tired of carrots and of all of the chicken choices" * "Please add cream pies to the new menu and ice cream." c. 5/16/16 Minutes * "Discussed the rollout of the new menu. They understand that HCSG (food service management company) wanted me to do a complete meal rotation, as ordered, with the new menu. After the rotation the we will meet and discuss any changes that they might want to do." * "Residents want more Jello. I will work that in." 3. Review of the 4-week cycle menu (regular and alternate menu items) demonstrated issues raised in the Resident Meal Forum Meetings and	F 363	Resident Council will be held weekly with Administrator and Facility Dietary Manager in attendance per invitation until such times Resident Council decides to decrease frequency. 4. Beginning the week of 8/15/16 the assigned Meal Monitor (members of the IDT and facility management) will monitor meals five times weekly to ensure resident satisfaction with menu and meals. A report will be submitted to the QAPI committee monthly for three months for further recommendations. The ADM is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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	135094		07/19/2016

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F 363	Continued From page 212 issues by residents in the group interview were valid and not incorporated into the 4-week cycle menu: -Chicken was on the menu 5 times in week 1, 8 times in week 2, 6 times in week 3, and 7 times in week 4. Concerns were raised of chicken being served too often in the Resident Meal Forum meeting and in the resident council meeting. -Carrots were on the menu 5 times in week 1, 3 times in week 2, 4 times in week 3, and 4 times in week 4. Concerns were raised of carrots being served too often in the Resident Meal Forum meeting and in the resident council. -Jello was on the menu once in week 1, and once in week 2. Jello was not on the menu in week 3 or week 4. Concerns were raised twice of Jello not being served often enough in the Resident Meal Forum meetings. -Omelets were not included on the menu during any of the 4 weeks. Omelets were requested in the Resident Meal Forum meeting. -Soup with grilled cheese or grilled ham and cheese sandwich was not the menu during the 4-week cycle. Grilled cheese sandwich or grilled ham and cheese sandwich with vegetables (not soup) was on the menu twice in week 1, once in week 2, and once in week 3. A request had been made to served grilled cheese sandwich with soup instead of grilled cheese sandwich with vegetables in the Resident Meal Forum meeting. -Hamburgers (or beef patties) were on the menu 8 times during the 4-week cycle menu. Hot dogs were not on the menu at all. A request had been made to substitute some hamburger meals with hot dog meals in the Resident Meal Forum meeting.	F 363		

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	135094		07/19/2016

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F 363	Continued From page 213 -Cream pies were not included on the menu during any of the 4 weeks. Cream pies were requested in the Resident Meal Forum meeting. -Green beans were on the menu 6 times in week 1, 3 times in week 2, 4 times in week 3, and 4 times in week 4. Residents in the group interview stated green beans were on the menu too often. -Peas were on the menu 3 times in week 1, 5 times in week 2, twice in week 3, and 3 times in week 4. Residents in the group interview stated peas were on the menu too often. -Fresh fruit was on not on the menu in week 1, 3 or 4; fresh fruit was on the menu once in week 2. Residents in the group interview stated fresh fruit was not served often enough. 4. Observations during the survey demonstrated the menu was not consistently followed; the Diet Guide Sheet and Menu Nutrient Analysis did not match. The menus were not posted and available for all residents to see. a. The breakfast meal was observed on 7/12/16 starting at 8:25 a.m. in both the assisted and Royal Fork dining rooms. Residents on regular diets were served a small square of coffee cake, scrambled eggs or a hard-boiled egg, and a small piece of ham (a third the size of a deck of cards). Approximately half the residents were served cereal, juice and milk; the remainder were not. Residents in the assisted dining room did not have salt and pepper available on the tables or served with their meals. In addition, margarine was not served with the coffee cake or offered to any of the residents. The eggs served to residents on pureed diets were regular scrambled eggs. They were not	F 363		

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	135094		07/19/2016

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F 363	Continued From page 214 pureed as they should have been in accordance with the therapeutic menu, or Diet Guide Sheet. The Diet Guide Sheet, used for daily meal preparation and meal service for 7/12/16 breakfast, called for 1 hard cooked egg, 1 square of coffee cake, and 1 ounce of ham (typical meat portions were 2-3 ounces for other meals on the menu). The menu did not include milk, juice, cereal or margarine with the coffee cake. The meal was inadequate for some residents with only egg, a small piece of coffee cake, and a small piece of ham being served (see comments under group interview). The nutrient analysis print-out was requested for all days and meals for the week the survey. The Menu Nutrient Analysis, provided by the Regional Dietary Manager, demonstrated the following items were to be served with this meal: margarine with the coffee cake, 4 ounces (oz) of orange juice, .75 cup of oatmeal, and 8 oz of milk; none of these items were included on the weekly menu or Diet Guide Sheet. The Menu Nutrient Analysis report was not available in the facility for staff to refer to. There was no documentation on the weekly menu or therapeutic extension to direct staff to serve the margarine, juice, oatmeal or milk. The Regional Dietary Manager requested that the Menu Nutrient Analysis be sent to him from corporate because there was no copy in the facility. Although the Menu Nutrient Analysis report documented adequacy of the menu, not all items were included on the weekly or Diet Guide Sheet. b. The pureed diet breakfast meal was observed on 7/13/16 at 8:30 a.m. The "Diet Guide Sheet"	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135094		07/19/2016

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F 363	Continued From page 215 called for pureed scrambled eggs and pureed muffin only for residents on pureed diets. No other foods or beverages were included on the menu. Residents on pureed diets were observed to be served only pureed scrambled eggs and pureed muffin. Review of the Menu Nutrient Analysis report showed residents should be served margarine, orange juice, oatmeal and milk, in addition to the muffin and scrambled egg. c. Pureed preparation for the lunch meal was observed on 7/12/16 at 11:15 a.m. The menu consisted of pureed cheese manicotti with marinara sauce, pureed mixed vegetables, pureed garlic bread and pureed strawberry shortcake. Although residents on regular diets were served garlic bread, pureed wheat bread was prepared and served to residents on pureed diets. In addition, residents on pureed diets received pureed green beans instead of pureed mixed vegetables. Residents had complained about being served too many green beans. (see group interview comments). d. There were 2 dining rooms: one dining room off the kitchen for residents who needed assistance with meals and the other dining room (Royal Fork) for residents who were independent with eating. The menu was not posted outside or in close proximity to the Royal Fork dining room at any time during the survey from 7/11/16 - 7/15/16. There was no established place to post the menu. The dining room for residents who required assistance included plastic document holders outside the entrance into the dining room. Menus were to be posted for the day and meal per	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 363	Continued From page 216 facility protocol. On 7/11/16 at 10:33 a.m. the document holder outside the assist dining room held no document. The menu was not posted. On 7/12/16 at 8:25 a.m., the menu that was posted for breakfast: French toast with syrup, sausage patty, cereal and juice was the menu from the day before. On 7/12/16 for breakfast, residents were served scrambled or hard-boiled egg, coffee cake, and ham. 4. The Regional Dietary Manager, facility Dietary Manager (hired within the past month), and the dietitian were interviewed together on 7/14/16 at 11:50 a.m. The Regional Dietary Manager stated a new cycle menu was rolled out approximately 2 months earlier. When asked if any of the residents ' suggestions from the food committee had been incorporated into the current menus, the Regional Dietary Manager stated they had not. He stated they been instructed by the Corporate Dietitian to run through the menu cycle at least once prior to making any changes. They stated the Corporate Dietitian developed the menus. When asked about the use of fresh fruits and vegetables due to the summer season, the Regional Dietary Manager stated they did not have seasonal menus; however, the facility had fruit available. The Dietary Manager stated residents were regularly served bananas on snack trays.	F 363		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is	F 364		8/12/16

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F 364	Continued From page 217 palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, family interview and staff interview, the facility failed to serve flavorful and appealing food to 3 of 27 sampled residents (#5, #6, and #27), 5 of 8 residents in the group interview, and all 9 residents who received pureed diets. Foods were not sufficiently hot, recipes were not followed resulting in foods being too salty or bland, condiments were not consistently available, pureed foods were not prepared in a manner enhancing flavor. This deficient practice created the potential for residents to experience unplanned weight loss, diminished nutritional health, and decreased sense of control of their environment. Findings include: 1. Observations of meal preparation and meal service were made during the survey. a. Pureed preparation for the lunch meal was observed on 7/12/16 at 11:15 a.m. The menu consisted of pureed cheese manicotti with marinara sauce, pureed mixed vegetables, pureed garlic bread and pureed strawberry shortcake. The cook did not refer to recipes during the pureed food preparation. The cook prepared pureed cheese ravioli as a sufficient supply of manicotti (per the menu) was not available. Although residents on regular diets were served garlic bread, pureed wheat bread	F 364	F364 1. Facility cooks were provided education by Regional Dietary Manager regarding following menu and recipes beginning on 7/24/16. Resident #5 discharged from the facility on 7/29/16; no further corrective actions indicated. Resident #27 discharged from the facility on 1/21/16; no further corrective actions indicated. Resident #6 was assessed by Licensed Nurse on 7/16/16 and by Registered Dietician on 7/16/16 in regards to nutritional needs; comprehensive care plan was reviewed and revised as indicated. 2. Resident Council meeting was held 7/20/16 with Regional and facility Dietary Managers in attendance by invitation to review Resident group concerns regarding dietary services; Dietary Manager followed up with Resident Council on resolution of concerns at the next meeting. 3. Root Cause Analysis conducted by the IDT determined that facility cook was not following recipes. Regional Dietary Manager and Regional Dietician have provided additional on-going education and support for facility dietary department to ensure	

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	135094		07/19/2016

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F 364	Continued From page 218 was prepared and served to residents on pureed diets. The cook placed wheat bread, that he removed from the bag of bread, with hot milk into the Robot Coupe food processor and processed the product. The menu item was tasted; it tasted like wheat bread and not garlic bread. The cook stated he had added garlic and onion powder to the hot milk and confirmed nothing else was added. No margarine had been added. The cook proceeded to add more garlic powder. Recipes were requested by the surveyor. The recipe for garlic bread directed staff to puree garlic bread (bread, margarine, garlic powder), that had been cooked in the oven, and to blend until smooth. Green beans were pureed next. The Cook stated he was using green beans instead of mixed vegetables. The cook put green beans and low sodium broth into the food processor and added 5 pieces of bread. The cook stated he always used low sodium broth so residents on renal and low sodium diets would be able to eat the menu item. The pureed green beans were tasted and were bland. No margarine was added to the green beans. The recipe for pureed mixed vegetables was reviewed and called for margarine to be added and did not call for the addition of bread. The use of low sodium broth was not indicated on the recipe. b. Pureed preparation for the dinner meal was observed on 7/13/16 at approximately 5:00 p.m. The menu called for pureed open faced turkey sandwich, pureed broccoli, mashed potatoes and pureed blonde brownie. The turkey was pureed with the broth it was cooked in per the Senior Cook. The item was tasted and it was very salty. The Dietary Manager tasted it and confirmed it	F 364	processes and recipes are followed and that resident satisfaction has remained consistent. Facility clinical staff were educated by SDC beginning on 8/10/16 on the requirement of F363 and reviewing menu with resident, palatability of food, reviewing meal ticket against what is served, offering seconds, reporting when a resident does not eat at least 50%, offering substitutes and alternatives, and that Meal Monitors will monitor meals five times weekly. 4. Beginning the week of 8/15/16 the facility Dietary Manager will continue to attend weekly Resident Council meeting until such time Resident Council determines to decrease frequency of meeting and provide follow up on concerns as indicated. The Dietary Manager will audit meal preparation by the cook five times weekly to ensure recipes are being followed. The members of the IDT/facility managers will conduct audits five times weekly by interviewing residents regarding satisfaction with meals. Audits will be conducted for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to QAPI committee monthly for three months for further recommendations. The ADM/designee is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 364	Continued From page 219 was salty stating the turkey was probably, "sodium injected." Preparation of the pureed broccoli was observed. The Senior Cook added regular chicken broth to the broccoli. It was tasted and also found salty. Margarine was not added to the broccoli although the recipe called for it. The cook had not referred to recipes during meal preparation. The blonde brownies prepared for residents on regular diets had been cooked in muffin tins. The brownies fell and were inverted in the center, not appetizing in appearance. The recipe called for the brownies to be cooked in a greased rectangular sheet pan, not in round muffin tins. No condiments were observed in the assist dining room on 7/11/16 or 7/12/16 (through 11:50 a.m). The Dietary Manager was asked at about this on 7/12/16 at 11:50 a.m., considering there were condiment caddies with sugar, sugar substitute, salt and pepper on the tables in the Royal Fork dining room. The Dietary Manager stated he did not know, but would find out. The Senior Cook was asked at this time and she stated because some of the residents in the dining room ate the packets, they did not put them out. The Senior Cook stated residents could get condiments if they wanted and the staff knew which residents wanted condiments. However, meal observations on 7/12/16 at breakfast noted residents were not offered salt and pepper in the assisted dining room. Meal service was observed on 7/13/16 in the Royal Fork Dining room, starting at 6:35 p.m. The plate warmer was not heating the plates. When the edge of the plates were touched, they were cold. When the Senior Cook was asked about	F 364		

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	135094		07/19/2016

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F 364	Continued From page 220 this, she stated she did not know why it was not working. At 7:10 p.m., the Dietary Manager stated the plate warmer would be replaced because it was not working. 2. The group interview was held on 7/13/16 at 11:05 a.m. with 8 residents in attendance. Five residents expressed concerns with the food. Residents' comments included: -Three residents stated the food was not hot if you received a room tray. -Two residents stated the food was, "awful." -One resident stated she was served a hamburger patty with gravy and it was, "disgusting." -One resident stated the food was, "terrible." 3. Minutes from the Resident Meal Forum Meetings were reviewed. Concerns were raised in May 2016; no meetings were held in June or July (as of the survey). Palatability concerns noted in Resident Meal Forum Meeting minutes, dated 5/16/16 included: * "They do not want veggies (vegetables) cooked in water, and if water is used they want it drained well. They do not want 'water' on their plate. I asked if veggies were tossed with margarine. They said no, but that they wanted it to be because veggies are really bland otherwise." * "The oatmeal is still too thick and lumpy many times. " 4. Resident #5 was interviewed on 7/11/16 at 2:36 p.m. and reported he gave the food a, "thumbs down" and stated, "It sucks. The taste is poor; it is very bland." The resident reported he got condiments at times but not often. The	F 364		

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F 364	Continued From page 221 resident reported food was frequently cold when he received his room tray. 5. Resident #27's family member was interviewed on 7/13/16 at 8:15 a.m. He stated Resident #27 lived at the facility for about a month starting in mid-December 2015. Resident #27's family member stated he came to the facility regularly and was often present during meals and sampled the food: breakfast, lunch and dinner, for the first 3 days after the resident's admission. He stated he had 60 years of experience in the food industry. The family member stated the steamtable (in the Royal Fork dining room) had only three quarters of an inch of water in it which was not enough to keep the food hot. The family member further stated the plate warmer was not turned on and food was served on cold plates. Concerns included that some of the food was, "extremely salty." He reported there was a potato pork casserole on the menu that was poor; 8 of 13 residents in the dining room did not eat it at all. The family member reported when beef stroganoff was served, it was all mixed together instead of the sauce being on top. He further stated the noodles were not sufficiently cooked. The family member stated, "They served frozen chicken. The temperatures were between 75-80 degrees...They (residents) were served cold food, poor food. I tried to be a voice (for the residents)." He said he talked to a corporate person and was told there was nothing that could be done. A Record of Concern, dated 1/19/16, had been initiated by Resident #27's family member. One of the concerns identified was, "Not happy with the quality of food and the temp (temperature) of	F 364		

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	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY LANE REHABILITATION AND HEALTHCARE CENTER	2105 12TH AVENUE ROAD NAMPA, ID 83686

(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 364	Continued From page 222 food at times." Findings of the investigation did not identify a concern, "Temp of food exceeded temps at 180-186 for hot foods. Food is served directly from hot cart to table where (Resident #27) sits." No corrective action was documented as being taken. A Social Service Progress Note, dated 1/21/16 read, "(Resident #27's family member) was angry and expressed his displeasure re: (regarding) the food at the facility. Provided support and agreed to inform management of his concern." 6. Resident #6 was admitted to the facility on 5/1/14 with diagnoses which included RA, dysphagia, and malnutrition. Resident #6 received a Modified Pureed diet with small portions beginning 6/24/16. Resident #6 wanted off of the feeding tube and the facility was trying to transition her to solid foods. Resident #6's Up-graded Diet Care Plan, dated 6/24/16, documented she would tolerate a pureed diet. Resident #6's July 2016 ADL Meal Intake Record Sheet documented: * 60% of the time Resident #6 consumed 0-25% of her meals. *17% of the time Resident #6 consumed 50% of her meals. * 11% of the time Resident #6 consumed 75% of her meals. * 11 % of the time Resident #6 consumed 100% of her meals.	F 364		

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F 364	Continued From page 223 On 7/12/16 at 8:36 am, Resident #6's was lying down in her bed and she had a meal tray sitting on her bed side table. The meal was not being touched by Resident #6. She stated she did not want to be on the tube feeding at all and the facility was trying to help her transition off of the tube feeding but the food was not good. She stated she was not eating the majority of the meals because of the bad taste. Resident #6 stated she was still full from the tube feeding and the meal was here and she did not want to eat it. The tube feeding was administered 8:00 pm to 8:00 am this day. On 7/13/16 at 8:39 am, Resident #6's was lying on her back hooked up to the tube feeding pump. The tube feeding had run from 8:30 pm till 8:30 am. She had a meal tray next to her bed and the meal tray had a pureed muffin and pureed egg on it. The meal ticket next to the meal tray indicated the tray should have contained pureed muffin, pureed egg, pureed cream of wheat, and orange juice. Resident #6 stated the food on the tray did not look appealing and she would have been willing to try and eat the cream of wheat if it was provided. She stated she was still full from the tube feeding since it had barely shut off. Resident #6 stated it was ok to look at the tray; the pureed muffin had an eggy look on the top and looked lumpy. CNA #24 entered the room was asked if everything was on the tray that the meal ticket stated should be there. CNA #24 stated no and that she was trying to get the cereal and juice from the kitchen. On 7/14/16 at 10:52 am, the RD stated the beverages were placed in an ice bath on top of the meal carts and nursing staff was to put the	F 364		

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F 364	Continued From page 224 drinks on the meal trays before delivering them. She stated nursing knew they were to provide the liquids to the staff.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to ensure food was prepared and served in a manner to decrease the risk of cross contamination for the 73 residents in the facility who received nutrition orally. This deficient practice placed the 73 residents at risk of infection. Findings include: 1. The initial kitchen tour was conducted on 7/11/16 at 10:10 a.m. with the following issues identified: -Two of 2 buckets of sanitizer solution located in the kitchen, in which wiping rags were stored, were checked by the Dietary Manager using a quaternary ammonia (quat) test strip. Neither bucket registered as having any quat sanitizer	F 371	F371 1. The sanitizer buckets were emptied and refreshed to the correct levels by Dietary Manager on 7/11/16. The jar with unknown item inside was disposed of by Dietary Manager on 7/11/16. The cup with the solution in the Royal Fork was removed and discarded by the Dietary Manager on 7/11/16. The cook was educated on 7/12/16 by Dietary Manager on sanitation requirements and not placing cooking utensils on the counter in between use. Dietary staff were educated on the requirements of F371 and covering food items on the hall by Dietary Manager on 7/24/16; no additional negative findings were noted.	8/12/16

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F 371	Continued From page 225 present in the solution. The Dietary Manager stated the buckets were changed 3 times a day and were due to be changed. -A clear container, shaped like a jar, was observed with an unidentified food item inside located on a shelf in the kitchen. The container did not have a label present. It was not obvious what the contents of the container were. The Dietary Manager stated it was parmesan cheese and he would ensure that it would be labeled. 2. On 7/11/16 at 3:45 p.m., the Dietary Manager and surveyor toured the kitchenettes within the facility. Inside the kitchenette located off the Royal Fork dining room was a digital food thermometer stored in an unknown solution in a clear glass cup. The Dietary Manager stated he did not know what the solution was; he was asked if the solution could be checked for sanitizing agent. He stated he did not know where test strips were in that location and removed the cup with the solution and stated he would discard it. 3. On 7/12/16, the cook was observed to prepare pureed menu items. While pureeing cheese ravioli with marinara sauce, he placed a rubber spatula directly on the counter top. He then scraped out the contents of the Robot Coupe food processor bowl into a pan using the spatula that had been placed directly on the counter. 4. Meal service for room trays on the 500 hall was observed on 7/13/16 at 5:51 p.m. The brownies were served in bowls. The bowls with the brownies were not covered as the meal trays were carried down the hallway to residents'	F 371	2. An audit was conducted to determine if there were other sanitation concerns by the Regional Dietary Manager on 7/20/16; corrections made as indicated. 3. Root Cause Analysis was conducted by the IDT and determined that dietary staff required additional training on requirements of F371. Dietary staff were educated on requirements of F371 beginning 7/24/16 by Regional Dietary Manager. Facility clinical staff were educated beginning on 8/10/16 by SDC on ensuring food items are covered in the halls. 4. Beginning the week of 8/15/16 the ADM/designee will conduct three observations of the dietary area to ensure that the requirements of F371 are being maintained, including but not limited to sanitation levels at correct reading, no unlabeled items, and utensil on the counter. Audits will be conducted for four weeks, then monthly for two months and quarterly thereafter. The ADM is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 371	Continued From page 226 rooms from the nurses' station (location of the food cart). Approximately 12 trays were served from the cart. The beverages for the same residents were poured into cups from a cart located in the hallway near the nurses' station. The beverages were also carried down the hallway and were not covered. The Dietary Manager was interviewed at the conclusion of meal service and stated he was not aware the beverages and all foods had to be covered.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it	F 425	1. Resident #7□s orders were reviewed	8/12/16

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F 425	Continued From page 227 was determined the facility failed to ensure medications ordered by the physician were available. This was true for 3 of 27 (#6, #7, and 26) sampled residents. This deficient practice had the potential to cause more than minimal harm if residents did not receive medications as ordered. Findings include: 1. Resident #7's record documented he a history of a left gluteal pressure ulcer. On 5/24/16, the physician wrote an order for staff to apply Zinc cream two times daily on Resident #7's affected area (Left Gluteal). On 7/12/16 at 9:00 a.m., the Treatment Record was reviewed with the Regional Nurse Consultant. The Treatment Record showed the Zinc cream was not applied on 6/12/16, 6/13/16 and 6/14/16. Staff documented on the Treatment Record that the cream could not applied because the cream was "out of stock." The Regional Nurse Consultant expressed surprise that the facility did not have zinc available and stated staff probably did not look for it in central supply. 2. Resident #26 was admitted to the facility on 8/24/15, for rehabilitation after a surgical repair of a fractured hip. Resident #26's Physician's Order, dated 8/26/15, included,"Change Norco 5-325 mg to 1 tablet PO every 4 hours PRN and add Tramadol 50 mg 1 tablet PO every 4 hours PRN." A SNF Communication from the pharmacy on 9/4/15, included, "Pt was recently prescribed	F 425	by RNC and revealed no treatment order missed. Resident #7 was assessed by RNC on 7/24/16 and coccyx was healed. Resident #7□s orders and TAR were reviewed and revealed zinc treatment was omitted; provider and resident were notified with no new orders indicated. Care plan was reviewed and revised as indicated by RNC on 7/24/16. Resident #26 discharged from facility on 10/1/15; no further corrective actions indicated. Resident #6□s provider was notified of medication not available by licensed nurse on 7/13/16; new order obtained. Pharmacy provider was notified, medication was administered upon arrival. 2. Medication carts were audited by contracted pharmacy supplier beginning 7/25/16 related to medication availability; findings addressed as indicated. 3. Root Cause Analysis by the IDT determined that licensed nurses needed additional education regarding reordering medication procedures and obtaining over the counter products from central supply. On 7/26/16 contracted pharmacy supplier educated licensed nurses on reordering processes to ensure timely delivery of medication refills. Beginning on 8/10/16 SDC/RNC educated licensed nursing staff on requirements of F425, administering medications per physician orders, notifying physician if medication is refused or not available for timely administration, and accessing in facility	

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F 425	Continued From page 228 Tramadol 50 mg...Our pharmacy will not fill the order because no quantity was noted..." On 7/13/16 at 4:30 pm LN #2 was asked the reason for the the 9 day in Resident #26 receiving the prescribed Tramadol. LN #2 said their previous pharmacy would deliver medications at 3:00 pm and at 8:00 pm. If the order was incomplete they would not deliver the medications. LN #2 said the nurses should have called the pharmacy and asked why the medication was not delivered. She also said they had a lot of new graduate nurses during that time and the order should have been checked for completeness. 3. On 7/13/16 at 9:50 am, during the Medication Pass LN #4 was observed preparing medications for Resident #6. The LN looked for Replesta 50,000 units wafer which was to be given to Resident #6, but did not find it in the medication cart. LN #4 went to the Medication Room and came back and said the Replesta 50,000 units was not available in the facility. On 7/13/16 at 2:25 pm, LN #4 said Resident #6 had not receive the 50,000 units of Replesta. On 7/13/16 at 5:45 pm, the ADON said the pharmacy had not yet delivered Resident #6's medication due to an insurance issue but they were able to work it out and the medication would be delivered later that night.	F 425	medication supplies. 4. Beginning the week of 8/15/16 the DON/ADON/SDC will conduct three medication pass observations weekly to ensure that medications are available and administered per physician orders. Observations will be conducted for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee. The DON is responsible for monitoring and compliance.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		8/12/16

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F 431	Continued From page 229 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure insulin pens were labeled when first used, and expired medications and vaccine were removed from the	F 431	F431 1. Expired medications and unlabeled insulin pens were disposed of by licensed nurse and replacements ordered from	

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F 431	Continued From page 230 medication cart and medication rooms. This was true for 1 of 3 medication carts and 2 of 2 medication rooms checked for expired medications. This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings include: On 7/12/16 at 3:40 pm, during inspection of the Ventilator #1 Medication Cart with LN #2 present, the following expired medications and pre-filled insulin pens with no "open" date were found: *One bottle of 325 mg ASA with an expiration of 5/17/16, *10 tablets of 5-325 mg Hydrocodone-Acetaminophen with an expiration of 4/20/16, *2 Pre-filled Lantus Solostar with no open date; and *2 Novolog Flex Pen with no open date. LN #2 said she did not realized the medications were expired, and insulin pens should have been dated by LN who opened it first. On 7/13/16 at 9:50 am, during the inspection of the 100-200 Hall Medication Room with LN #1 and LN #4 present, the following were found: *1 Multidose vial of Influenza Vaccine with an expiration date of June 2016 and *4 Pre-filled Influenza Vaccine syringes with an expiration date of June 2016 LN #1 confirmed the expiration dates and said the vaccines would be discarded.	F 431	pharmacy where indicated at the time of notification. 2. Beginning on 7/25/16 contracted pharmacy supplier conducted audits of medication carts and medication prep rooms to check for expired/unlabeled medications; finding corrected as indicated. 3. Root Cause Analysis conducted by the IDT determined that licensed nurses required additional education on storage/labeling requirements of medications. On 7/26/16 contracted pharmacy supplier educated licensed nurses on storage/labeling requirements for medications. Beginning on 8/10/16 the SDC/RNC educated licensed nurses on requirements of F431 specifically regarding labeling/dating of multi dose vials and pens, checking of expiration dates and discarding medications that are opened and not labeled and those that are expired. 4. Beginning the week of 8/15/16the DON/ADON/SDC will conduct three medication pass observations weekly to ensure that multi dose vials/pens are dated when opened, and that medications are within expiration dates. Observations will be conducted for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee monthly for three months. The DON is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

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F 431	Continued From page 231 On 7/13/16 at 10:08 am, during the inspection of Ventilator Medication Room with LN #1 present the following were found: *10 Pre-filled Influenza Vaccine syringes with an expiration date of June 2016, *About 1/8 full bottle of 250 mg/5 ml CMP Vancomycin with an expiration date of 6/24/16 and *About 3/4 full bottle of 250 mg/5 ml CMP Vancomycin with an expiration date of 6/24/16. LN #1 said the expired medications and vaccine would be discarded.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		8/12/16

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F 441	Continued From page 232 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility did not have a policy and procedure regarding identifying and prohibiting contact with residents by employees with open lesions or communicable diseases, and failed to ensure staff demonstrated proper infection control practices. This failed practice placed all residents at risk for infection. Findings include: 1. On 7/12/16 at 9:05 am, during the Medication Pass, LN #2 was observed to open a new can of Active Protein Powder and used her pen to dig for the scoop inside the can. On 7/12/16 at 9:35 am, LN #2 said she used her pen to dig for the scoop from the can of Active Protein Powder. 2. On 7/13/16 at 12:20 pm, the ice cooler cart in the 200 Hall was observed and the ice scoop	F 441	1. On 7/12/16 Active Protein Powder was disposed of and a new replacement was obtained by licensed nurse. On 7/13/16 ice chest was cleaned and ice scoop properly stored by facility staff. Facility policy was amended by corporate personnel to include notification of supervisor for open skin lesions and requirement to keep them covered. 2. On 7/19/16 a facility wide audit was conducted by RNC to identify other potential infection control practice breaches; findings were addressed as indicated. 3. Root Cause Analysis conducted by the IDT determined that facility staff required additional education regarding infection control practices. Facility policy regarding covering of employee open skin lesions was reviewed	

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F 441	Continued From page 233 was not in its holder. MDS Coordinator #2 who was walking down the 200 Hall said, "Hopefully it's not inside" she then opened the ice cooler and found the ice scoop inside. MDS Coordinator #2 said she would ask the SDC to do an inservice regarding the ice scoop not to be left inside the ice cooler. 3. A policy and procedure regarding identifying and prohibiting contact with residents by employees with open lesions or communicable diseases was not found. On 7/12/16 at 9:40 am the SDC said that she did not know if there was a policy and procedure that prohibited employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. She stated that she would provide the policy if it existed. A policy was not provided.	F 441	and revised by corporate personnel and reviewed and adopted by facility QAPI committee. Review of current facility Infection Control policy indicates current policy requiring employees to adherence to infection control policy and procedures as well as reporting any signs and symptoms of illness to supervisor and that DON is responsible for overall adherence to infection control policies. Beginning on 7/28/16 the facility Infection Control Nurse conducted education with facility staff regarding adherence to infection control practices including but not limited to not putting items into containers of powders, proper storage of ice scoop and revised policy regarding covering of open skin lesions and reporting such to the nursing supervisor. Beginning on 8/15/16 SDC/RNC educated facility clinical staff on requirements of F441 and on not putting items into containers of powders, proper storage of ice scoop and the revised policy regarding covering of open skin lesions and reporting such to the nursing supervisor. 4. Beginning the week of 8/15/16, the ADON/SDC will conduct observational rounds three times weekly to ensure infection control practices are being followed by facility staff. Rounds will be conducted for four weeks, then monthly for two months and quarterly thereafter. A report will be submitted to the QAPI committee for further recommendations. The DON is responsible for monitoring	

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	135094		07/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 234	F 441	and compliance.	
F 490 SS=L	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation; resident, staff, resident group, and resident family interviews; and review of facility policies and procedures, staffing records, resident records, the facility's grievances, facility in-service records, Resident Council minutes, and the facility's menus and food service; it was determined the facility was not administered in a manner to effectively use its resources to attain or maintain the highest practicable well being of each resident. The administration failed to ensure the facility was in compliance with the following regulatory requirements which affected or potenitally affected all residents in the facility. The failed practice placed the health and safety of 8 of 27 sampled residents (#2, #6, #8, #10, #11, #13, #15, and #25) in Immediate Jeopardy of serious harm, impairment, or death, and had the potential to negatively impact the remaining residents receiving services and treatment at the facility. The facility's administration failed to ensure there were sufficient numbers of qualified staff to provide care and that services were adequate to protect residents from neglect and/or abuse.	F 490	F490 1. On 7/15/16 the ADM and DON were educated by the Regional Vice President on the requirements of F490, F353 and F224 and the requirement to administer the facility effectively and efficiently to attain or maintain the highest practicable, physical, mental and psychosocial well-being of each resident. 2. Beginning on 7/15/16 facility residents were assessed or interviewed by Regional/facility licensed nurses/LSW in regards to abuse/neglect and to ensure that they felt their respective needs were being met effectively and efficiently and that there were adequate staff to attend to their needs. Beginning 7/15/16 facility staff were interviewed by Regional/facility licensed nurses/department heads to ensure that they felt resident needs were being met and that there was sufficient staff available to meet the resident needs. A new orientation process for agency staff was implemented on 7/20/16 to ensure that agency staff is oriented to the facility	8/12/16

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F 490	Continued From page 235 Specifically, it was determined the facility failed to ensure adequate numbers of trained RN, LPN, and CNA staff were on duty throughout the facility to provide care as planned, and to ensure residents' needs were met, including those with special needs. Facility Administration was informed of the Immediate Jeopardy, and the need to develop and implement an acceptable plan to remove the Immediacy, at 4:20 pm on 7/15/16. Findings include: Widespread Immediate Jeopardy for all resident in the facility was identified in the following areas: * F224 for the facility's failure to ensure residents were free from abuse and neglect. * F353, for the facility's failure to ensure there were sufficient numbers of nursing staff to enable residents to reach their highest practicable physical, emotional, and psychosocial well-being. On 7/13/16 at 4:15 pm, the Administrator stated the facility had been through a number of leadership changes in the preceding months, starting with a long-time administrator and a number of staff in leadership positions leaving the facility en masse. The Administrator stated he had been working in the facility a little over four months, and when he started there was a DNS in place who was not effective. The Administrator stated he had to "go through the process" to remove the DNS, which took some time, before bringing on the current DNS. The Administrator stated the current DNS had been in place for 2 weeks prior to survey. The Administrator stated he knew the facility had some "serious	F 490	prior to taking an assignment. Beginning 7/15/16 observations are being conducted daily by Regional/facility licensed nurses/department heads to validate that resident care needs are being met in an effective and efficient manner. Corrective actions are implemented at the time that negative findings are noted. 3. Root Cause Analysis conducted by the IDT revealed that the facility needed to develop an orientation process for agency staff and needed additional training for current staff on providing care to resident that attains or maintains the highest practicable, physical, mental and psychosocial well-being of each resident. And that additional training/staffing was required to ensure sufficient qualified staff available to meet resident care needs. Beginning on 7/16/16 facility staff were educated by RNC/RVP/ADM/DON regarding requirements of F490 and the facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Weekly Resident Council meetings will continue, with the ADM in attendance, until such time that the residents determine to decrease the frequency, to discuss any new concerns and monitor facility progress. 4. Beginning the week of 8/10/16 a weekly QAPI meeting will be held to review staffing, on-going audits of the plan of correction with regional and/or	

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F 490	Continued From page 236 problems," but had not had a chance to address them due to the short time he had been in the facility. The Administrator stated the facility had identified a staffing shortage, and had been utilizing agency nurses from four different agencies, but through their recruiting efforts anticipated they would be able to rely solely on facility staff by 8/1/16. On 7/15/16 at 9:00 am, the RVP stated he had been aware of the facility staffing shortages and the use of agency staff. The RVP stated he was aware the use of agency staff could be "problematic" in terms of consistency of care, but did not think there had been significant care outcomes for facility residents. The RVP stated the facility's former parent organization had eliminated most nursing policies and procedures approximately a year prior.	F 490	corporate staff in attendance for four weeks, then monthly for two months and quarterly thereafter. The RVP is responsible for monitoring and compliance. Date of Compliance: 8/12/16	

Bureau of Facility Standards

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	MDS001260		**07/19/2016**

NAME OF PROVIDER OR SUPPLIER

HOLLY LANE REHABILITATION AND HEALTHC

STREET ADDRESS, CITY, STATE, ZIP CODE

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NAMPA, ID 83686

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C 000	16.03.02 INITIAL COMMENTS A State Licensure Survey and Complaint survey was conducted at the facility from July 11, 2016 to July 18, 2016. The surveyors conducting the survey were: Presie C. Billington RN, Team Coordinator Nina Sanderson, LSW Teresa Kobza, RD, LD Jennifer McCants, RD Ophelia McDaniels, RN Rachel Moorhead-Lopez, LSW Angelia Newsome, RN	C 000		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/16