



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

August 26, 2016

Randal Barnes, Administrator
Valley View Nursing & Rehabilitation
1140 North Allumbaugh Street
Boise, ID 83704-8700

Provider #: 135098

Dear Mr. Barnes:

On **August 12, 2016**, a survey was conducted at Valley View Nursing & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be **PATTERN** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) in writing on **August 8, 2016**.

On **August 10, 2016**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form CMS-2567, whereby significant corrections are required.

Attached 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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 6, 2016**. Failure to submit an acceptable PoC by , may result in the imposition of additional civil monetary penalties by **September 28, 2016**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).
- If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

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

Based on the immediate jeopardy cited during this survey:

F0323 -- S/S: K -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

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:

Denial of payment for new admissions effective as soon as notice requirements can be

met. [42 CFR §488.417(a)]

A 'per instance' civil money penalty of **Federal Civil Money Penalty of \$4,500.00 per instance for the instance on August 8, 2016 described at deficiency F0323 (S/S: K).**

(THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED IN THE STATE OPERATIONS MANUAL §7510) (42 CFR §488.430)

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 12, 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:

F0323 -- S/S: K -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

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 #8, #11, #23, #24, and any resident using the first or second floor shower rooms 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

Randal Barnes, Administrator
August 26, 2016
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Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

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

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



NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/lj

Randal Barnes, Administrator
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Enclosures



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Randal Barnes, Administrator
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1140 North Allumbaugh Street
Boise, ID 83704-8700
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Provider #: 135098

Dear . Barnes:

On **August 12, 2016**, a survey was conducted at Valley View Nursing & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **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 **September 5, 2016**. Failure to submit an acceptable PoC by **September 5, 2016**, may result in the imposition of penalties by **September 30, 2016**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 16, 2016 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on

Randal Barnes, Administrator
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Page 3

November 10, 2016. A change in the seriousness of the deficiencies on **September 26, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 10, 2016** includes the following:

Denial of payment for new admissions effective **November 10, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 8, 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 & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 10, 2016** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

Randal Barnes, Administrator
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Page 4

<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 **September 5, 2016**. If your request for informal dispute resolution is received after **September 5, 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,

NINA SANDERSON, Supervisor
Long Term Care

NS/lj
Enclosures

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

PRINTED: 11/02/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2016
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from August 8, 2016 to August 12, 2016. Immediate Jeopardy was identified at:</p> <p>42 CFR 483.25(h) [F323]</p> <p>The immediate jeopardy was removed prior to the exit conference.</p> <p>The surveyors conducting the survey were:</p> <p>Presie C. Billington, RN, Team Coordinator Teresa Kobza, RD, LD Amy Youngman, RN Karen Gray, RD, LD</p> <p>Definitions include:</p> <p>@ = at BM = Bowel Movement B/P- Blood Pressure CKD- Chronic Kidney Disease CP- Care Plan CVA- Cerebrovascular Accident DM- Diabetes Mellitus DON- Director of Nursing GDR- Gradual Dose Reduction H&P- History and Physical IC = Infection Control LN- Licensed Nurse LSW- Licensed Social Worker MAR- Medication Administration Record MD- Physician MDS- Minimum Data Set mg- Milligram</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

09/06/2016

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 mL- milliliter NN- Nurses note OOF- Out of Facility RD- Registered Dietitian s/s- signs and symptoms TAR- Treatment Administration Record	F 000			
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 qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure residents' care plans accurately reflected their status. This was true for 1 of 6 (#11) residents reviewed for psychotropic medication use and	F 280	F280 This requirement was not met as evidenced by the determination that the	9/26/16	

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F 280	<p>Continued From page 2</p> <p>resulted in a care plan for Resident #11 which did not reflect her use of an antipsychotic medication. Findings include:</p> <p>1. Resident #11 was admitted to the facility on 4/29/14 with multiple diagnoses which included muscle weakness and CVA.</p> <p>Resident #11's H&P from 5/6/14 documented possible dementia and the facility would monitor her cognition for signs of dementia.</p> <p>A 2/11/15 psychiatrist evaluation note documented Resident #11 was diagnosed with dementia with delusions. The note documented she was started on Seroquel 50 mg at that time.</p> <p>Resident #11's August 2016 Physician Orders Review documented she began receiving Seroquel 75 mg at bedtime for delusions and hallucinations on 12/31/15.</p> <p>Resident #11's current Psychosocial Well-being and Impaired Cognitive Skills care plans did not include her use of the antipsychotic medication, specific behaviors, and black box/side effects staff was to monitor.</p> <p>On 6/12/16 at 11:00 am, the LSW stated Resident #11's care plan addressing the use of the antipsychotic and her behaviors was discontinued on 6/5/16 and that the current care plan was incorrect. He stated Resident #11's care plan should, but did not, include the use of the antipsychotic medication, resident-specific behaviors, and the side effects to be monitored.</p>	F 280	<p>facility failed to</p> <p>¿ Ensure residents <input type="checkbox"/> care plans accurately reflected their status, related to antipsychotic medication. Resident #11 <input type="checkbox"/>s care plan did not include the use of the antipsychotic medication, resident specific behaviors and the side effects to be monitored.</p> <p>¿</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #11 <input type="checkbox"/>s Psychosocial care plan has been updated to reflect the use of the anti-psychotic medication, the resident specific behaviors and the side effects to be monitored.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>Residents who receive anti-psychotic medications are at risk. Residents who receive anti-psychotic medication have been reviewed to ensure that the anti-psychotic medication, resident specific behaviors and the side effects to be monitored are present in their comprehensive plan of care.¿</p> <p>3.¿¿¿¿¿¿¿¿What measures will be put in place or what systemic change you will</p>		

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F 280	Continued From page 3	F 280	<p>make to ensure that the deficient practice does not recur.</p> <p>¿ Residents <input type="checkbox"/> who admit with a physician <input type="checkbox"/>s order for anti-psychotic medication will have a care plan completed within 3 days following admission includes anti-psychotic medication, resident specific behaviors and the side effects to be monitored.</p> <p>Existing residents <input type="checkbox"/> who receive a new order for anti-psychotic medication will have a plan of care put into place by the IDT that indicates the anti-psychotic medication, resident specific behaviors and side effects to be monitored.</p> <p>Facility procedures: Psychosocial Functioning and Psychoactive Protocol have been updated to include the expectation that a resident on anti-psychotic medication will have a plan of care that indicates the anti-psychotic medication, resident specific behaviors and side effects to be monitored.</p> <p>Social Services and Licensed nursing staff have been in-serviced the week of 9/12/16 by the DON or designee on the expectation and how to complete the plan of care for a resident on anti-psychotic medication.</p> <p>DON or designee will complete an audit of all newly admitted residents within 72 hours of admission to ensure that resident admitted with order for anti-psychotic</p>		

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F 280	Continued From page 4	F 280	<p>medication has an appropriate plan of care.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>DON or designee will complete an audit of 10 residents with antipsychotic medication orders weekly to ensure that all residents have a plan of care in place x 2 weeks, then 10 residents will be audited every 2 weeks x 2 then ten residents will be audited every monthly x 3, then ten residents will be audited quarterly ongoing.</p> <p>Results of audits will be reviewed monthly in QAPI meeting until a lesser frequency deemed necessary per the QAPI team.</p>		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents were provided with care and services necessary to achieve their highest</p>	F 309	<p>F309 This requirement was not met as evidenced by: Based on observation, staff interview, and record review, it was</p>	9/26/16	

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F 309	<p>Continued From page 5</p> <p>practicable physical wellbeing. This was true for 2 of 18 sampled residents (#13 and #17). As a result, Resident #13 was placed at risk of harm when the facility failed to ensure complete coordination of care with a dialysis unit, and Resident #17 was placed at risk of harm when there was a 4-day delay in administration of an antibiotic treatment. Findings include:</p> <p>1. Resident #13 was re-admitted to the facility on 5/4/16 with diagnoses which included end stage renal disease Stage V with dialysis, Type II diabetes, obesity, and major depression.</p> <p>Resident #13's recapitulated August 2016 Physicians' Orders and the August 2016 MAR through 8/10/16 documented:</p> <p>*Resident #13 received hemodialysis at an off-site dialysis center three times a week, Mondays, Wednesdays, and Fridays.</p> <p>*Staff were to monitor for s/s of infection at the dialysis site every shift.</p> <p>*Staff were to monitor for thrill and bruit every shift and to notify nephrologist if absent.</p> <p>* Humalog insulin 100 units before meals and at bedtime for DM beginning 7/26/16.</p> <p>* Renvela [a medication used to control phosphorus levels in people with CKD who are on dialysis] 800 mg three times a day, beginning 5/4/16.</p> <p>Resident #13's August 2016 Physicians' Orders and August 2016 MAR through 8/10/16 did not</p>	F 309	<p>determined the facility failed to ensure complete coordination of care with a dialysis unit for resident #13 and resident #17 had a 4-day delay in administration of an antibiotic treatment</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #13's physician's orders and care plan have been updated to reflect the resident's dialysis shunt site and the appropriate care for this site. Dialysis communication forms are being completed; and they are being sent and returned with the resident The resident's dialysis time has changed been so routine medications that are to be given the facility, and will not have to be sent with the resident. Care plan has been updated. Resident #17 has discharged from the facility at the time of the survey. He received the appropriate antibiotic and completed the course of antibiotics per MD order during his stay</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) should be taken? Residents who receive dialysis have potential to be affected by the deficient practice. Audit of residents receiving dialysis has been completed to ensure their orders and care planning have been updated to</p>		

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F 309	<p>Continued From page 6 include:</p> <ul style="list-style-type: none"> * The location of the dialysis port. * When the bandage from the Resident #11's dialysis port site should be removed after dialysis. * Instructions not to complete B/P checks on Resident #13's left arm, where the port was located. <p>The July 2016 Physicians' Orders documented Resident #13's left arm was not to be used for B/P assessments, and included a 5/4/16 order for insulin prior to meals and blood sugar assessments.</p> <p>Resident #13 had two Dialysis Care Plans, dated 5/4/16 and 7/5/16, however neither care plan identified the location of the resident's dialysis port or type of access, such as AV fistula, graft, or catheter.</p> <p>Additionally, Resident #13's Dialysis Care Plans did not include the need for the dialysis center to send documented communication to the facility regarding the resident's status upon return to the facility after dialysis; how staff were to attain Resident #13's dry weights [post dialysis weight]; and how Resident #13 was to receive medications on days when he was out of the facility receiving dialysis.</p> <p>Resident #13's clinical record did not contain communication from the facility to the dialysis center when he received dialysis on 5/6/16, 6/10/16, and 6/18/16.</p>	F 309	<p>reflect appropriate site care and access. Residents who admit to the facility with faxed admission orders have the potential to be affected by the deficient practice. No other residents were found to be affected.</p> <p>3.What measure will be put in place or what systemic changes will be made to ensure that the deficient practice will not happen again? Dialysis procedure developed and the Point Click Care batch entry order set has been modified to ensure that each resident receives complete coordination of care such as communication with dialysis center, identifying type and location of access site, etc. Admission audit has been modified to include a review for dialysis procedures and to include an audit to check H&P/admission paperwork with admission medication list and identify any medications that need to be reconciled. Licensed nursing staff have been re-educated by DON or designee week of 9/6/16 to the Dialysis procedure and how to utilize the dialysis batch order entry set. Upon admission, residents who require dialysis treatment will be identified per the dialysis procedure to ensure that the resident has the appropriate plan of care in place such as communication with dialysis center, type and location and care of access site, coordination of medications to be given at dialysis, etc. DON or designee will complete Admission Audit within 72 hours Admissions fax machine was modified in</p>		

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	<p>Continued From page 7</p> <p>Resident #13's clinical record did not contain communication from the dialysis center to the facility when he received dialysis on 5/6/16, 6/10/16, 6/18/16, 7/13/16, 8/3/16, and 8/8/16.</p> <p>The communication forms used between the facility and the dialysis center were not consistently complete. Examples of missing information included:</p> <p>* On 7/21/16, dry weights were not documented after Resident #13 received dialysis.</p> <p>* On 7/20/16, a meal was sent with Resident #13 to eat at the dialysis center. However, the facility did not include instructions to the dialysis center regarding administration of Resident #13's insulin prior to the meal. Additionally, the communication form documented no medications were sent with Resident #13.</p> <p>* On 7/15/16, dry weights were not documented after Resident #13 received dialysis.</p> <p>* On 7/13/16, dry weights were not documented after Resident #13 received dialysis. In addition, a meal was sent with Resident #13, however, there was no documentation that insulin instructions were provided to the dialysis center. The communication form documented no medications were sent with Resident #13.</p> <p>* On 6/21/16, dry weights were not documented after Resident #13 received dialysis.</p> <p>* On 6/1/16, a meal was sent with Resident #13, however there were no insulin instructions</p>		<p>June 2016 so that while the machine receives and prints a paper fax, the same faxed information being received is also being sent to multiple key administrative staff (Executive Director, DON, ADON, SDC, Case Manager). This allows nursing staff have access to any information received during off hours.</p> <p>4.How will the corrective action(s) be monitored to ensure the deficient practice will not recur? DON or designee will complete an audit of Pre and Post Dialysis Communication assessment to ensure that communication sheets are filled out completely and returned to the facility by the dialysis center within 24 hours of the dialysis appointment, ongoing. DON or designee will complete audit of current residents with dialysis orders to verify the appropriate orders are in place, the care plan is correct. This audit will be conducted weekly x 1 month, then monthly x 3 months. DON or designee will complete an audit of newly admitted residents within 72 hours of admission to verify residents have the appropriate dialysis orders and care plan and that admission medication list has been reviewed for reconciliation. Results of audits will be reviewed monthly in QAPI meeting until a lesser frequency deemed necessary per the QAPI team.</p>		

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F 309	<p>Continued From page 8 provided to the dialysis center. The communication form documented no medications were sent with the resident.</p> <p>* On 5/30/16, a meal was sent with Resident #13, but insulin instructions were not provided to the dialysis center; no instructions were provided to the dialysis center as to when the resident should eat his meal; and the communication documented no medications were sent with Resident #13.</p> <p>Resident #13's May - July 2016 MAR documented:</p> <p>* Apidra and Renvela, 7/13/16: "1= Absent from the facility without medications" for 2 shifts at 7:00 am and 12:00 pm.</p> <p>* Apidria and Renvela, 7/20/16: "1= Absent from the facility without medications" for 1 shift at 5:00 pm.</p> <p>* Renvela, 7/22/16: "1= Absent from the facility without medications" for 1 shift at 5:00 pm.</p> <p>* Apidra, 6/30/16: Resident #13 was at hemodialysis outside of the facility with no medications for lunch.</p> <p>* Apidra, 5/16/16: Resident #13 was out of the facility with no medications for lunch.</p> <p>* Apidra, 5/30/16: Resident #13 was out of the facility with no medications for lunch.</p> <p>On 8/11/16 at 2:48 pm, the DON stated the facility did not always receive communications</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>back from the dialysis center and when that happened staff called the dialysis center. She stated Resident #13 received all his medications at the facility, and that she did not know what medications Resident #13 received at the dialysis center. In addition, she stated the facility was trying to ensure they had correct weights and measured dry weights for residents who received dialysis.</p> <p>On 8/11/16 at 3:23 pm, the Unit Manager stated the facility called the dialysis center when communication was not sent to the facility after Resident #13 received dialysis. She stated the dialysis center assured the facility it would fax the documentation to the facility, but that the facility often did not receive the faxed information.</p> <p>2. Resident #17 was admitted to the facility on 5/6/16 with diagnoses which included Stage III pressure ulcer to the right ankle, peripheral vascular disease (PVD), edema, and Stage III chronic kidney disease.</p> <p>Prior to admission to the facility, Resident #17 received treatment at a wound clinic for osteomyelitis of the left ankle pressure ulcer. He had been prescribed and received Doxycycline Hyclate 100 mg orally twice daily for six weeks beginning 3/25/16, which was scheduled to end on 5/6/16, the date of his admission to the facility. Documentation from the wound clinic demonstrated improvement of the infection.</p> <p>Resident #17's clinical record included a Wound Care Orders Fax, dated 5/6/16, sent to the facility</p>	F 309			

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

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F 309	<p>Continued From page 10</p> <p>on that date from the wound care clinic. The fax included a medication order for Doxycycline 100 mg by mouth for 11 days for treatment of the Stage III pressure ulcer to the right ankle. The order was not stamped as received or initiated by the facility on 5/6/16.</p> <p>A second copy of the same fax located in Resident #17's clinical record documented, "resend 5/10/16 and to see med order please." The fax was stamped by the wound care clinic as faxed to the facility on 5/6/16, and stamped a second time as faxed to the facility on 5/10/16.</p> <p>On 8/10/16 at 3:00 pm, the Unit Manager reviewed Resident #17's orders and confirmed the antibiotic was not initiated until the second fax was received on 5/10/16. The Medication Administration Record documented Resident #17 received his first dose of the antibiotic at bedtime on 5/10/16.</p> <p>On 8/10/16 at 3:45 pm, the Admission Coordinator, when asked about receipt of the faxed orders for Resident #17 on 5/6/16 and 5/10/16, stated she took faxed orders to "Medical Records" and did nothing more with them.</p> <p>On 8/10/16 at 3:55 p.m., the Medical Records Supervisor, when asked about the faxed orders, stated she must not have received the original fax on 5/6/16 or she would have entered the order into the records system.</p> <p>On 8/10/16 at 4:00 pm, the DON, when asked how faxes were received at the facility, stated the system had been corrected and all of the nurses now received the faxes, rather than only</p>	F 309			

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F 309	Continued From page 11 Admissions Coordinator.	F 309			
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility water temperature logs, observations, and staff, resident, and family interviews, it was determined the facility failed to ensure residents were not exposed to hot water temperatures in showers and resident room sinks in excess of 120 degrees Fahrenheit and that a resident's wheelchair was safe for use. As a result: a) Residents were exposed to hot water temperatures of 120.5 to 131 degrees Fahrenheit in 2 of 2 facility shower rooms and 5 of 5 randomly tested resident room sinks. This deficient practice placed 4 of 4 residents (#8, #11, #23, #24) and all other residents who came into contact with hot water coming from the faucets in resident room sinks and shower rooms at imminent risk of sustaining severe burns. The Administrator was notified of the immediate jeopardy to residents' health and safety on 8/8/16 at 4:00 pm. The facility provided, and initiated, a plan to keep residents safe and remove the immediate jeopardy. Key components of the	F 323	F 323 This requirement was not met as evidenced by the determination that the facility failed to ensure that residents were free from excessive water temperatures on 8/8/16 between 1130 and 1300. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. As the survey team did not identify the resident who called out "That's hot". All residents on the first and second floor who received a shower today 8/8/16 were assessed by the Unit Manager of their unit for s/sx of injury related to hot water touching their skin. No actual injury identified. Resident #12 <input type="checkbox"/> Wheelchair was checked by Maintenance and Therapy and found to be working properly on 8/12/16.	9/26/16	

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F 323	<p>Continued From page 12 removal plan included:</p> <ul style="list-style-type: none"> * A contracted maintenance technician was called to the facility on 8/8/16 to resolve boiler system issues which resulted in the excessive water temperatures. The technician identified a problem with the mixing valve and parts were replaced on 8/8/16. Water temperatures were rechecked and found to be less than 120 degrees Fahrenheit. * All staff and outside service providers were to be in-serviced to ensure residents did not have independent access to sink and shower faucets until assessed to independently adjust water temperatures. * An immediate cessation of all showers until water temperatures were verified to be 118 degrees F or less. * Ongoing assessment of water temperatures and systems in place to immediately respond to reports of water temperatures above 115 degrees. * Education provided to 4 staff by the contracted mechanical technician on how to perform daily checks of the tempering mixing valve station, which were to be performed daily by facility staff. <p>Completion and initiation of the above actions were verified by an on-site survey team and the immediate jeopardy was removed on 8/10/16.</p> <p>b) Resident #12 sustained a hip fracture which required surgical repair when her legs were hyper-extended while being propelled forward in her wheelchair.</p> <p>Findings include:</p>	F 323	<p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All residents had the potential to be affected by the same deficient practice. Director of Maintenance notified Grant Mechanical HVAC of the water temperature being too hot and not maintaining appropriate temperature. Grant Mechanical in on 8/8/16 and serviced</p> <ol style="list-style-type: none"> a. The low flow temperature station was cleaned and adjusted b. Showers and sinks were run to properly adjust temp. c. Checked supply and return temps <p>Unit and temp station was noted to be operating properly after serviced by Grant Mechanical.</p> <p>Grant Mechanical provided a written statement on 8/9/16 that with the current maintenance service done 8/8/16, the mixed valve will prevent water hotter than 118 degrees F from leaving the boiler room. This means that the water that flows to the resident sink/shower areas will be 118 degrees F or less. Per Grant Mechanical the part for the high flow temp station is part of the preventative maintenance plan. VVNR staff present in the facility since survey team identified the water temperature issue have been in-serviced on water temperature and instructed to immediately notify maintenance, Executive Director, or Director of Nursing</p>		

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F 323	<p>Continued From page 13</p> <p>1. During the initial tour of the facility from 11:30 am to 1:00 pm on 8/8/16, the following resident room temperatures were observed with the facility Maintenance Assistant present:</p> <p>Room 115 (sink): 131 degrees F Room 125 (sink): 127.9 degrees F Room 206 (sink): 124.0 degrees F Room 215 (sink): 129.8 degrees F Room 234 (sink): 120.5 degrees F First Floor Shower Room: 128.5 degrees F Second Floor Shower Room: 126.2 degrees F</p> <p>The Maintenance Assistant stated during the tour that he did not normally audit water temperatures in the building and did not know required safe water temperature ranges. The facility boiler room was observed with the maintenance assistant, who was not able to read the boiler temperature or state how the overall facility water temperature could be lessened to bring water temperatures into a safe range.</p> <p>* On 8/8/16 at 12:40 pm, when asked if the hot water in her bathroom ever got too hot, Resident #23 stated, "Sometimes I have to cool it down. I wash my hands and face, and brush my teeth every morning. It was too hot to drink this morning."</p> <p>* On 8/8/16 at 12:45 pm, when asked if the hot water in her bathroom ever got too hot, Resident #24 stated, "It has gotten too hot a couple of times, but they have turned it down or something."</p> <p>* On 8/8/16 at 1:20 pm, Resident #8 stated, "The water here gets hot, way too hot. I wash my</p>	F 323	<p>should the water in the faucet/shower feel too warm or hot.</p> <p>Will not utilize the shower rooms until the shower aides on 8/9/16 can be in-serviced to complete a water temp check prior to having the water touch the resident.</p> <p>On 8-8-16 to 8-9-16 (6pm 8-8-16 to 6am 8-9-16) facility will have licensed nurse on night shift perform random water temp check in resident room- will check two rooms on each hall every four hours on both first and second floor and will record the date/time and temp. Maintenance to be notified immediately of any temperature greater than 115 degrees F. Facility staff/All Departments will be in-serviced to immediately notify maintenance, Executive Director, or Director of Nursing should the water in the faucet feel too warm or hot.</p> <p>All other reclining wheelchairs were assessed by maintenance and therapy to ensure they are working properly</p> <p>3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>All Nursing and Therapy staff will be in-serviced that a resident in the shower room will not adjust their own shower faucet unless assessed by a licensed nurse or therapist and found to be safe to do their own water temperature adjustment. These residents will have their care plan updated to reflect their</p>		

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F 323	<p>Continued From page 14</p> <p>hands in my sink and I have to turn the heat down. The shower water gets too hot, too. They [staff] turn it down by adding cold water."</p> <p>* Resident #11 was observed on 8/8/16 while receiving a shower in the first floor shower room at approximately 1:40 pm. The resident was alone behind a privacy curtain alone when she independently turned on the water and said, "That's hot! Ouch! That burns!" A shower aide on the other side of the privacy curtain immediately went into the shower stall and turned down the water temperature. Resident #11 then stated, "That's better."</p> <p>* On 8/8/16 at 1:45 pm, second floor shower aide CNA #5 stated, "I am always adjusting the [shower] water. The water seems like it's gotten hotter during the last week or two. I don't have a guage to measure the temperature. I set up some of the residents, then they do their own thing, including [Resident #11]. There are several other residents, maybe 10 or so, who we also set up and then they are independent with their showers."</p> <p>* On 8/8/16 at 1:55 pm, first floor shower aide CNA #1 stated, "The water has been too hot. It goes in and out ... It might be okay then change half way through a shower. The upstairs [second floor] shower does it too. Residents have told me, 'Ouch. That's way too hot!' This has been going on for the month that I have been working as a shower aide."</p> <p>* On 8/8/16 at 1:35 pm, LPN #2 stated, "Sometimes when I turn the water all the way up it's too hot. It's not safe to touch, so I turn up the</p>	F 323	<p>ability to do this task.</p> <p>Facility has designated and trained specific staff members on 8/9/16 on how to perform daily checks on the tempering mixing valve station. Grant Mechanical completed the in-service training for the four designated staff members.</p> <p>Mixing Valve: The boiler room mixing valve will be monitored by the following individuals: a) Maintenance Director b) Maintenance Assistant c) Director of Environmental Services d) Executive Director of VVNR Maintenance Director or his designee will: A. Check the gauge of the mixing valve and record the temperature daily. The desired reading for this valve is between 105 - 119 degrees F. a. If the mixing valve gauge reading is between 105-119 deg F the Maintenance Director or his designee will obtain daily water temperature readings for all bathing units (tub and showers) and 10% of resident rooms. b. If the mixing valve gauge reading is 120 deg F or greater the Maintenance Director or his designee will: i. Use walkie-talkie alert staff on the first and second floor of water temperature being greater than 120 deg F. 1. Nursing and Therapy staff will cease doing resident showers/bathing until the water temperature issue has been corrected and the water reads the desired temperature of 105-119 degrees F. ii. Check to ensure the boiler is functioning properly.</p>		

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F 323	<p>Continued From page 15 cold water."</p> <p>* On 8/8/16 at 1:30 pm, the Maintenance Director acknowledged the water temperatures were too hot, and stated he had just called the company who was responsible for maintaining the hot water-related equipment, which stated the issue was most likely related to a broken gasket or mixing valve. He stated he audited temperatures in 2 to 3 random resident rooms and recorded the temperatures each Monday and Friday. He stated the audited room water temperatures were not too hot.</p> <p>The facility's Water Temperature Logs for June, July, and August 2016 documented 2 resident room water temperatures were monitored twice weekly. No recorded resident room water temperatures were greater than 115 degrees, and there was no documentation indicating shower room temperatures were monitored by the facility.</p> <p>On 8/9/16 at 1:20 pm, a mechanical technician stated he was called to the facility after hot water temperatures of 128-130 degrees fahrenheit were identified by the survey team. He stated the water temperature was a "little high" at 128-130 degrees and that the system was 2-3 weeks overdue for service. The technician said the facility's Maintenance Director was on vacation and that he was "turned away" when he arrived at the facility for the regularly-scheduled service check. He stated he then went on vacation and the 6-month service check was not completed. The mechanical technician stated, "It just fell through the cracks." The mechanical technician stated that following repairs to the system, he</p>	F 323	<p>iii. Ensure hot water recirculating pump is operating properly</p> <p>iv. Adjust mixing valve to reduce temperature to facility, if these adjustments do not correct the temperature then</p> <p>v. Call boiler vendor to immediately come service the mixing valve and boiler to correct the issue.</p> <p>vi. Obtain 100% water temperature reading for all tub, shower and resident rooms.</p> <p>vii. All facility tubs will remain out of use until they can be serviced.</p> <p>viii. Notify the Executive Director or designee of the issue.</p> <p>1. Executive Director or designee will contact all Director of Nursing/ Designee for all current Hospice providers to ensure that no hospice staff provides bathing services without first checking in with the licensed nurse.</p> <p>Therapy and maintenance staff were trained on wheelchair preventative maintenance and repair on 8/23/16. Maintenance work order forms were revamped to a duplicate copy format so that one copy will go to maintenance and the other copy to the Executive Director. Facility staff in-serviced on the new duplicate copy format for work order forms week of 9/12/16.</p> <p>4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur.</p> <p>Executive Director or his designee will</p>		

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F 323	<p>Continued From page 16</p> <p>took temperatures at the facility for an hour and the readings ranged from 110-115 degrees. He stated he wrote on the invoice that residents in the facility were safe from hot water burns, and noted the system's "tempering station" needed to be checked daily.</p> <p>2. Resident #12 was admitted to the facility on 7/9/16 with multiple diagnoses including, breast cancer and inflammation of the spinal cord.</p> <p>Resident #12's Quarterly MDS assessment, dated 6/28/16, documented she was cognitively intact, required extensive assistance of 2 staff members with all her cares, except eating. The MDS documented Resident #12 had an indwelling catheter, was not steady with surface to surface transfer, used a wheelchair for locomotion, and required staff to propel the wheelchair.</p> <p>On 8/11/16 at 10:26 am, Resident #12, with one of her family member present, said she saw a doctor on 7/29/16. She said on 7/29/16 LN #1 and a CNA transferred her from her bed, via a hooyer lift, to her wheelchair which was in a reclined position. She was in her wheelchair when the CNA left to get clean linen and LN #1 stayed with her. The LN was behind Resident #12's wheelchair and pressed the lever of the wheelchair to bring the chair to an upright sitting position. Resident #12 said LN #1 was having trouble bringing the chair to an upright position because the lever was sticking. Resident #12 said she told LN #1 to stop and wait for the CNA to return, but the LN told her "I think I got it" and suddenly, she was lurched forward and bent at</p>	F 323	<p>audit to ensure that the temperature reading from the mixing valve has been recorded as well as daily water temperature readings for all bathing units (tub and showers) and 10% of resident rooms was completed. ED will also ensure that if the temperature readings were not within the desired range of 105-116 deg F that the appropriate actions were taken. Executive Director or designee will complete this audit daily x 2 weeks; then weekly x 2 weeks; then every other week x 2; then monthly.</p> <p>Maintenance work orders will be reviewed weekly x 2 weeks then every two weeks x 2, then monthly x 3. Results of audits will be reviewed monthly in QAPI meeting until a lesser frequency deemed necessary per the QAPI team.</p>		

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F 323	<p>Continued From page 17</p> <p>her waist, with her bottom almost at the edge of the wheelchair. Resident #12 said her legs were both hyper-extended with her knees extended backwards and her face was almost touching her toes. Resident #12 said she screamed "My legs, my legs." A CNA and 2 more LNs came in and helped LN #1 to position Resident #12 back to her wheelchair. Resident #12 said she had the same problem with her wheelchair before with the lever sticking and she was told it was repaired. Resident #12's family member said the incident was a traumatic experience for her and for their family. The family member also said Resident #12 fractured her hip because of the incident and required surgery. After the surgery Resident #12 was saying "Let me go, let me go" because of the pain she was enduring.</p> <p>An Incident Report, dated 7/29/16, documented "...patient sitting in reclining position back, this nurse attempted to assist patient into upright sitting position, upper chair propelled forward in rapid motion tipping wheelchair and patient forward bent @ waist with legs and wheelchair leg extension's facing towards door causing knee's to hyper extend back. I attempted to prevent injury of patient from falling forward onto face by holding back of chair and upper body of patient..." Immediate action taken "Therapy notified for evaluation of possible equipment malfunction and possible contributing factor upper body weight disproportion."</p> <p>NN documented in Resident #12's record after the incident included:</p> <p>*On 7/29/16 at 1:59 pm, "Nurse from [name of the hospital] reported that [Resident #12] has</p>	F 323			

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F 323	<p>Continued From page 18 been having pain while at hospital."</p> <p>*On 7/29/16 at 6:47 pm, an x-ray of the Resident #12's left knee was completed and the result was negative for fracture.</p> <p>*On 7/30/16 at 2:46 am, "...no c/o of any unusual pain from fall out of w/c."</p> <p>*On 7/30/16 at 12:07 pm, "...Resident was demanding to have demonstrated the functionality of her chair, explained to resident the therapist had checked out her chair and it is functioning safely. She continued to want to see it demonstrated. Covered chair with barrier for IC and had a staff member sit in her chair and demonstrated over and over the tilt mechanism...She declined to get up..."</p> <p>*On 7/30/16 at 5:55 pm, "...Stated her pain has not been less than 8 regardless of PRN use..."</p> <p>*On 7/31/16 at 10:49 am, "...Resident declines to get out of bed at this time..."</p> <p>*On 8/1/16 at 12:13 pm, "Request for pain meds due to severe pain and discomfort...Resident declines to get up again today..."</p> <p>On 8/3/16 at 5:24 pm, "Resident continues to demonstrate Behaviors [of] staff splitting, verbal aggression and accusations of neglect ie request task to be performed states she's satisfied then, reports to management that cares are not being met to her satisfaction, ...Patient demonstrates constant irritability anger and tearfulness..."</p> <p>*On 8/4/16 at 1:08 pm, Resident #12 expressed</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>that her left hip/knee was hurting and the pain was too much and it was getting worse. She asked for an x-ray of her left leg which showed a fracture of the left femoral neck [hip]. The UM interviewed the staff on duty and none reported an increase in pain reported by Resident #12. The NN also documented the UM had been in and out of Resident #12's room several times that week but never received reports of increased pain of Resident #12's left lower extremity or anywhere else.</p> <p>*On 8/4/16 at 10:36 pm, Resident #12 was transported to the hospital by non emergent ambulance for evaluation.</p> <p>On 8/10/16 at 6:05 pm, LN #1 said she and a CNA had just transferred Resident #12 to her wheelchair which was in a reclined position when the CNA left to take the trash and dirty linen out of the room. She was assisting Resident #12 to a sitting position by pressing the lever at the back of the wheelchair. She said when she pressed the lever it did not engaged when the chair was in the upright position and Resident #12 was "propelled forward". LN #1 said she immediately grabbed Resident #12's upper body to prevent her from falling on the floor and yelled for help. She said Resident #12's bottom was still on the edge of the wheelchair. Two LNs and a CNA came in and they all assisted Resident #12 back to her wheelchair.</p> <p>On 8/11/16 at 11:20 am, PT #1 said Resident #12 could not sit on her own and had no upper or lower body strength. PT #1 said Resident #12's wheelchair was called a "Tilt in Space" wheelchair and could only go 5 degree forward</p>	F 323			

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F 323	<p>Continued From page 20</p> <p>from the vertical position and 35 degree backward from the vertical position. PT #1 said the lever periodically stuck but she would not consider it a malfunction. She said it was common for this kind of wheelchair. She said, "You just have to press it [the lever] hard." PT #1 said they tried to recreate the incident with one therapist sitting on the reclined wheelchair, but they were not able to reproduce the scenario. When asked what could cause Resident #12 to lurch forward, PT #1 said she did not know. When asked if she reported it to maintenance, the PT said she had. When asked if this incident could have caused the Resident #12's hip injury, PT #1 said the increased hip flexion could possibly cause the injury.</p> <p>On 8/12/16 at 8:50 am, LN #1 said she did not recall Resident #12 saying anything to her after the CNA left the room. When asked if she was anticipating the CNA to return to Resident #12's room to assist her, LN #1 said there was no need for the CNA to come back and help her because Resident #12 was appropriately positioned on the wheelchair and she had worked with Resident #12 before many times. She said she had no problem using Resident #12's Tilt in Space wheelchair and had no recollection of it previously malfunctioning. LN #1 said when she pressed the lever and brought the chair to sitting position it was a smooth upward motion, however, it did not lock.</p> <p>On 8/12/16 at 9:50 am, the Maintenance Director said he did not receive a work order for Resident #12's wheelchair recently. When asked if he had received any work order for Resident #12's wheelchair, the Maintenance Director checked</p>	F 323			

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F 323	Continued From page 21 and provided a copy of a work order for Resident #12's wheelchair completed on 6/3/16. On the comments section of the order documented, "Resident w/c it's good we can't find any problems, brakes good, wheels good, all w/c it's good." The Maintenance Director was also asked if he checked the lever of the wheelchair, he said everything was checked, and he did not recall any problem with it. On 8/12/16 at 10:08 am, PT #1 said they did not keep a copy of the work order. She said she spoke to [name of the maintenance person] about the wheelchair and also gave him the written request after the 7/29/16 incident. On 8/12/16 at 10:30 am, the assistant to the Maintenance Director said he did not receive a work order for Resident #12's wheelchair. The facility failed to ensure Resident #12's wheelchair was in proper working order, which resulted in Resident #12 sustaining a fractured hip. Subsequently, Resident #12's wheelchair was not checked by maintenance staff to ensure it was functioning properly.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		9/26/16	

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F 329	Continued From page 22 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 a) psychotropic medications were provided with adequate indication for use and monitoring, and b) residents' sleep medications were monitored to avoid excessive dosages and/or polypharmacy. This was true for 2 of 24 sampled residents (#2 and #11) and created the potential for harm if residents experienced adverse outcomes due to the use of unnecessary medications. Findings include: 1. Resident #11 was admitted to the facility on 4/29/14 with multiple diagnoses, including a history of muscle weakness and CVA. The 5/6/14 H&P documented Resident #11 had possible dementia and the facility would monitor her cognition for signs of dementia.	F 329	F 329 <input type="checkbox"/> Drug regimen is free from unnecessary drugs This requirement was not met as evidenced by the determination that the facility failed to ensure a) psychotropic medications were provided with adequate indication for use and monitoring, and b) residents <input type="checkbox"/> sleep medications were monitored to avoid excessive dosages and/or polypharmacy. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 11 has been assessed by residents <input type="checkbox"/> physician for an gradual dose reduction. Residents <input type="checkbox"/> anti-psychotic		

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F 329	<p>Continued From page 23</p> <p>A 2/11/15 psychiatrist evaluation note documented Resident #11 was diagnosed with dementia with delusions and that she was started on Seroquel 50 mg.</p> <p>The manufacturer's recommendations for the antipsychotic Seroquel stated the medication was for the treatment of schizophrenia and bipolar disorder. The manufacturer's black box warning advised of an increased mortality rate in the elderly with dementia-related psychosis and was not approved for use for the elderly with dementia-related psychosis.</p> <p>Resident #11's August 2016 Physician Orders Review documented she received Seroquel 75 mg at bedtime for delusions and hallucinations, beginning 12/31/15.</p> <p>The 5/29/16 Annual MDS assessment documented Resident #11 exhibited no behaviors or cognitive or decision making impairments, and presented with minimal signs of depression. The MDS documented no delusions, hallucinations or psychosis-related behaviors. Resident #11's previous MDS assessments from July 2014 through February 2016 also documented no delusions or hallucinations.</p> <p>Resident #11's current Psychosocial Well-being and Impaired Cognitive Skills care plans did not include her use of the psychotropic medication, resident-specific behaviors staff were to monitor, or that staff were to monitor the medication's potential black box/side effects.</p> <p>Resident #11's 3/1/16 - 7/5/16 MAR/TAR</p>	F 329	<p>medication and resident specific behaviors have been identified for this resident related to the use of anti-psychotic medication. Resident is being monitored and documented on related to these resident specific behaviors every shift.</p> <p>Resident #2 has been assessed by physician and order obtained to discontinue two of the medications resident was receiving for sleep. Resident continues to be monitored every shift for number of hours slept.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. Residents who reside in the facility and who receive psychotropic medication have the potential to be affected by the same deficient practice. Residents who receive one or more psychotropic medication have been reviewed to ensure that:</p> <p>a) there is adequate indication for use of the psychotropic medication(s), b) resident specific behaviors have been identified and c) the resident is being monitored every shift for these behaviors,</p> <p>Residents who receive one or more medications for sleep will have their sleep monitors assessed to determine if the sleep medication is effective.</p> <p>Residents who receive psychotropic</p>		

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F 329	<p>Continued From page 24</p> <p>Behavior Monitoring records documented staff were to monitor for behaviors, including perseveration on health concerns, intruding into others' business, and hoarding.</p> <p>The 3/1/16 through 7/5/16 MAR/TAR did not include space for staff monitoring of hallucinations and delusions.</p> <p>Resident #11's 7/6/16 - 8/8/16 MAR/TAR Behavior Monitoring section documented staff were to monitor the following behaviors:</p> <p>0 = no behaviors exhibited 1 = Fear/Panic 2 = Perseveration on health concerns 3 = Intrusive into other's business 4 = Danger to self 5 = Danger to others 6 = Hallucinations 7 = Delusions 8 = Hoarding</p> <p>The 7/6/16 - 8/8/16 MAR's/TAR documented Resident #11 did not experience hallucinations or delusions.</p> <p>A 3/25/15 psychiatrist note documented Resident #11 had no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychosis.</p> <p>A 6/23/15 psychiatrist note documented Resident #11 reported no hallucinations, delusions, or other symptoms of psychosis, and the psychiatrist examination revealed no apparent signs of hallucinations, delusions, bizarre behaviors, or other psychotic indicators.</p>	F 329	<p>medication will be assessed for the need of a gradual dose reduction or if possible a discontinuation of the psychotropic medication.</p> <p>3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Facility procedures: Psychoactive Protocol and Psychotropic Review Committee have been reviewed and updated to clarify the expectation that a resident on psychotropic medication will be monitored every shift by licensed nurse for resident specific behaviors and that the medication, specific resident behaviors and side effects of the medication will be implemented into the residents plan of care. Also clarified within the Psychoactive Protocol the gradual dose reduction guidelines. Nursing staff (Licensed and Certified) and Social Services department members have been in-serviced by DON or designee week of 9/12/16 to the updated Psychoactive Protocol and Psychotropic Review Committee procedures and emphasis on how to identify the resident specific behaviors, how to document these behaviors, polypharmacy and gradual dose reduction DON or designee will complete an audit within 72 hours of admission or the start of a new psychotropic medication to verify that resident has appropriate indication for use, resident specific behavior</p>		

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F 329	<p>Continued From page 25</p> <p>A 9/8/15 psychiatrist note documented Resident #11's affect was blunted and she had grandiose ideas. The documentation did not include a description of the grandiose ideas or their effect on Resident #11.</p> <p>A 12/8/15 psychiatrist note documented Resident #11 had grandiose ideas, but did not describe the ideas or their effect on Resident #11. No other Psychiatrist Notes were found in Resident #11's record or provided by the facility.</p> <p>The type and frequency of delusions and hallucinations were not addressed in Resident #11's 12/17/15 and 2/18/16 Psychotropic Medication Reviews. A GDR was initiated at the time of the 12/17/15 review.</p> <p>A 6/6/16 Pharmacy Consultant Report documented the pharmacist recommended decreasing Resident #11's Seroquel to 50 mg at bedtime, as the last GDR was on 12/31/15. The MD declined the recommendation, documenting Resident #11 had presented with continued delusional statements. The note did not document describe the delusional statements or behaviors, or how they affected Resident #11.</p> <p>A NN, dated 6/26/16 at 10:30 pm, documented Resident #11 stated she saw something in her window which scared her. Other NN's from 2/29/16 to 8/12/16 did not document whether Resident #11 continued to experience delusions or hallucinations.</p> <p>Resident #11 was not effectively monitored for hallucinations and delusions to measure the</p>	F 329	<p>monitoring in place.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. DON or designee will complete an audit of ten residents who receive psychotropic medication weekly x 2 weeks, then ten residents every 2 weeks <input type="checkbox"/> x 2 then ten residents <input type="checkbox"/> monthly x 3 then no less than quarterly. Results of audits will be reviewed monthly in QAPI meeting until a lesser frequency deemed necessary per the QAPI team.</p>		

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F 329	<p>Continued From page 26</p> <p>efficacy and continued use of the antipsychotic medication, Seroquel.</p> <p>2. Resident #2 was admitted to the facility on 4/4/16 with diagnoses that included a history of brain tumor and insomnia.</p> <p>Resident #2's quarterly MDS assessment, dated 7/5/16, documented moderate cognitive impairment and use of multiple psychotropic medications on a regular basis.</p> <p>Resident #2's Psychosocial Care Plan, dated 7/15/16, stated he had a potential psychosocial problem related to "feeling tired half or more of the time." Staff were to encourage activities and provide medication per order.</p> <p>Resident #2's August 2016 Physician Orders included the following 4 sleep-enhancing medications were to be administered daily:</p> <ul style="list-style-type: none"> * Concerta Extended Release 36 mg for circadian rhythm regulation * Melatonin 3 mg every night for insomnia * Remeron (an anti-depressant sometimes used to enhance sleep) 30 mg at bedtime for sleep * Trazodone (an anti-depressant medication also used for sleep) 100 mg at bedtime for insomnia <p>Sleep Monitoring Records for July and August 2016 documented Resident #2 slept between 9 and 16 hours during each 24 hour period, and 6 to 7 hours of this sleep was at night.</p> <p>Resident #2's Pharmacy Consultant Review Records for July and August 2016 did not include</p>	F 329			

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F 329	Continued From page 27 recommendations regarding his medication regime. There was no documentation in Resident #2's clinical record to indicate a dosage reduction of sleep medication had been attempted since his admission on 4/4/16. Observations were conducted of Resident #2 each morning from 8/9/16 through 8/12/16. He was observed to remain sleeping in bed until between 11:00 am and 12:00 pm each day. On 8/10/16 at 9:40 am, LPN #1 stated Resident #2 had slept "all morning" since she came in for her shift at about 6 am, and that it was his normal pattern to sleep until "lunchtime" or later. She stated, "He sleeps a lot." On 8/9/16 at 10:05 am, the DON acknowledged Resident #2's multiple medications for sleep and stated the resident's sleep records indicated he was sleeping more hours than necessary for optimal health and that it may be time to change his medications.	F 329			
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 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	F 431		9/26/16	

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F 431	<p>Continued From page 28</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure expired medications were removed from medication carts. This was true for 3 of 4 medication carts checked for expired medications. This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings include:</p> <p>On 8/10/16 at 9:45 am, during inspection of Medication Cart B in 200 Hall with LN #4 present, 30 tablets of 2 mg Loperamide with an expiration</p>	F 431	<p>F 431 Drug Records, Label/Store Drugs & Biological This requirement was not met as evidenced by the determination that the facility failed to ensure expired medications were removed from medication carts. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p>		

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F 431	<p>Continued From page 29 of 1/30/16 were found. LN #4 confirmed the expiration date and said the medication would be destroyed.</p> <p>On 8/11/16 at 9:25 am, during inspection of Medication Cart 1A with LN #5 present, the following expired medications were found:</p> <p>*2 tablets of 150 mg Ranitidine with an expiration of 12/2015 *13 tablets of 150 mg Ranitidine with an expiration of 5/2016</p> <p>LN #5 confirmed the expiration dates and said the medications would be discarded.</p> <p>On 8/11/16 at 9:30 am, during inspection of Medication Cart 1B with LN #5 present, the following expired medications were found:</p> <p>*28 tablets of 4 mg Tizanidine with an expiration of 3/3/16 *25 tablets of 10 mg Baclofen with an expiration of 4/30/16</p> <p>LN #5 confirmed the expiration dates and said the medications would be discarded.</p>	F 431	<p>No residents were found to have been affected by the deficient practice.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents have the potential to be affected by the deficient practice. The expired medications identified by the surveyor were removed from the medication carts and disposed of per facility procedure. Audit done of all medication, treatment carts and central supply room on to verify there were no other expired medications and none were identified.</p> <p>3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur. Procedure developed for monitoring medication expiration dates. Licensed nursing staff have been in-serviced by DON or designee week of 9/6/16 related to monitoring of medication expiration dates and the need to pull expired medications and treatments off of the carts.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. DON or designee will conduct audit of medications on all medication/treatment carts and central supply bulk medications to ensure that there are no expired</p>		

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F 431	Continued From page 30	F 431	medications. Audit will be done weekly x 4 weeks; then monthly x 3 months; then no less than quarterly. Results of audits will be reviewed monthly in QAPI meeting until a lesser frequency deemed necessary per the QAPI team.		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure complete and accurate medical records were maintained for each resident. This was true for 1 of 18 (#10) sampled residents. This failed practice created the potential harm if care decisions were based on incomplete or inaccurate information. Findings include:</p> <p>1. Resident #10 was admitted to the facility on 11/13/15 with multiple diagnoses which included mild cognitive impairment, gastrostomy, aphasia,</p>	F 514	<p>F 514 Resident records complete accurate and accessible This requirement was not met as evidenced by the determination that the facility failed to ensure complete and accurate medical records were maintained for each resident.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</p>	9/26/16	

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F 514	<p>Continued From page 31 dysphagia, dyskinesia of the esophagus, colitis, and aschhalasia.</p> <p>Resident #10's recapitulated May 2016 Physicians Orders documented:</p> <ul style="list-style-type: none"> * A diet order allowing Resident #10 water or hot beverages such as broth. * Staff were to dissolve each crushed tablet of medication in 10-20 mL of water. * Staff were instructed to flush 10-20 mL of water between each medication. <p>The above orders were not included on the August 2016 Physician's orders and there was no documentation in the resident's clinical record that the orders were discontinued.</p> <p>On 8/10/16 at 12:45 pm, the DON stated the orders were not in the August 2016 Physician orders, but should have been.</p>	F 514	<p>practice.</p> <p>Resident #10's physician's orders were reviewed, identified the missing orders and updated the resident's physician and obtained new orders as physician deemed appropriate. These orders had not been entered when the resident's medications were transferred into Point Click Care from previous EMR.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All residents who reside in the facility are at risk for this deficient practice. Audit completed to cross check of all orders in Point Click Care versus actual medications in the medication cards as well as cross checked with any hand written orders and faxes to verify that each resident's recapitulation of medications was accurate.</p> <p>¿ ¿3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>Procedure developed for entering in admit/readmit orders, including order sets for such things as enteral feedings, oxygen, nebulizer, standing orders, etc.</p> <p>Licensed nursing staff in-serviced by DON or designee week of 9/6/16 on</p>		

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F 514	Continued From page 32	F 514	<p>procedure for entering admission/readmission orders into PCC by DON or designee.</p> <p>Audit for newly admitted/readmitted residents will be done to ensure that all of their admission orders were properly put into Point Click Care (PCC).</p> <p>Month End Recap Procedure developed and will be completed each month by the DON or designee(s). Nurse Managers were in-serviced by DON or designee week of 9/6/16 on how to complete admit/readmit audit and month end recap procedure.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>DON or designee will complete audit for newly admitted/readmitted residents within 72 hours ongoing. Month End Recap will be completed monthly ongoing for all residents.</p>		