



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
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BUREAU OF FACILITY STANDARDS  
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P.O. Box 83720  
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October 7, 2016

Landon Taylor, Administrator  
Life Care Center of Idaho Falls  
2725 East 17th Street  
Idaho Falls, ID 83406-6601

Provider #: 135091

Dear Mr. Taylor:

On **September 23, 2016**, a survey was conducted at Life Care Center of Idaho Falls 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 no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) 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.

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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 **October 17, 2016**. Failure to submit an acceptable PoC by **October 17, 2016**, may result in the imposition of penalties by **November 11, 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 **October 28, 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 **December 22, 2016**. A change in the seriousness of the deficiencies on **November 7, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **December 22, 2016** includes the following:

Denial of payment for new admissions effective **December 22, 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 **March 22, 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 **December 22, 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:

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

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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 **October 17, 2016**. If your request for informal dispute resolution is received after **October 17, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink that reads "Nina Sanderson for". The signature is written in a cursive style.

Nina Sanderson, LSW, Supervisor  
Long Term Care

NS/lj

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

PRINTED: 10/19/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF IDAHO FALLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from September 19, 2016 to September 23, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Haley Young, LSW Ophelia McDaniels, RN</p> <p>Abbreviations: A/V = Arteriovenous BIMS = Brief Interview for Mental Status BUN = Blood, Urea, Nitrogen CBC = Complete Blood Count CMP = Comprehensive Metabolic Profile CNA = Certified Nursing Assistant C-PAP = Continuous Positive Airway Pressure CVC = Central Venous Catheter diff = differential DON = Director of Nursing Services ESRD = End Stage Renal Disease IPOST = Idaho Physician Orders for Scope of Treatment IV = Intravenous LPN = Licensed Practical Nurse mg = milligram(s) MAR = Medication Administration Record NC = Nasal cannula PA-C = Physician Assistant-Certified P&amp;P = Policy and Procedure PNR(s) = Progress Note Review(s) PRN = As needed PTA = Physical Therapy Aide O2 = oxygen RAR = Resident at Risk</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

10/14/2016

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 RN = Registered Nurse Stat = immediately TID = Three times a day TO = Telephone Order r/t = related to	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		10/28/16	

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F 157	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to notify the responsible party of 1 of 15 sample residents (#15) regarding changes in the resident's condition. The failure created the inability for the responsible party to contribute to the health care decisions when the resident pulled out her/his central venous catheter [CVC]. Findings include:</p> <p>Resident #15's clinical record documented s/he was admitted to the facility in June 2015 with multiple diagnoses, including ESRD.</p> <p>The record documented Resident #15 had a CVC, which was used during dialysis, and a new A/V fistula in the left arm.</p> <p>A progress note, documented on 6/22/15 at 5:26 am, stated a nurse found blood on the right side of Resident #15's shirt and the CVC on the floor at 1:45 am. The nurse checked the CVC insertion site, applied pressure to the site, cleansed the site and applied a dressing. The note documented no bleeding after that and that the CVC "appeared intact." Resident #15's physician and the dialysis provider were both notified. There was no documentation Resident #15's responsible party was notified about the CVC incident.</p> <p>On 9/22/16 at 5:25 pm, the DON said notification of Resident #15's responsible party regarding the CVC being pulled out was not documented.</p>	F 157	<p>Preparation and /or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p> <p>Specific Resident: Resident #15 has been discharged from the facility.</p> <p>Other Resident: Residents within the facility that have a Central Venous Catheter (CVC) displaced will have notification of the responsible party documented in their medical record.</p> <p>Systemic Changes: 1) The facility updated the definition of "immediately" as defined in Idaho State Informational letter #2014-04 which states; "immediate" means as soon as reasonable possible, and no later than 24 hours from the discovery of the incident (pg. 3 of 5). 2) Licensed staff (LN) educated on the facility's policy for responsible party notification which includes having the notification documented in the medical record.</p> <p>Monitoring: All incidents involving displacement of a CVC line will be monitored to ensure documentation of the</p>		

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F 157	Continued From page 3	F 157	notification of the responsible party is present in the medical record. Audits will be performed by Director of Nursing (DON) and/or designee three times a week for one month, then twice weekly for one month, and then weekly for one month. Results of audits will be reviewed at PI for trending and ongoing education needs to ensure ongoing compliance		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, it was determined the facility failed to promote and maintain the dignity for 2 of 15 sampled residents (#4 and #16). The practice created the potential for a negative effect on the residents' psychosocial well-being when staff failed to knock prior to entering Resident 4's room, and to fully cover Resident #16 during transport to a shower room. Findings include:</p> <p>1. On 9/20/16 at 8:35 am, CNA #4 was observed as she entered Resident #4's room without knocking. Resident #4 requested toileting assistance and the CNA said she would get help. As CNA #4 left the room, she said she had not knocked before she entered Resident #4's room.</p>	F 241	<p>Specific Resident: 1) Resident #4 has been discharged from the facility. 2) Resident #16 has been discharged from the facility.</p> <p>Other Resident: 1) Residents residing in the facility will have their privacy rights met by facility staff knocking on the door prior to entering their rooms. 2) Residents requiring to be undressed prior to leaving their room for a shower will have skin, from the neck down to their ankles, covered from view.</p> <p>Systemic Changes: 1) Facility staff received education relating to residents' privacy rights in relation to knocking on</p>	10/28/16	

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F 241	<p>Continued From page 4</p> <p>On 9/20/16 at 2:05 pm, Resident #4 said s/he liked privacy at times and that most, but not all, staff knocked before they entered his/her room.</p> <p>2. On 9/19/16 at 4:20 pm, CNA #1 was observed transporting Resident #16 to the shower room. Resident #16 was seated in a rolling shower chair with a bathing sheet wrapped around him and a towel hanging around his neck. Resident #16's hip, lower back and buttock on the left side were uncovered and visible. Resident #16 did not appear to be aware that he was exposed.</p> <p>On 9/23/16 at 11:30 am, the DON said residents receiving assistance from 2 staff are undressed in in their rooms and transported by rolling chair to the shower rooms. She said residents should be wrapped and covered with bathing sheets. The DON said it was unacceptable for any resident to be exposed while being transferred to the shower room.</p>	F 241	<p>the door prior to entering the residents' rooms. 2) Direct care staff received education in relation to resident dignity if undressed prior to transportation to the shower room. Direct care staff educated to ensure the resident is fully covered from view prior to exiting the residents' rooms. 3) Facility wide audit completed to determine those residents who are undressed prior to transportation due to mechanical lift transfers to the shower room to determine observation of dignity. Residents identified in the audit were observed for one shower to ensure dignity was maintained during transportation. 4) Facility wide interviews completed with residents and/or families to ensure staff members are respecting privacy by knocking on the door prior to entering.</p> <p>Monitoring: 1) Executive Director (ED) and/or designee to observe seven facility staff members on duty for compliance with facility protocol by knocking on the residents' doors prior to entering. Audits to be completed three times a week for one month, then two times a week for one month and then weekly for one month. 2) Staff Development Coordinator (SDC) and/or designee to observe two residents that transport undressed to shower room for complete coverage from their neck to ankle is maintained. Audits to be completed three times a week for one month, then twice weekly for one month, and then weekly for one month. 3) ED and/or designee to follow up with resident council members monthly for three</p>		

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F 241	Continued From page 5	F 241	months in relation to privacy and dignity. Results of audits will be reviewed at PI for trending and ongoing education needs to ensure ongoing compliance.		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview it was determined that the facility failed to ensure that physician orders were transcribed accurately and that nurses administering medications ensure that the medication order, the medication/pharmacy label and the medication given and documented on the MAR are alike. This failure affected 1 of 15 sampled residents (#1). The findings include:</p> <p>1. On 9/21/16 at 3:00 pm, during medication pass, LPN #1 was observed as s/he poured and administered a PRN hydrocodone to Resident #1.</p> <p>The pharmacy label on the hydrocodone documented Resident #1 was to receive one tablet every six hours as needed for pain.</p> <p>The September 2016 recapitulated physician orders documented the medication was to be administered every 8 hours as needed for pain, rather than every 6 hours as noted on the pharmacy label.</p>	F 281	<p>Specific Resident: 1) Resident #1 had complete medication audit. Audit conducted to ensure medication ordered, medication label and medication given were alike. 2) Resident #1 had MD clarification order obtained related to frequency of PRN Hydrocodone order, medication label and Hydrocodone given were alike.</p> <p>Other Residents: Residents within the facility will have LN administer as needed medication with the execution of facility policy/procedure; which includes verifying the medication order, the medication label and the medication given are alike prior to administering the medication.</p> <p>Systemic Changes: 1) LNs educated to follow policy/procedure for medication administration including verification that medication order, medication label, and medication given are alike prior to administering medication. 2) Facility wide audit conducted to verify that as needed</p>	10/28/16	

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F 281	Continued From page 6  On 9/22/16 at 2:15 pm, the DON said the discrepancy between the order and pharmacy label for Resident #1's PRN hydrocodone was due to a transcription error in March 2016. The DON said LPN #3 corrected the error in April 2016, however, LPN #3 entered every 8 hours rather than prnTID, as originally ordered.	F 281	medications are alike with the medication order, medication label and medication given. 3) Nurse Management (NM) Team provided training on recapitulated physician orders including accuracy. 4) Medical Record Staff educated on accuracy with medication order transcription and review.  Monitoring: 1) LPN #3 will have ten completed recapitulated orders audited by DON and/or designee monthly for three months. 2) SDC and/or designee to conduct medication administration audit with three LNs during their scheduled shift for compliance using the policy for administering medications; including verifying as needed medications are alike on the medication order, medication label and medication given. Audit to be completed three times a week for one month, then twice weekly for one month and then weekly for one month. 3) NM and/or designee to audit seven facility residents with as needed medications to ensure that medication order, medication label and medication given are accurate within the medication cart. Audits will be conducted three times weekly for one month, then twice weekly for one month and then weekly for one month. Results of audits will be reviewed at PI for trending and ongoing education needs to ensure ongoing compliance.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must	F 309		10/28/16	

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F 309	<p>Continued From page 7</p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the facility/laboratory service provider contract, it was determined the facility failed to ensure care was consistently coordinated between the facility and a dialysis provider for 1 of 2 residents (#15) reviewed for dialysis care and services. Resident #15 was at risk of harm when the facility failed to obtain physician ordered lab tests for 2 days, did not communicate the need for the lab tests to the resident's dialysis provider, and the delayed lab tests showed critically high potassium and creatinine levels. Findings include:</p> <p>Resident #15 was admitted to the facility on 6/3/15 with multiple diagnoses, including ESRD and hyperammonemia [a potentially fatal metabolic disturbance characterised by an excess of ammonia in the blood].</p> <p>A 6/10/15 admission MDS assessment documented Resident #15 had severe cognitive impairment; received dialysis, used O2, and a CPAP and the resident received several days of Speech, Occupational, and Physical Therapy in the facility.</p> <p>Interdisciplinary Care Plan, dated 6/11/15.</p>	F 309	<p>Specific resident: Resident #15 has been discharged from the facility.</p> <p>Other Residents: 1) Residents residing in the facility with MD ordered labs will have labs drawn specific to MD order. 2) Residents residing in the facility requiring outside dialysis will have completed pre/post dialysis communication forms present in their medical record.</p> <p>Systemic Changes: 1) Facility DON contacted contracted lab company to clarify maximum amount of lab draws per day. From 10/08/2016 forward there will be no daily limit of lab draws. 2) House wide audit completed with dialysis residents to ensure documentation between facility and dialysis center is present in pre/post dialysis communication forms. 3) Education provided to facility LN staff related to completion of pre/post dialysis communication forms to provide documentation of communication between facility and dialysis center. 4) LNs provided education that when receiving orders from MD for lab work</p>		

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F 309	<p>Continued From page 8</p> <p>documented staff were to obtain Resident #15's weights and laboratory results from the dialysis provider.</p> <p>Resident #15's 6/16/15 care plan documented staff were to observe for, and report to the resident's physician, any complications related to renal failure, edema/fluid overload, respiratory difficulty/shortness of breath, increased weakness, changes in mental status; and nausea/vomiting. Facility staff were to "coordinate [Resident #15's] care in collaboration with [the] dialysis center."</p> <p>Resident #15's 6/3/15 orders included Resident #15 was to go to dialysis on Tuesday, Thursday, and Saturday.</p> <p>On 6/22/15 by 3:19 pm, the facility noted Resident #15 presented with "more confusion."</p> <p>On Tuesday, 6/23/15 at 2:45 pm, a facility nurse notified the physician Resident #15 had been "a lot more shaky, twitchy, aggitated [sic], lethargic" prior to going to dialysis.</p> <p>On 6/23/15 at 8:00 pm, the physician ordered staff to "look @ dialysis labs."</p> <p>On 6/23/15 at 9:00 pm, a facility nurse faxed the physician's office that dialysis had not drawn labs that day and requested an order for a CMP and ammonia level.</p> <p>On 6/24/15 at 2:00 pm, the facility received a telephone order from Resident #15's attending physician for a Chem Panel and ammonia level.</p>	F 309	<p>clarification will include when the MD wants the lab to be drawn. This will include immediate, the same day, a specific day and/or next available lab draw day, etc. 5) Dietary Manager to set a day of the month to contact dialysis to receive the monthly lab/weight report for dialysis residents.</p> <p>Monitoring: 1) DON and/or NM to conduct audit on MD ordered labs to ensure clarification of lab draw time is present on the MD order. Audit will be conducted three times a week for one month, then twice a week for one month, and then weekly for one month. 2) DON and/or NM to conduct audit on pre/post dialysis communication forms for completion three times a week for one month, twice a week for one month and then monthly for one month. 3) Medical Records to audit placement of pre/post dialysis forms in the medical record monthly for three months. 4) Medical Records to audit placement of monthly weight report/monthly lab report from dialysis center in the medical record monthly for three months. Results of audit will be reviewed at PI for trending and ongoing education needs to ensure ongoing compliance.</p>		

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F 309	<p>Continued From page 9</p> <p>On 6/26/15 at 11:51 am, the CMP and ammonia level lab tests were drawn, 2 days after they were ordered on 6/24/15. The CMP report documented the lab notified a facility nurse that Resident #15's potassium and creatinine levels were both critically high (6.6 and 8.6 respectfully) at 12:46 pm on 6/26/15. The ammonia level lab report also documented the resident's ammonia was high at 50 (normal reference range 0-22).</p> <p>On 6/27/15 at 3:07 pm, an RN documented a late entry for 6/26/15 at 12:45 pm, that the lab notified her of the critically high potassium and creatinine levels, she notified the physician and dialysis provider, and the facility was instructed to continue to monitor Resident #15 and not allow potassium-rich foods. The PNR documented Resident #15 rested well that afternoon.</p> <p>On 6/27/15 at 4:40 am, an RN documented that on 6/26/15 at 7:00 pm, Resident #15 sat on the bed but was "not looking well" and was assessed with "very low" O2 saturation levels. The O2 saturation returned to normal with additional O2 and laying down, but Resident #15 declined a dinner outing with his/her spouse and friends. Resident #15's vital signs stabilized, s/he continued to rest and "appears to be more comfortable," but did not eat dinner at the facility. Resident #15 said s/he did not feel well but denied pain, took bedtime medications without difficulty, continued to rest, and used the call light "appropriately part of the time." At 3:30 am, Resident #15 was assisted to the bathroom and the nurse called into the room "because he is not looking well."</p> <p>On 6/27/15 at 3:20 pm, an RN documented that</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>at 6:00 am the night nurse reported Resident #15 experienced "a hypoxic episode when up to bathroom early this am." The note further documented Resident #15 "had been having hard time" maintaining blood-oxygen saturation levels above 90%. At 7:00 am, Resident #15 was awake and answering questions appropriately, but agitated. O2 and C-PAP were in place and the spouse was at the bedside. At 7:30 am, the PA-C was called and a message left regarding a negative change in the resident's vital signs. At 8:15 am, the nurse was called into Resident #15's room and found the resident without a heart beat/pulse or respirations. A second RN verified Resident #15 was deceased and the PA-C was notified. Resident #15's family was present until the mortician arrived.</p> <p>Resident #15's record documented little communication between the facility and dialysis provider from 6/3/15 to 6/27/15. The dialysis provider sent orders to the facility on 6/8/15 and 6/13/15, then gave a telephone order on 6/15/15 to hold the 6/13/15 order. On 6/22/15, the dialysis facility SW faxed a monthly communication to the facility. The dialysis facility RD also faxed a monthly communication to the facility on 6/22/15, which noted Resident #15's albumin was "very low" and recommended daily protein/nutritional supplements. The dialysis facility RD also noted the phosphorus was "above [the] goal" [but] that the medication ordered on 6/8/15 "should help." Also on 6/22/15, the facility notified the dialysis facility the CVC was pulled out, and the dialysis responded. On 6/25/15, RD #2 documented a late entry for 6/24/15 that documented she called the dialysis RD about the high phosphorous and low protein concerns and recommendations. On</p>	F 309			

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F 309	<p>Continued From page 11</p> <p>6/27/15, a facility nurse documented a late entry for 6/26/15 at 12:45 pm, that the dialysis facility was notified of the critically high potassium and creatinine levels.</p> <p>Resident #15's record did not contain additional documentation, including weights or lab reports, of communication between the facility and dialysis provider. In addition, there was no documented evidence the facility communicated the need for the CMP and ammonia level to the dialysis provider before and while Resident #15 was at dialysis on 6/25/15.</p> <p>On 9/22/16 at 5:25 pm, the DON said Resident #15's 6/24/15 CMP and ammonia level lab tests were not ordered stat and they were scheduled for the next available lab draw day. The DON said the lab service provider made daily visits to the facility Monday through Friday, but would come back for stat lab orders, or facility nurses would draw stat lab work after hours and weekends. The DON said she did not know the specific reason Resident #15's CMP and ammonia level was not drawn on 6/25/15. The DON also said Resident #15's dialysis provider drew their own physician ordered lab tests, but would not take orders for lab work from the facility. The DON said Resident #15's lab tests were drawn on 6/26/15.</p> <p>On 9/23/16 at 9:00 am, the DON said the facility had a binder with Pre/Post Dialysis Communication forms for Resident #15 but she could not find it. The facility's contracts with the lab service provider was requested.</p> <p>On 9/23/15 at 10:00 am, the DON provided the</p>	F 309			

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F 309	Continued From page 12 facility's contract with the lab service provider and said "the routine" was that the lab service would visit the facility once a day Monday through Friday and do no more than 5 residents' lab tests, but that was not in the contract. Review of the facility/lab service provider contract confirmed that process was not in the contract. The DON also provided a copy of Resident #15's 6/26/15 CMP lab results from the dialysis provider with a 9/23/16, 8:51 am, fax date stamp. This copy of the CMP report contained a handwritten entry, dated 8/26/15, which documented, "RN notified from [facility]. Informed to let PCP know results and call on cell nephrologist if needed. May need to come to dialysis early."  On 9/23/16 at 11:00 am, the DON said she had not found Resident #15's Pre/Post Dialysis Communication forms, which the resident's dialysis provider had agreed to use. The DON provided Resident #15's dialysis records dated 6/6/15, 6/9/15, 6/11/15, 6/13/15, 6/16/15, 6/18/15, 6/20/15, 6/23/15, and 6/25/15, in which were received from the dialysis center on 9/23/19 at about 8:50 am.	F 309			
F 325 SS=D	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.	F 325		10/28/16	

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F 325	Continued From page 13  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure 1 of 15 sampled residents (#1) was provided with the level of dining assistance necessary to promote food and fluid intake. This created the potential for harm when Resident #1, who experienced a 7.7% weight loss between 7/3/16 and 9/18/16, was not provided cueing and encouragement to eat. Findings include:  Resident #1 was re-admitted on 2/22/16 with diagnoses that included Bell's Palsy, anxiety disorder, depression, bipolar disorder, insomnia and hypertension. The orders documented Resident #1 received a regular diet with mechanical soft meats and a strawberry "Mighty Shake" three times a day. Resident #1 also received Escitalopram 20 mg (an antidepressant) and trazadone 100 mg (an antidepressant) daily.  Resident #1's quarterly MDS assessment, dated 7/1/16, documented she was cognitively intact, required supervision, and the assistance of 1 staff for eating.  Resident #1's care plan, dated 10/27/15, documented a potential for nutritional alterations related to diagnoses of depression and anxiety. Staff were to set up her meals to increase independence.  A Monthly Weight Report documented Resident #1 weighed 143 pounds on 7/3/16, 136 pounds	F 325	Specific Resident: 1) Resident #1 had MDS modified to reflect current level of assistance for intakes. 2) Resident #1 had care plan updated to accurately reflect the level of assistance required for intakes.  Other Residents: Residents residing in the facility who are care planned for assistance with intakes of one will have that assistance provided.  Systemic Changes: 1) Facility wide audit completed for care plan accuracy for residents in relation to the level of assistance required for intakes. 2) Direct care staff provided education related to the accuracy of documentation; including the level of assistance required for intakes. 3) Education provided to direct care staff to provide the level of assistance that is stated in the residents' plan of care.  Monitoring: DON and/or NM to conduct audit of seven facility residents who are care planned to require assistance with meals of one for accurate delivery of assistance. Audits to be conducted three times weekly for one month, then twice weekly for one month and then weekly for one month. Results of audits will be reviewed at PI for		

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F 325	<p>Continued From page 14 on 8/8/16 and 132 pounds on 9/18/16.</p> <p>A Nutritional Progress Note, dated 9/20/16, documented Resident #1 experienced a "significant weight loss in 90 days at 7.7% (-11#'s)." The note also documented Resident #1 had poor intake, appropriate interventions were in place, and laboratory values were within normal limits.</p> <p>A monthly meal intake record for September 2016 documented Resident #1 had consistently poor intake for all meals, but a higher intake of snacks.</p> <p>On 9/19/16 at 6:25 pm, Resident #1's meal tray was observed as it was brought to her room and placed on the bedside table. Resident #1 was lying in bed watching TV with the lights off and the tray in front of her. No cueing or encouragement was provided to her and 35 minutes later a CNA came to collect Resident #1's uneaten meal.</p> <p>On 9/20/16 at 8:18 am, Resident #1 was observed in the independent dining room with her breakfast tray in front of her. Resident #1's tray was taken at 9:00 am with 0% eaten. No cueing or encouragement were provided by staff throughout the meal.</p> <p>On 9/20/16 at 11:15 am, LPN #1 stated staff providing eating assistance would set up the tray, cue and encourage eating, and provide any physical assistance needed, if necessary. LPN #1 said Resident #1 did not need physical assistance with eating, but required cueing due to poor intake.</p>	F 325	trending and ongoing education needs to ensure ongoing compliance.		

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F 325	Continued From page 15  On 9/20/16 at 2:35 pm, RD #1 said a resident who required the assistance of 1 staff with meals would receive tray set up and cueing to eat.  On 9/22/16 at 11:45 am, CNA #2 said a resident requiring the assistance of 1 staff with meals would have the tray set up, cueing, and necessary physical assistance. She said Resident #1 was alert and oriented but had poor intake so staff should encourage her to eat.	F 325			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure oxygen was provided as ordered for 2 of 4 residents (#4 and #5) reviewed for oxygen use. The failure placed both residents at risk for subtherapeutic effect from oxygen and increased risks for respiratory complications. Findings included:	F 328	Specific Resident: 1) Resident #4 discharged from the facility. 2) Resident #5 provided education on MD ordered liter flow. Resident states he will comply with MD orders. Resident will have his oxygen liter flow monitored more frequently (twice every shift) for accuracy.  Other Residents: Residents residing in	10/28/16	

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F 328	<p>Continued From page 16</p> <p>1. Resident #4 was admitted to the facility on 9/2/16, with multiple diagnoses, including obstructive sleep apnea.</p> <p>Resident #4's 9/2/16 transfer orders to the facility documented the resident was on room air and PRN O2 that staff was to adjust from 1 to 2 LPM PRN to maintain O2 saturation levels greater than 90%. C-PAP per home settings was also included in the transfer orders.</p> <p>Resident #4's admission Physician's Order Sheet, dated 9/2/16, documented the C-PAP but did not mention O2.</p> <p>A Telephone Order, dated 9/2/16 at 3:00 pm, documented O2 was to be delivered at 2 LPM when the C-PAP was used.</p> <p>A second Telephone Order, also dated 9/2/16 at 3:00 pm, documented O2 was to be delivered continuously via NC at 2 LPM.</p> <p>Resident #4 was observed breathing room air with the O2 concentrator by the bed in the off position on 9/19/16 at 5:45 pm; 9/20/16 at 10:45 am, 2:00 pm, and 3:25 pm; and on 9/21/16 at 8:40 am and 11:00 am.</p> <p>On 9/20/16 at 8:25 am, Resident #4 was observed in bed with the C-PAP mask in place. The C-PAP was connected to O2 set at 1.5 LPM on the O2 concentrator. A few minutes later, the resident independently removed the C-PAP mask. At 8:35 am, CNA #4 entered the room and asked if she could change the O2 from the C-PAP to the NC. The resident said no and that s/he did not use O2 during the day. The CNA</p>	F 328	<p>the facility with supplemental oxygen required will have oxygen administered per MD order.</p> <p>Systemic Changes: 1) LN staff provided education related to supplemental oxygen administration. Education included administration of supplemental oxygen specific to MD order. 2) If a resident removes, titrates and/or refuses their supplemental oxygen the facility will contact MD for clarification to reflect accurate use of and/or obtain new orders. 3) LNs will increase monitoring of oxygen flow to twice per shift; this increase of supervision has been educated to LN staff.</p> <p>Monitoring: Nurse Manager and/or designee to audit oxygen administration accuracy to MD order three times a week for one month, then twice weekly for one month and then once weekly for one month. Results of audits will be reviewed at PI trending and ongoing education needs to ensure ongoing compliance.</p>		

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F 328	<p>Continued From page 17</p> <p>then turned off the O2 concentrator. At 8:37 am, LPN #4 entered the room and assisted the CNA with providing personal care to the resident. The LPN did not ask the resident about the O2 and did not encourage or instruct the resident to use the O2.</p> <p>On 9/20/16 at 2:05 pm, Resident #4 said s/he "never" used O2 during the day and the facility "assumed I needed it during the day."</p> <p>On 9/21/16 at 10:50 am, the DON said Resident #4's O2 should be set at 2 LPM per the orders for 2 LPM continuously. At 11:00 am, the DON accompanied the surveyor to Resident #4's room and confirmed an O2 NC was not in place and the O2 concentrator was turned off.</p> <p>2. Resident #5 was readmitted to the facility on 11/4/15, with multiple diagnoses, including ESRD.</p> <p>Resident #5's 11/4/15 admission orders included O2 at 2 to 4 LPM. A frequency for the O2 was not documented in the admission orders.</p> <p>Resident #5's recapitulated physician orders for September 2016 included an 11/12/15 order for O2 at 2 LPM via NC every shift.</p> <p>Resident #5 was observed with an O2 NC in place and the O2 concentrator set at liter flow rates other than 2 LPM, as follows:</p> <p>*On 9/20/16 at 1:50 pm, the concentrator was set between 2.5 and 3 LPM and at 3:00 pm, it was set at 3 LPM.</p> <p>* On 9/21/16 at 12:15 pm, the O2 concentrator</p>	F 328			

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F 328	Continued From page 18 was set between 2.5 and 3 LPM.  On 9/21/16 at 3:15 pm, while in Resident #5's room, LPN #1 said Resident #5's O2 was set "just below three" and the LPN increased the O2 to 3 LPM on the concentrator.  On 0/21/16 at 3:30 pm, LPN #1 reviewed Resident #5's clinical record and said the O2 was ordered at 2 LPM. The LPN returned to Resident #5's room and adjusted the O2 concentrator to 2 LPM.	F 328			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  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.  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.  This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and P&P review, it was determined the facility failed to ensure the clinical records for 3 of 15 sample residents (#1, #4, and #5) were accurate and/or complete. This failure created the potential for inappropriate or unnecessary interventions based	F 514	Specific Resident: 1) CNA #3 provided direct education with DON on accuracy of charting meal intake percentage. Resident #1 had behavior monitoring re-written to have poor intakes reflected independently as a sign of depression to	10/28/16	

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F 514	<p>Continued From page 19</p> <p>on incomplete or inaccurate information which increased the risk for complications. Findings included:</p> <p>1. Resident #1 was re-admitted to the facility on 2/22/16, with diagnoses that included Bell's Palsy, anxiety disorder, depression, bipolar disorder, insomnia and hypertension. Physician orders documented Resident #1 received escitalopram 20 mg daily (an antidepressant) and trazadone 100 mg daily (an antidepressant) and was to be monitored for signs and symptoms of anxiety and depression every shift.</p> <p>Behavior/Intervention Monthly Flow Records from January 2016 to September 2016 documented Resident #1 had not exhibited any signs or symptoms of depression and did not have a poor appetite.</p> <p>The September 2016 Monthly Meal Flow Record documented Resident #1 had consistently poor intake for all meals and frequently refused meals.</p> <p>On 9/19/16 at 10:25 am, the DON stated nurses should indicate on the behavior monitoring sheet when Resident #1 had a poor appetite or did not eat, which would be considered a sign and symptom of depression, which was not accurately reflected in Resident #1's clinical record.</p> <p>On 9/20/16 at 8:18 am, Resident #1 was observed in the independent dining room with her set up breakfast tray in front of her. Resident #1's tray was taken at 9:00 a.m. with none of the meal eaten. The meal was monitored by PTA #1.</p>	F 514	<p>increase accuracy. 2) Resident #4 has been discharged from the facility. 3) LPN provided education directly with DON related to accurate execution of facility policy related to holding medications (Resident #5).</p> <p>Other Residents: 1) Residents in the facility receiving behavior monitoring related to depression will have accurate documentation including low intakes in applicable. 2) Residents in the facility requiring meal intake documentation will have accurate documentation reflecting amount of intake per meal. 3) Residents that have second skin observation completed after admission will have documentation in the medical record to reflect completed. 4) LNs who hold a medication will follow facility policy/procedure to document medication was held.</p> <p>Systemic Changes: 1) LN staff and Social Services educated on accuracy of behavior monitoring; including depression manifested by low/poor intakes. 2) LN staff educated on documentation requirements related to second skin observations reflected in the medical record. 3) LN staff educated on policy/procedure for holding medications and the documentation to reflect medication was held.</p> <p>Monitoring: 1) Social Service to audit seven facility residents with depression behaviors accurately documented; which</p>		

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F 514	<p>Continued From page 20</p> <p>The September 2016 Monthly Flow Record documented Resident #1 ate 75% of her breakfast on 9/20/16. This information was recorded by CNA #3.</p> <p>On 9/21/16 at 9:30 am, PTA #1 said Resident #1 did not eat any of her breakfast on 9/20/16, which she recorded on the resident's meal card. She said meal cards are given to CNAs, who then record the consumption percentages on the monthly flow record.</p> <p>On 9/21/16 at 11:20 am, CNA #3 said Resident #1 ate 75% of the 9/20/16 breakfast meal. She said she was not present during the meal, but recorded the percentage off the meal card that was given to her. She said Resident #1 normally had poor intake and she may have recorded the percentage incorrectly.</p> <p>On 9/21/16 at 11:30 am, the DON said CNA #3 should have questioned the high percentage that she recorded for Resident #1's meal because that was not her normal intake. She said the documentation was incorrect.</p> <p>2. Resident #4 was admitted to the facility on 9/2/16, with multiple diagnoses, including cellulitis in the left lower leg.</p> <p>Resident #4's 9/2/16 Initial Data Collection Tool/Nursing Service included a General Skin Condition section with a hand written entry that documented, "9/3/16 2nd skin check - see skin notes for detail." This entry was signed by LPN #2.</p> <p>Resident #4's clinical record, including Progress</p>	F 514	<p>includes low intakes if applicable three times weekly for one month, then twice weekly for one month and the weekly for one month. 2) NM and/or designee to audit meal documentation of seven facility residents for accurate documentation of percentage of intakes three times weekly for one month, then twice weekly for one month and the weekly for one month. 3) NM and/or designee to audit MAR documentation for proper execution of policy related to holding medications three times weekly for one month, then twice weekly for one month and then weekly for one month. 4) DON and/or designee to monitor new admissions records to ensure documentation of any second skin observations completed are documented in the medical record three times a week for one month, then twice weekly for one month and then weekly for one month.</p> <p>Results of audits will be reviewed at PI for trending and ongoing education needs to ensure ongoing compliance.</p>	

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F 514	<p>Continued From page 21</p> <p>Notes for 9/2/16 to 9/21/16, Pressure Ulcer Status Records for 9/2/16 to 9/19/16, and Weekly Skin Integrity Data Collection records dated 9/4/16 to 9/18/16, did not contain a 2nd skin check note.</p> <p>On 9/21/16 at 9:15 am, LPN #2 reviewed Resident #4's clinical record and said she did not find a 2nd skin assessment note for 9/3/16.</p> <p>On 9/22/16 at 2:15 pm, the DON said the facility usually does a 2nd skin assessment the day after a resident's admission but it was not policy to do that.</p> <p>3. Resident #5 was readmitted to the facility in November 2015 with multiple diagnoses, including hypertension.</p> <p>Resident #5's clinical record included a 9/19/16 order to hold Lisinopril (antihypertensive medication) at bedtime that day and the next morning.</p> <p>The September 2016 MAR documented an "H" in the spaces to document administration of Resident #5's Lisinopril on 9/19/16 at 7:00 pm (bedtime dose) and on 9/20/16 at 7:00 am. The "H" was not circled and there were no entries on the MAR to indicate the medication was held at 7:00 pm on 9/19/16 and 7:00 am on 7/20/16. Further down the same page of the MAR was a handwritten entry about holding the 2 doses of Lisinopril.</p> <p>On 9/22/16 at 10:15 am, the DON said the nurse who received the order to hold Resident #5's Lisinopril entered an "H for hold" instead of</p>	F 514			

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F 514	Continued From page 22 circling her initials and noting the reason the medication was not administered.  On 9/22/16 at 12:15 pm, the DON provided the facility's Medication Administration P&P which documented, "Circle initials on MAR if medication is not administered as ordered and record reason on MAR."	F 514			