August 18, 2017

James Burt, Administrator
Grangeville Health & Rehabilitation Center
410 East North Second Street
Grangeville, ID  83530-2258

Provider #:  135080

Dear Mr. Burt:

On August 10, 2017, a survey was conducted at Grangeville Health & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious 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.
After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by August 28, 2017. Failure to submit an acceptable PoC by August 28, 2017, may result in the imposition of penalties by September 22, 2017.

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 14, 2017 (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 November 8, 2017. A change in the seriousness of the deficiencies on September 24, 2017, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by **November 8, 2017** includes the following:

Denial of payment for new admissions effective **November 8, 2017**. [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 6, 2018**, 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. 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 8, 2017** 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:

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

- BFS Letters (06/30/11)

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

This request must be received by **August 28, 2017**. If your request for informal dispute resolution is received after **August 28, 2017**, 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,

![Signature]

Nina Sanderson, L.S.W., Supervisor
Long Term Care

NS/lj
Enclosures
The following deficiencies were cited during the federal recertification survey conducted at the facility from August 7, 2017 to August 10, 2017.

The surveyors conducting the survey were:
Brad Perry, LSW, Team Coordinator
Candy Shugars, RN

Survey Abbreviations:
CNA = Certified Nurse Assistant
LN = Licensed Nurse
LPN = Licensed Practical Nurse
MDS = Minimum Data Set
RN = Registered Nurse
VPCS = Vice-President of Clinical Services

§483.10(e) Respect and Dignity.

The resident has a right to be treated with respect and dignity, including:
§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).

42 CFR §483.12, 483.12(a)(2)
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident’s symptoms.
### F 221

Continued From page 1

(a) The facility must-

1. Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident’s medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

This REQUIREMENT is not met as evidenced by:

- Based on observation; record and policy review; and resident, interested party and staff interviews; it was determined the facility failed to:
  * Identify the ongoing medical needs for restraints,
  * Re-evaluate the restraints,
  * Provide residents with the least restrictive options in lieu of the restraints, and
  * Release the restraints when supervised by staff.

This was true for 2 of 2 (#6 & #8) residents sampled for restraints. The deficient practice had the potential for physical harm if restraints were improperly used, and the potential for psychosocial harm if residents experienced a psychological decline due to feelings of being restricted in movement. Findings include:

The facility's 11/25/16 Physical Restraint & Adaptive Equipment policy and procedure documented:

- When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document

This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor’s conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.

Please accept this plan of correction as our credible allegation of compliance

F221

Resident Specific:

Restrains will be gradually reduced on residents’ #6 & #8. Both residents will
F 221 Continued From page 2
ongoing re-evaluation of the need for the restraint.
* The purpose of restraints was to treat the resident's medical symptoms, improve mobility and independent function, and prevent the resident from injuring themselves and others.

1. Resident #6 was readmitted to the facility on 2/10/16 with multiple diagnoses, including dementia and a history of falls.

Resident #6’s 6/25/17 quarterly Minimum Data Set (MDS) assessment documented the resident:
* Had a physical restraint,
* Was severely cognitively impaired, and
* Required extensive assistance for transfers.

Resident #6’s 2/10/16 Assessment of Need for Physical Restraint completed by the Director of Nursing, documented a lap buddy (a cushion that fits snugly between the resident a wheelchair to facility upper body alignment, prevent rising and to prevent forward leaning) was put into place due to advanced dementia, recurrent falls with a recent hip fracture, unsteady gait, lower extremity weakness, leaning and sliding forward. The assessment documented the device was used to "enable better sitting [and] help maintain hip precautions” and for resident safety. The restorative section of the assessment documented the resident had “fair” posture. The resident's power of attorney signed the consent portion of the document.

Resident #6’s clinical record did not document any physical restraint assessments, after the initial assessment dated 2/10/16.

F 221
work with Occupational and Physical therapy during the reduction attempts to ensure safety.

Other Residents:

Please see systemic changes

Systemic Changes:

Grangeville Health & Rehabilitation does not use restraints in lieu of supervision. The administrator or designee will review all restraint orders to ensure that there is an ongoing medical need for the restraint, that all restraints are evaluated on a quarterly basis, that the least restrictive option is used, and that the restraint will be released when supervised by staff.

Monitors:

Administrator or designee will review all restraint orders to ensure that there is an ongoing medical need for the restraint, that all restraints are evaluated on a quarterly basis, that the least restrictive option is used, and that the restraint will be released when supervised by staff weekly times four and monthly times five. Administrator or designee will report findings at the QAPI meeting and will make changes to the above plan of correction as needed.

Date of Compliance
09/01/2017
Resident #6's progress notes, dated 7/4/17, documented, "The Lap Buddy (restraint) remains in place when she is up in her wheelchair to prevent rising related to recurrent falls with injury and impaired mental status/awareness. She will rarely remove the Lap Buddy herself and throw it on the floor."

Resident #6's August 2017 Physician Orders documented a physician's order, dated 2/10/16, "Lap Buddy to prevent rising unassisted while in w/c [wheelchair]" with diagnoses of dementia, unsafe choices, frequent falls and recent fracture.

Resident #6's clinical record failed to document the medical need for the lap buddy or what less restrictive measures where implemented prior to the lap buddy.

Resident #6's current care plan, with a revised date of 7/4/17, documented, "Reassess [sic] use of restraint use (reduction) quarterly and PRN [as needed] for continued use and Remove [every] 2 h[our]s and PRN for toileting, repositioning and/or comfort."

On 8/7/17 at 5:05 pm to 5:48 pm, Resident #6 was observed in the assisted dining room in her wheelchair with the lap buddy in place. The lap buddy is slide in lap type pillows that help a resident sit up straight and stay in a wheelchair. The resident appeared sitting up in her wheelchair, was calm and did not attempt to rise or move out of the wheelchair. At 5:48 pm, Certified Nurse Assistant #4 (CNA) sat across the table from the resident and assisted the resident to eat. The lap buddy was still observed to be in place when CNA #4 joined the resident. At 5:58 pm resident #6 was observed sitting in her wheelchair with the lap buddy in place eating cake. The lap buddy appeared to be keeping her in seat.
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<td>pm, Resident #6 appeared to lean back in her wheelchair. When the resident relaxed back into the chair the CNA was no longer able to feed the resident without standing. On 8/8/17 at 7:00 am, 10:00 am, 10:45 am, and 12:40 pm, Resident #6 was observed sitting up with good truck control in her wheelchair with the lap buddy in place. The resident appeared calm and did not attempt to rise or move out of the wheelchair. On 8/8/17 at 7:40 am, Resident #6 was observed in the assisted dining room in her wheelchair at the same table as the previous night, with the wheelchair pushed up to the table and the lap buddy in place and pushed under the table. The Activity Director, who was also a CNA, was observed across the table from the resident and assisted the resident to eat. On 8/8/17 at 8:40 am, two CNAs were observed to remove the lap buddy to assist the resident on the toilet. At 8:55 am, the resident was placed back in the wheelchair with the lap buddy in place and Certified Nurse Assistant #1 (CNA) said the lap buddy was used because the resident &quot;climbs out&quot; of the wheelchair and it prevented the resident from falling. On 8/9/17 at 8:10 am, Resident #6 was observed in the assisted dining room in her wheelchair with the lap buddy in place, at the same table as the previous day, with the wheelchair pushed up to the table and the lap buddy tucked under the table. A staff member had just finished assisting the resident with her breakfast and stood up to remove the resident's bowl.</td>
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On 8/8/17 at 3:30 pm, Resident #6's Interested Party said the lap buddy was placed due to falls and said it had helped. The Interested Party was unsure if the facility had tried other alternatives prior to the lap buddy placement, if the lap buddy had been re-evaluated for the ongoing need for it or if any new interventions had been tried.

On 8/9/17 at 9:20 am, CNA #2 said the lap buddy was used to prevent the resident from slouching and from rising from the wheelchair. She said the lap buddy was to be in the wheelchair at all times, except when the resident ate.

On 8/9/17 at 9:32 am, CNA #1 said the lap buddy was used to prevent falls and was to be in the wheelchair at all times, except when the resident ate.

On 8/9/17 at 10:30 am, Registered Nurse #2 (RN) said the lap buddy was used because the resident was impulsive and tried to walk, which could result in a fall.

On 8/10/17 at 10:20 am, the Director of Therapy said he had tried other interventions prior to the placement of the lap buddy but those interventions did not work because the resident continued to fall and said the current lap buddy had worked since the resident had not fallen for a long time and did not have any skin issues. He said he had not re-evaluated the ongoing need for the lap buddy because he thought nursing was supposed to assess the lap buddy each quarter.

On 8/10/17 at 11:30 am, the Vice-President of
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Clinical Services (VPCS) said the lap buddy was used to keep the resident from falling and the medical justification was due to the resident's dementia diagnosis. He said the lap buddy should be released by staff every two hours and during meals. He said the lap buddy should have been re-evaluated quarterly, but it had not.

2. Resident #8 was admitted to the facility on 4/21/15 with multiple diagnoses, including schizoaffective disorder.

Resident #8's 7/14/17 quarterly MDS assessment documented the resident:
* Did not have a physical restraint,
* Was severely cognitively impaired, and
* Required extensive assistance for transfers.

Resident #8's 5/12/16 Assessment of Need for Physical Restraint, completed by the Director of Nursing, documented a lap buddy was put into place due to schizoaffective disorder, frequent falls, inability to follow directions for safety, leaning forward, unsteady gait, and poor safety awareness. The resident's power of attorney signed the consent portion of the document.

Resident #8's clinical record did not document any physical restraint assessments, after the initial assessment dated 5/12/16.

Resident #8's August 2017 Physician Orders documented a physician's order, dated 5/12/16, "Lap Buddy at all times while up in wheelchair" with diagnoses of schizoaffective disorder, frequent falls, inability to follow directions for safety and very poor safety awareness.
F 221  Continued From page 7

Resident #8's clinical record failed to document the medical need for the lap buddy.

Resident #8's current care plan, with a revised date of 7/21/17, documented interventions of:
- "Assure the medical record contains documentation of the medical condition justifying the use of restraint."
- "Attempt restraint reduction with goal being to discontinue restraint."
- "Complete a restraint assessment before applying restraint and quarterly thereafter as long as restraint is used."

On 8/9/17 at 4:38 pm, Resident #8 was observed in the front lobby in her wheelchair with a lap buddy in place. The lap buddy is slide in lap type pillows that help a resident sit up straight and stay in a wheelchair. The resident appeared calm, sitting up, and did not attempt to rise or move out of the wheelchair.

On 8/9/17 at 4:45 pm, Resident #8 said the lap buddy was for her own safety because she tended to slide forward in her wheelchair. She said she also used the buddy to place things on it when she wanted to. She said she could remove the lap buddy, but said if she removed it, she risked sliding out of the wheelchair.

On 8/10/17 at 9:30 am and 11:00 am, Resident #8 was observed in her wheelchair with the lap buddy in place. The resident appeared calm, sitting up, and did not attempt to rise or move out of the wheelchair.

On 8/10/17 at 9:43 am, Nursing Assistant #2 said the lap buddy was used to prevent the resident...
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**
GRANGEVILLE HEALTH & REHABILITATION CENTER

**Address:**
410 EAST NORTH SECOND STREET
GRANGEVILLE, ID 83530

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<th>Summary Statement of Deficiencies</th>
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<th>Provider’s Plan of Correction</th>
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<td>F 221</td>
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<td>from falling out of her wheelchair.</td>
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<td>On 8/10/17 at 9:45 am, CNA #3 said the lap buddy was used because the resident leaned forward and was a fall risk.</td>
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<td>On 8/10/17 at 9:50 am, RN #3 said the lap buddy was used to prevent falls.</td>
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<td>On 8/10/17 at 10:35 am, the Director of Therapy said the lap buddy was a safety reminder to the resident as well as an enabler to allow the resident to place items on the buddy as she moved throughout the facility. He said he had tried other interventions prior to the placement of the lap buddy, but those interventions did not work and said the current lap buddy worked. He said since he interacted with resident most every day and observed her with the lap buddy, he did not feel he needed to formally re-assess and document the need for the buddy.</td>
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<td>On 8/10/17 at 11:45 am, the VPCS said the lap buddy was used due to poor safety awareness of the resident. He said the lap buddy should have been re-evaluated quarterly, but it had not.</td>
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**Requirements Violated:**

F 241 8/28/17

**Regulatory Basis:**

483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY

(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident’s individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and staff
F 241  Continued From page 9

interview, it was determined the facility failed to ensure assistance at meals was provided in a manner to maintain to enhance each resident's dignity when a staff member stood while assisting a resident to eat and when staff did not release the resident's lap buddy when assisting the resident to eat. This was true for 1 of 11 (#6) sampled residents observed for dining. This deficient practice had the potential for harm if the resident experienced a sense of decreased self-worth. Findings include:

On 8/7/17 at 5:05 pm to 5:48 pm, Resident #6 was observed in the assisted dining room in her wheelchair with a full cushioned 14-inch wide lap buddy in place and sitting in front of a 16-inch wide table. The lap buddy attached without straps to the front of the resident's wheelchair handles and covered the resident's upper legs and lap area. The resident was sitting up in her wheelchair, was calm and did not attempt to rise or move out of the wheelchair. At 5:48 pm, Certified Nurse Assistant #4 (CNA) sat across the table from the resident and assisted the resident to eat. The lap buddy was still observed to be in place when CNA #4 joined the resident. At 5:58 pm, Resident #6 appeared to lean back in her wheelchair. From 6:00 pm to 6:03 pm, Resident #6 was observed leaned back in her wheelchair and CNA #4 stood up, leaned towards the resident, and fed the resident milk and a pureed dessert cake.

Resident #6's current lap buddy care plan, with a revised date of 7/4/17, documented, instructed staff to remove the lap buddy every two hours and as needed for toileting, repositioning and/or comfort.

Resident Specific:

Resident #6 will be treated with dignity and respect in all aspects of care. All staff will stay seated while assisting with meals.

Other Residents:

Please see systemic changes

Systemic Changes:

All staff have been in-serviced on the importance of maintaining resident dignity and respect in all aspects of their cares to provide an environment that promotes maintenance or enhancement of quality of life. This includes but not limited to, staying seated while assisting during meals.

Monitors:

Administrator or designee will monitor all staff during meals to ensure they stay seated while assisting residents weekly times four and monthly times five. Administrator or designee will report findings at the QAPI meeting and make changes to the above plan of correction as needed.

Date of Compliance

08/28/2017
### F 241

**Continued From page 10**

On 8/8/17 at 7:40 am, Resident #6 was observed in the assisted dining room in her wheelchair at the same table as the previous night, with the wheelchair pushed up to the table and the lap buddy was attached to the wheelchair and was tucked under the table. The Activity Director, who was also a CNA, was observed across the table from the resident and assisted the resident to eat, while sitting down.

On 8/8/17 at 2:50 pm, CNA #4 said she stood up to assist feed Resident #6 because the lap buddy did not fit under the table and it was hard to reach the resident's mouth if the resident did not lean forward in her wheelchair. She said that she stood up to assist fed the resident whenever the resident sat back in her wheelchair.

On 8/9/17 at 8:10 am, Resident #6 was observed in the assisted dining room in her wheelchair at the same table as the previous day, with the wheelchair pushed up to the table and the lap buddy was attached to the wheelchair and was tucked under the table. A staff member had just finished to assist the resident with her breakfast and stood up to remove the resident's bowl.

On 8/9/17 at 9:20 am, CNA #2 said the lap buddy was to be removed when the resident ate.

On 8/9/17 at 9:32 am, CNA #1 said the lap buddy was used to be removed when the resident ate.

On 8/9/17 at 2:50 pm, the MDS Coordinator said she had assisted Resident #6 with meals "plenty of times" and the resident's lap buddy fit under the table. She said staff should not stand while...
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<td><strong>Assistanting residents to eat.</strong></td>
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<td><strong>8/28/17</strong></td>
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<td>F 258</td>
<td><strong>483.10(i)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS</strong></td>
<td>F 258</td>
<td><strong>(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:</strong> &lt;br&gt; Based on observation, Resident Group Interview and staff interview, it was determined the facility failed to maintain comfortable sound levels when the facility's overhead paging system was used frequently. This was true for 3 of 7 residents in the Resident Group Interview and had the potential to affect most residents in the facility. This deficient practice had the potential for physical and/or psychosocial harm if residents did not receive adequate rest and/or experienced a noisy environment. Findings include: &lt;br&gt; On 8/7/17 from 3:46 pm to 4:30 pm there were seven overhead announcements for staff to pick up phone lines and/or for staff to go to certain parts of the facility. The announcement was audible throughout the facility. &lt;br&gt; On 8/8/17 from 8:43 am to 11:32 am four announcements were made overhead. &lt;br&gt; On 8/9/17 from 8:32 am to 11:05 am and 3:04 pm to 4:52 pm, 12 announcements were made overhead. &lt;br&gt; On 8/9/17 at 9:45 am, during the Resident Group Interview, 3 of 7 residents said the overhead paging system, which was used during the day, had negatively affected them or other residents. The residents stated an overhead page could be heard from any part of the facility.</td>
<td><strong>F 258</strong>&lt;br&gt; <strong>Resident Specific:</strong>&lt;br&gt; No specific residents were identified&lt;br&gt; <strong>Other Residents:</strong>&lt;br&gt; Please see systemic changes&lt;br&gt; <strong>Systemic Changes:</strong>&lt;br&gt; The facility will purchase hand held radios for all staff in the facility. All staff will be in-serviced upon arrival of hand held radios to maintain comfortable sound levels in the facility.&lt;br&gt; <strong>Monitors:</strong>&lt;br&gt; Administrator or designee will monitor the use of the paging system to ensure comfortable sound levels in the facility weekly times four and monthly times five. Administrator or designee will report findings at the QAPI meeting and will make changes to the above plan of correction as needed.&lt;br&gt; <strong>Date of Compliance</strong>&lt;br&gt;</td>
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F 258 Continued From page 12

heard throughout the building. One resident said the overhead paging disturbed her rest when trying to sleep during the day. Another resident said she knew it was "annoying" to other residents, who were not in the group interview. A different resident said the residents in the facility have "just gotten used to it."

On 8/10/17 at 9:30 am, Licensed Nurse #3 said when a call for a staff member came into the facility, she and other staff used the overhead paging system to let the staff member know that they had a call waiting on the line.

On 8/10/17 at 11:10 am, the Activity Director said when a call for a staff member came into the facility, she would see if the staff member was nearby and would let them know in person that they had a call. She said if the staff member was not readily available, then she used the overhead paging system to let the staff member know that they had a call waiting on the line and would repeat the page if the staff member did not pick-up the line in a timely manner.

On 8/10/17 at 11:15 am, the Business Office representative said when a call for a staff member came into the facility, she used the overhead paging system to let the staff member know that they had a call waiting on the line and would repeat the page if the staff member did not pick up the line in a timely manner.

On 8/10/17 at 11:20 am, the Administrator said most calls could be directed to staff member's office phones, but other calls and pages for meetings were announced using the overhead paging system.
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<td>SS=E</td>
<td>483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
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The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws,
F 431 Continued From page 14

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.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, policy review, and interview, the facility failed to ensure drugs and biologicals were labeled with an expiration date. This was true for 4 random residents (#s 13-16). This failed practice created the potential for harm if residents had poor blood glucose control from receiving expired insulin.

Findings include:

Review of facility's policy titled, "UVANTA Recommended Temperature and Storage for Insulin," dated 4/4/16, documented vials of Humalog, Humulin, and Novolog insulin expire after 28 days after opening, and Novolin R insulin expires 42 days after opening.

On 8/7/17 at 5:10 pm, the 300 hall medication cart contained:

a. An opened Humulin R insulin bottle for Resident #13 which was dispensed on 8/1/17. There was no date written on to bottle indicating...
F 431 Continued From page 15
the date it had been opened.

b. An open vial of Novolin R insulin for Resident #14 which was dispensed on 7/21/17. There was no date written in the bottle indicating when it had been opened.

c. An open bottle of Humulin R for Resident #15 that was dated as opened on 7/1/17. The bottle had expired nine days prior to the observation. Resident #15's Medication Administration Record documented the resident had not received Humulin R medication since 7/25/17.

On 8/7/17 at 5:30 pm, the 100/200 hall med cart contained a vial of Lantus insulin dispensed on 8/2/17, and a vial of Novolin R dispensed on 8/1/17 for Resident #16. Both vials were opened, but no date documented as to when they had been opened.

On 8/7/17 at 5:10 pm LPN #1 stated she planned to date the insulin vials for Resident #13 and Resident #14 with the dispensed date as this would assure the shortest usage date for compliance, and dispose of Resident #15's expired Humulin R. At 5:32 pm, LPN #2 stated she had the same plan to add fill date as opened dated on Resident #16's insulin.

At 12:00 noon on 8/10/17, the Pharmacy Consultant stated he had last conducted an audit at the facility on 7/28/17, which had included checking the medication refrigerator for undated or expired medications. He stated he checked the refrigerator monthly during his visits but last checked the medication carts in the spring. The Pharmacy Consultant stated the pharmacy

Administrator or designee will monitor all opened insulin bottles in med carts to ensure there is an open date and that there is no expired insulin weekly times four and monthly times five. Administrator or designee will report findings at the QAPI meeting and will make changes to the above plan of correction as needed.

Date of Compliance

08/28/2017
### SUMMARY STATEMENT OF DEFICIENCIES

**Provider's Plan of Correction**

(Each Corrective Action Should Be Cross-Referenced To The Appropriate Deficiency)

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<tr>
<th>ID</th>
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<th>F 431</th>
<th>8/28/17</th>
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<td>F 431</td>
<td>Continued From page 16</td>
<td>Applies the blank &quot;Date Opened&quot; stickers to each insulin vial for nurses to record the date opened so that the nurses have a visual reminder to discard when outdated. The Pharmacy Consultant stated giving insulin past expiration date decreases its effectiveness to lower the resident's blood glucose level.</td>
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<td>F 441</td>
<td>SS=E</td>
<td>483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>(a) Infection prevention and control program.</td>
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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

1. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

2. Written standards, policies, and procedures for the program, which must include, but are not limited to:

   i. A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the
(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an
Continued From page 18

annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Based on observation, interviews, and review of the facility's policy, the facility failed to maintain accepted infection control standards. Specifically, the facility:

1. Failed to ensure sanitation of glucometer(s) was performed per Manufacturer recommendations & facility policy after use on 1 of 4 residents observed (Resident #13).
2. Failed to ensure staff utilized standard precautions when administering injections for 2 of 4 residents observed (Resident #3 and Resident #10).

Findings Include:

1. On 8/7/17 at 5:10 pm, LPN #1 completed blood glucose testing using a glucometer on Resident 13. LPN #1 exited the room holding glucometer. Upon return the glucometer was no longer visible with LPN #1 or on the top of her medication cart.

On 8/7/17 at 5:12 pm, LPN #1 stated she had cleaned the glucometer with 2 alcohol sanitizer wipes and showed that the glucometer was back in the top drawer of the medication cart in its own divider section. LPN #1 stated she usually used bleach wipes but "someone had borrowed them earlier," so she used the alcohol to clean it before putting it away. She then opened the bottom drawer to show where the bleach wipes were usually kept at which time they were present in the bottom drawer. LPN #1 was verbally in-serviced by the administrator on the proper cleaning of glucometers during the survey.

Residents 3 and 10's nurses will wear gloves while administering injections. RN #1 was verbally in-serviced by the administrator on the importance of wearing gloves while administering injections during the survey.

Other Residents:

Please see systemic changes

Systemic Changes:

All licensed staff have been in-serviced on the proper cleaning of glucometers and the importance of wearing gloves while administering injections.

Monitors:

Administrator or designee will monitor 3 glucometer cleanings and 3 injections weekly times four and monthly times five to ensure proper cleaning and that all nurses wear gloves while administering


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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<td>F 441</td>
<td>Continued From page 19</td>
<td>the drawer. LPN #1 stated she was not sure of the facility’s policy for which product to use for disinfection but she would find out. At 5:30 pm, LPN #1 stated she had “spoken with another nurse in the building and she agreed that alcohol is ok to use on the glucometer.” LPN #1 further stated she would look for the policy.</td>
<td>F 441</td>
<td>injections. Administrator or designee will report findings at the QAPI meeting and will make changes to the above plan of correction as needed.</td>
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<td>On 8/7/17 at 6:45 pm, the Administrator stated he had spoken to the Vice President of Clinical Services, who was covering for Director of Nursing in her absence, and was directed to the &quot;Glucometer and Coaguchek Policy&quot; verifying bleach wipes are to be used. LPN #1 was present and stated she would go immediately to clean the glucometer with the bleach wipe and the drawer area in which she had placed it.</td>
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<td>The facility's &quot;Glucometer (tests blood sugar levels) and Coaguchek (tests clotting times of blood) Disinfection&quot; policy, dated 7/21/2015, documented, &quot;Glucometer and Coaguchek (PT/INR) machines will be cleaned and disinfected according to current CDC (Center for Disease Control) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard. Procedure step 1. a. documented, &quot;After completing patient blood testing and prior to leaving patient room, thoroughly clean and disinfect the machine by wiping all surfaces with an approved disinfecting wipe. (Micro-kill Bleach Germicidal Bleach Wipes) ...Step 1. c. Surface of the machine requires a 5-minute contact/wet time for effectiveness before repeat use.&quot;</td>
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<td>2. On 8/9/17 at 4:45 pm, RN #1 injected Resident</td>
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### Summary Statement of Deficiencies

**F 441**  
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#10 with insulin. RN #1 did not wear gloves while to injecting the insulin into Resident #10's abdomen. At 5:05 pm, RN #1 was preparing to inject Resident #3 with insulin, again not wearing gloves, until stopped by the surveyor.

On 8/9/17 at 4:45 pm RN #1 stated, "Normally I don't wear gloves just to give insulin." At 5:05 pm, RN #1 stated, "No one ever told me I have to wear gloves when giving insulin." RN #1 stated she had received training on standard precautions and the use of personal protective equipment when hired at the facility, but had not realized there was potential for her to come in contact with residents' blood when administering insulin injections.

On 8/9/17 at 5:30 pm, the Administrator and Vice President of Clinical Services confirmed it is their expectations that standard precautions be followed and gloves should be worn when administering injections. The Administrator stated he would re-educate RN #1 immediately.

The facility's "Standard Precautions" policy, dated 4/1/2016, documented Standard Precautions were "the minimum precautions utilized on all patients when there is potential or actual contact with body fluids which may or may not contain blood and or infectious organisms. Wear gloves...when touching blood, body fluids, secretions, excretions and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin."