IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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February 12, 2018

Dennis Carlson, Administrator
Bear Lake Memorial Skilled Nursing Facility
164 South Fifth Street
Montpelier, ID 83254-1557

Provider #: 135070

Dear Mr. Carlson:

On **January 26, 2018**, a survey was conducted at Bear Lake Memorial Skilled Nursing Facility 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 an isolated deficiency that constitutes actual 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 **February 22, 2018**. Failure to

submit an acceptable PoC by **February 22, 2018**, may result in the imposition of penalties by **March 19, 2018**.

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*.

The remedy, which will be recommended includes the following:

- Civil Monetary Penalty

- Denial of payment for new admissions effective **April 26, 2018**. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 26, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 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

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

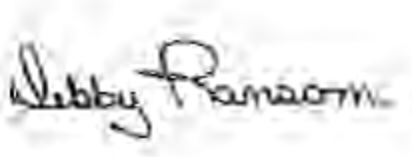
- BFS Letters (06/30/11)

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

This request must be received by **February 22, 2018**. If your request for informal dispute resolution is received after **February 22, 2018**, 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 cme at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135070	A. BUILDING _____ B. WING _____	01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR LAKE MEMORIAL SKILLED NURSING FACILITY	164 SOUTH FIFTH STREET MONTPELIER, ID 83254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted January 22, 2018 to January 26, 2018. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Jenny Walker, RN ABBREVIATIONS: ADLs = Activities of Daily Living AIT = Administrator in Training CNA = Certified Nursing Assistant DNS = Director of Nursing Services EMR = Electronic Medical Record LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set ml = milliliters mg = milligrams MRR = Medication Reconciliation Record PRN = As needed RD = Registered Dietitian r/t = related to TAR = Treatment Administration Record	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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	F 600		3/21/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/22/2018

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F 600	Continued From page 1 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, and review of facility policies and Incident Reports and investigations, it was determined the facility failed to ensure 1 of 8 (#23) sampled residents were free from all forms of abuse, including verbal and mental abuse. Resident #23 sustained psychosocial harm when she was verbally and mentally abused by the LSW, when the LSW coerced Resident #23 to sign a contract stipulating that Resident #23 was responsible for her own falls, and would waive her right to decline a room change if further falls occurred. Following the abuse, Resident #23 and her interested party were afraid she would be discharged from the facility if she did not follow the rules. This deficient practice placed residents residing in the facility at risk of abuse. Findings include: The facility's Abuse Policy and Procedure, revised 9/13/16, defined verbal abuse as "use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families... examples include threats of harm, saying things to frighten a resident, such as telling a resident he/she will never be able to see his/her family again."	F 600	1. Safety contract for resident #23 has been discontinued on 1/30/2018. Resident made aware of the termination of the contract. Resident interviewed and stated she had no concerns or fear of being moved. Resident records audited, no other contracts in place. Alleged abuse investigation completed and submitted to DHW/Facility Standards on 1/30/2018. Facility investigation did not substantiate abuse. 2. Any resident that had a contract in place would have the potential of being impacted by this alleged deficient practice. Facility charts reviewed, no other residents had a contract in place. 3. Facility staff that were present, including the DNS, AIT, LSW, Attending MD, ADON during the contract discussion with resident #23 have received additional education on Mental abuse on or before 3/21/2018. 4. Admin or designee will conduct abuse investigation interviews with 2-3 residents that have had meetings with the LSW and IDT weekly x4, then monthly x3, then quarterly x3 and report findings to the QAPI committee for review and further	

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F 600	Continued From page 2 The facility's Abuse Policy and Procedure, revised 9/13/16, defined mental abuse as "includes, but is not limited to humiliation, harassment, threats of punishment, or deprivation. Mental abuse may occur through either verbal or non-verbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation." Resident #23 was admitted to the facility on 5/31/17 with multiple diagnoses, including Parkinson's Disease and Lewy body dementia. Resident #23's annual MDS assessment, dated 6/6/17, and quarterly MDS assessments dated 9/6/17 and 12/7/17 documented Resident #23 was cognitively intact. An Incident and Accident Report, dated 9/23/17 at 10:20 AM, documented Resident #23 fell when attempting to ambulate without assistance. Resident #23 obtained a laceration to back of her head and was sent to the emergency room for further evaluation. Resident #23's clinical record had a contract developed by the LSW and signed by Resident #23 and the LSW, dated 10/19/17, documented, "I, Resident #23, am entering into a contract of safety with [facility name] as my noncompliance with staff assist transferring has resulted in multiple falls, including a fall with injury. I understand that by continuing to self-transfer, I am putting myself in danger. I, Resident #23, agree to use the call light when I need assistance and wait for the assistance to come. I will not	F 600	recommendations. 5. Facility will be in substantial compliance as of 3/21/2018.	

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F 600	Continued From page 3	F 600		

make any attempts to self-transfer. I will not remove my alarms and I understand that the alarms I have in place are related to my noncompliance with transferring and are there for my safety. I understand that my failure to comply with this contract of safety may result in a room change allowing me to be closer to the nurse's station for increased supervision."

The LSW's Psychosocial Note, dated 9/19/17 at 1:40 PM, did not document behavioral concerns related to Resident #23 self transferring or falling.

The LSW's Psychosocial Note, dated 9/27/17 at 6:30 PM, documented staff reported Resident #23 was depressed. The LSW documented Resident #23 was happy to have the staple removed from the back of her head. The LSW documented she visited with Resident #23 about her tab alarm and Resident #23 stated the tab alarm was a reminder to use the call light for help.

The LSW's Psychosocial Note, dated 10/16/17 at 2:59 PM, documented the LSW, DNS, and RN educated Resident #23 on the purpose of the tab alarm and not to remove it to self-transfer. The LSW documented Resident #23 stated after the last fall, she thinks she needs the alarm because she doesn't want to fall again. The LSW validated Resident #23's feelings and encouraged her to use her call light, and not to remove the alarm.

The LSW's Psychosocial Note, dated 10/18/17 at 3:24 PM, documented the LSW spent 1:1 time with Resident #23. The LSW documented Resident #23 did not have signs or symptoms of depression.

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F 600	Continued From page 4	F 600		

The LSW's Psychosocial Note, dated 10/19/17 at 2:33 PM, documented the LSW provided Resident #23 with a copy of a safety contract. The LSW documented, "Res [sic] stated she was okay with interventions being placed and understood it was for her safety."

The LSW's Psychosocial Note, dated 10/20/17 at 12:27 PM, documented, "LSW followed up res r/t recent fall interventions put in place. Res stated that she thought the seat belt was going to be good." There was no documentation regarding the "safety contract" that Resident #23 received by the LSW on 10/19/17 and how it made her feel.

Resident #23's care plan, dated 1/23/18, documented, "Resident #23 is a high risk for falls r/t Gait/balance problems r/t diagnosis of Parkinson's and history of falls at home prior to SNF admission." Interventions included, "Has pressure sensitive bed alarm, chair alarm and seat belt alarm to wheelchair as well to alert staff of attempts to stand unassisted. Be aware that alarms will not prevent falls and are only intended to alert staff that she has a need that must be met. Respond promptly to all alarms." The care plan did not document the "safety contract."

On 1/25/18 at 1:00 PM, Resident #23 stated signing the contract did not make her "feel right," but she did not want to lose her private room, so she signed the contract and had been following the rules. Resident #23's interested party stated with the contract, we thought Resident #23 was going to be "kicked out" of the facility if Resident #23 did not comply with the rules of the contract.

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F 600	Continued From page 5 On 1/25/18 at 3:15 PM, the Administrator, DNS, and AIT was not aware of the contract in Resident #23's clinical record. The LSW was not available for an interview for the duration of the survey.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §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). §483.12 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 medical symptoms. §483.12(a) The facility must- §483.12(a)(2) 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	F 604		3/21/18

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F 604	Continued From page 6 restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free from physical restraints. This was true for 1 of 2 residents (#22) reviewed for restraints. Resident #22 had the potential for harm after the implementation of a seat belt, which the facility failed to assess or recognize as a restraint. Findings include: Resident #22 was admitted to the facility on 12/27/16 with diagnoses, including Alzheimer's disease, anxiety, and depression. A quarterly MDS assessment, dated 10/12/17, documented Resident #22 had a severe cognitive impairment, and he required extensive assistance of two staff members for transfers and ambulation. The MDS documented he wandered frequently and no restraints were used. On 1/23/18 at 3:06 PM, Resident #22 was observed in his wheelchair with a seat belt strapped across his waist and a tab alarm placed on the back of his shirt. On 1/24/18 at 8:26 AM, Resident #22 was observed in his wheelchair with a seat belt strapped across his waist and a tab alarm placed on the back of his shirt. On 1/24/18 at 9:14 AM, Resident #22 was observed in his wheelchair, near the nurse's station, with a seat belt strapped across his waist. Resident #22 smiled at the interaction with the surveyor, and raised his arms and legs in a	F 604	1. Resident # 22 was assessed for seat belt on 1/25/2018. Seat belt was discontinued on 1/25/2018. MD notified of seat belt use and discontinuation on 2/22/2018. 2. Residents with a restraint or potential restraint may be impacted by this alleged deficient practice. All current residents with a restraint or potential restraint will have restraint evaluation, restraint order and restraint care plan reviewed and updated as appropriate on or before 3/21/2018. 3. Facility Restraint assessment updated to include specific medical symptoms being treated, type of restraint, and timing/frequency of restraint use on or before 3/21/2018. Nurses educated that prior to restraint placement an assessment must be completed, an order obtained, and the CP updated. CNA□s educated that restraint or potential restraint devices can not be applied without specific care plan interventions. Education completed on or before 3/21/2018. 4. DNS or designee will conduct walking rounds M-F x 2 weeks to monitor for restraint/potential restraints that are in place but that have not been ordered. DNS or designee to audit behind all new restraints/potential restraints to ensure Assessment, Order, Care Plan and proper placement are in place weekly x4, monthly x3 and quarterly x4 and will	

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F 604	Continued From page 7 dancing motion. Resident #22's right hand reached down at the seat belt, and stopped smiling, closed his eyes, and hung his head, when he could not release the seat belt. The Elopement Care Plan, dated 7/27/17, documented Resident #22 wandered "aimlessly," and he had a "wander guard" attached to his wheelchair. On 1/24/18 at 2:57 PM, the DNS stated Resident #22 had the seat belt to prevent him from "wandering or falling." The DNS was unsure when the seat belt was ordered. The DNS stated she thought Resident #22 could release his seat belt, and she would look for the evaluation and the other missing items identified. On 1/25/18 at 5:49 PM, the DNS stated she was unable to locate the missing items above. The DNS stated she reevaluated Resident #22, and he could not release the seat belt. Resident#22's clinical record did not contain evidence that Resident #22 had medical symptoms that warranted the use of the seat belt. Resident #22's clinical record did not include a physician's order with identified medical symptom being treated, and an order for the use of the specific type of restraint. The facility failed to include assessments, care planning by the interdisciplinary team, and documentation of the medical symptoms and use of the seat belt for the least amount of time possible and provide ongoing re-evaluation.	F 604	report findings to the QAPI committee for review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		3/21/18

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F 658	Continued From page 8 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 14 sampled residents (#17). Resident #17's medications and feedings were administered via PEG tube without checking for tube placement prior to administration of medications or feedings. This failed practice had the potential to adversely affect or harm residents whose cares were not delivered according to accepted standards of clinical practices. Findings include: Lippincott Manual of Nursing Practice, Ninth Edition, the definition of a PEG was a tube inserted into the stomach. The manual documented for peg tube placement, "inject 30 cc of air while listening with a stethoscope positioned at the epigastric area" prior to administration of water flushes, medications, or feedings. The facility's Administering Medications via Feeding Tube policy and procedure, updated 7/1/13, included, "Place stethoscope over stomach and instill a small amount of air into the feeding tube. Listen for air to enter the stomach." Resident #17 was admitted to the facility on 8/7/13 with multiple diagnoses, including dysphagia related to a stroke.	F 658	1. Resident #17 was assessed on 1/24/2018 at 2133 during Tube Feeding and resident tolerated well. Upon documentation review no adverse effects were noted from failure to check PEG Tube placement prior to feeding. Effective 1/25/2018 Tube feeding order updated to include checking Tube Feeding placement by checking residual (recommended procedure per Fundamentals of Nurse, Potter & Perry, 9th Edition). 2. Residents with PEG tube feedings may be impacted by this alleged deficient practice. There are no other residents at the facility that have a PEG tube in place or receive tube feeding. 3. Facility Tube Feeding Policy was updated on 1/29/2018 to meet recommendations based on Fundamentals of Nursing, Potter & Perry, 9th Edition which recommends tube placement to be verified utilizing the following method: (a) Check for gastric residual volume (GRV) before each feeding for bolus and intermittent feedings. (b) Draw up 10-30 ml of air into syringe. Connect to end of feeding tube. Flush tube with air. Pull back slowly to aspirate total amount of gastric contents and measure. (c) Return aspirated	

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F 658	Continued From page 9 Resident #17's peg tube was changed on 12/28/17 per facility's protocol. On 1/24/18 at 11:45 AM, LPN #1 was observed not checking peg tube placement prior to administering water flushes and feedings. LPN #1 stated, she does not check tube placement for Resident #17, because he had his peg tube for more than six years.	F 658	contents to stomach unless volume exceeds 250ml. Additionally, Potter & Perry states: Auscultation of insufflated air is not a reliable method for verification of placement of a tube because a tube inadvertently placed in lungs, pharynx or esophagus transmits sound similar to that of air entering the stomach (Kenny and Goodman, 2010; Stewart, 2014) Review of most current Aspen recommendations are consistent with Potter & Perry. Nurses educated on updated Tube Feeding Policy and Procedure on or before on or before 3/21/2017. 4. DNS or designee to audit tube feeding placement verification daily x3 and then weekly x4, then monthly x3, then quarterly x3 and report findings to QAPI committee for review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		3/21/18

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F 688	Continued From page 10 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease in range of motion (ROM). This was true for 1 of 8 residents (#11) reviewed for treatment and services related to ROM. This failure created the potential for harm when Resident #11 did not have a splint placed on a contracted limb and the care plan di dnot provide instructions for the use of the splint or ROM to prevent deterioration of existing ROM limitations. Findings include: Resident #11 was admitted to the facility on 9/22/17 with diagnoses, including joint disorder of the left shoulder and degenerative disease of the nervous system. An admission MDS assessment, dated 9/28/17, documented Resident #11 had a severe cognitive impairment, had an upper extremity one-sided impairment, and she required extensive assistance with cares. The MDS documented she did not use braces or splints. On 1/23/18 from 10:39 AM to 11:35 AM, Resident # 11's fingers were observed contracted into her left palm and her thumb contracted over her fingers. Resident #11's wrist was contracted towards the underside of her arm. Resident #11	F 688	1. Resident #11□s skin was assessed on 1/31/2018 and no skin integrity impairment was noted under the splint. An order was obtained for resident #11□s splint on 2/22/2018. Resident #11□s care plan was updated on 2/22/2018 for splint placement and care. Education on new splint order and care plan initiated on 2/22/2018, education provided at shift change to ensure all direct care staff are aware of the changes. 2. Residents who require a splint may be impacted by this alleged deficient practice. Current residents with brace/splint placement will have orders reviewed and care plans updated on or before 03/21/2018 3. Interdepartmental Communication Procedure updated on 2/21/2018, all departments to utilize new Interdepartmental Communication form to communicate new recommendations or orders that may impact other departments. All department managers educated on communication policy on or before 3/21/2018, department managers educated staff impacted by this procedure on or before 3/21/2018. 4. DNS or designee to audit residents with splint or brace placement weekly x4,	

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F 688	Continued From page 11 was not wearing a brace or splint. This was also true on 1/23/18 at 3:21 PM and 1/24/18 from 8:35 AM to 10:30 AM during observations. On 1/24/18 at 11:08 AM, Resident #11's left hand was observed with a black splint, which extended just under her wrist to 5 centimeters past the first knuckles of her fingers. An Occupational Therapy (OT) note, dated 11/7/17, documented Resident #11 was evaluated for a contracture of her left upper extremity (LUE). The note documented Resident #11 was fitted for a splint, and nursing was educated on leaving the splint "on most of the time." An OT Note, dated 11/15/17, documented Resident #11's splint was designed to separate her fingers, provide thumb support, and correct her ulnar deviation. The splint was on order at this time. An OT Note, dated 11/27/17, documented Resident #11's splint arrived to the facility and the OT educated Resident #11's caregiver CNA on "donning splint and caring/cleaning for it." An OT Note, dated 11/30/17, documented Resident #11's splint was adjusted for comfort. An OT Note, dated 1/25/18, documented Resident #11's splint was to be worn for 6 hours a day, 7 days a week. On 1/25/18 at 5:19 PM, the DNS stated she was unaware that Resident #11 wore a splint, and she would look for the missing information.	F 688	then monthly x3, then quarterly x 3 and report findings to QAPI committee for review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018	

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F 688	Continued From page 12 On 1/25/18 at 6:28 PM, the OT stated he told "the CNA working with her," how to place the splint and ensure it was functioning. The OT stated he did not think about what would happen on the days that CNA was not working. The OT stated he should have communicated better with nursing. On 1/25/18 at 6:35 PM, the DNS stated the splint was not managed well. The DNS stated the splint should have been ordered, care planned, and once they knew about the splint, they would assess Resident #11's skin under the splint every shift.	F 688		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		3/21/18

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F 692	Continued From page 13 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents received nutritional and hydration interventions to prevent unplanned weight loss and dehydration. This was true for 4 of 5 residents (#s 11, 14, 21, and 22) reviewed for weight loss and hydration concerns. a) Resident #14 was harmed when she experienced a 9.3% weight loss in three months, prior to her being placed on comfort care measures, and she was harmed when she experienced dehydration and multiple UTIs; b) Resident #21 was harmed when she experienced a 15.99% weight loss in five months; and c) Resident #'s 11 and 22 had potential for harm when they were not provided with fluids and/or assistance to consume them, and were observed with dry mouths. Findings include: 1. Resident #14 was admitted to the facility on 1/11/16 with diagnoses, including Vitamin D deficiency, anemia, dementia, and gastroesophageal reflux disease (GERD). A quarterly MDS assessment, dated 12/19/17, documented Resident #14 had a severe cognitive impairment, required extensive assistance with eating, lost food and drink from her mouth while eating, and had significant unplanned weight loss. a. Nutrition concerns: Resident #14's January 2018 Physician's Orders documented Resident #14 was on a pureed diet	F 692	1. Resident #14 nutritional and hydration status were evaluated on 2/21/2018. Recommendations included a change of diet order to Fortified Pureed and to change supplement order to 240 CC Supplement TID after or between meals to meet residents caloric and hydration needs. MD and resp party notified of wt change on 2/22/2018. Resident #14 CP was updated on 2/22/2018. Resident #14□s MD reviewed UTI history and stated that in his medical opinion UTI□s were not a result or caused by dehydration or poor nursing care, rather her incontinence and the wearing of briefs and the aging process place her at high risk. Resident #21 Nutritional and hydration status was evaluated on 2/21/2018. RD recommended changing diet order to Fortified diet and to change supplement order to 240 cc supplement (such as Ensure or equivalent) BID after or between meals. MD and Resp party notified on 2/22/2018. Resident #21 care plan updated on 2/22/2018. Resident #22 Nutrition and hydration status was evaluated on 2/21/2018. Resident has had positive weight gain. Resident care plan updated on 2/22/2018 to include offer/encourage fluids frequently throughout the day. Resident #11 nutrition and hydration evaluated on 2/21/2018. Resident has had a 13 lb wt gain since 10/16/2017, current wt is 137 lbs. Wt gain appears to be plateaued this	

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F 692	Continued From page 14 with thickened liquids, dated 2/11/17. Resident #14's Physician's orders did not contain an order for nutrition supplements. The Nutrition Care Plan, initiated 1/29/16, documented the following interventions for Resident #14: * Resident #14 required a pureed diet with honey thick liquids, initiated 7/22/17. * The Dietitian would review Resident #14's weights weekly and report concerns to the physician, initiated 2/1/16. * Resident #14 was dependent on staff for nutritional and fluid intake, initiated 12/20/16. * Resident #14 wore a clothing protector due to excessive loss of foods and fluids during meals, revised 6/27/17. The Nutrition Care Plan's interventions were not updated regarding Resident #14's weight loss. A Weight Flow Sheet, dated 7/20/17 through 9/15/17, documented the following weights for Resident #14: * 7/20/17 - 140 pounds * 7/31/17 - 137.5 pounds * 8/7/17 - 136 pounds * 8/15/17 - 138 pounds * 8/22/17 - 136 pounds * 8/25/17 - 134 pounds * 8/29/17 - 132 pounds * 9/1/17 - 132 pounds * 9/5/17 - 131 pounds * 9/8/17 - 131 pounds * 9/15/17 - 127 pounds	F 692	month. Resident care plan updated on 2/22/2018 to include offer/encourage fluids frequently throughout the day. 2. Any resident with wt loss or that is at risk for dehydration may be impacted by this alleged deficient practice. Current residents with wt loss or s/sx of dehydration will have nutrition and hydration assessment completed, RD will evaluate and provide further recommendations, MD and responsible party will be notified and care plan updated on or before 03/21/2018. 3. RD consultant from the state of ID with 10 + years□ experience working with tube feedings in the LTC setting providing guidance and mentoring to the facility RD. Nutrition policy updated on 1/29/2018 to include Residents to be offered an alternate meal or nutritional supplement if less than 25% of meal consumed. Supplements that can be purchased over the counter, such as Ensure, may be provided per resident request or as an alternate if it is residents preference. Residents to be weighed upon admission and then weekly x4 and then monthly. RD to review wts and monitor for wt changes. Residents with significant wt changes to be weighed weekly. RD or designee to notify MD and resp party of wt change and provide recommendations to ensure residents caloric and hydration needs are met. CNA□s and Nurses educated on updated policy, on requirement to offer/assist fluids to residents frequently throughout the day. 4. DNS or designee will audit nutrition and	

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F 692	Continued From page 15 A 9/27/17 Physician's order documented Resident #14 was placed on comfort measures. Resident #14 lost 9.3% of her body weight between 7/20/17 and 9/15/17 before comfort measures were initiated. The 6/1/17 through 9/30/17 Activities of Daily Living (ADL) Documentation Survey Report, Nutrition Amount Eaten at meal and Nutritional Supplements, documented Resident #14: * consumed less than 25% of her meals for 80 of 366 opportunities; * refused meals 36 of 366 opportunities; * was not offered a meal 13 of 366 opportunities; * was not offered a supplement 316 of 366 opportunities; * was not offered a meal alternative 129 of 129 opportunities; and * was not offered a snack 366 of 366 opportunities. Resident #14's ADL Documentation Survey Reports, dated 10/1/17 through 1/24/18, documented similar findings in the Nutrition Amount Eaten and Nutritional Supplement sections. Resident #14's Nutritional Risk Assessments (NAR), Weight Change Progress Notes (WCPN), and Nutrition/ Dietary Progress Notes (NDPN) documented the following: * A 3/21/17 WCPN documented Resident #14 had decreased in weight due to problems with swallowing. The note documented the Dietitian	F 692	hydration evaluation, recommendations and care plans on all significant wt changes weekly x4, then monthly x3, then quarterly x3 and findings reported to QAPI committee for review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018.	

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F 692	Continued From page 16 would "follow up with SLP (Speech Language Pathologist), and suggest that resident have a higher calorie liquids/ nutritional supplements with meals." * A 3/25/17 NDPN documented Resident #14 experienced a "significant" weight loss in the past 30 days and she required honey thick liquids in a "sippy cup." * A 3/25/17 NAR documented Resident #14 was currently receiving a nutritional supplement and the Dietitian recommended nutrition supplements with meals. * A 6/23/17 NAR documented Resident #14 was not receiving supplements and the Dietitian would review her weights weekly. * A 6/27/17 NDPN documented Resident #14 was doing well with her altered texture diet and there were no nutrition related concerns. * A 9/18/17 WCPN documented Resident #14 experienced a 9.3% weight loss over the past 3 months. The WCPN documented Resident #14 had increased difficulty swallowing food, and she required honey thick liquids from a spoon. The WCPN documented Resident #14 did not want tube feeding. * A 9/21/17 NDPN documented Resident #14 experienced "weight loss due to problems with swallowing." The note documented comfort measures were initiated. * A 9/26/17 WCPN documented Resident #14 experienced an 8.6% weight loss over the past 3 months. The WCPN documented Resident #14 ate her meals in the dining room, and she was able to take a "few bites" of her meals. * A 10/1/17 NAR documented Resident #14 choked on thin liquids, and she was not receiving a nutrition supplement. The NAR documented Resident #14 was on comfort measures and tube	F 692		

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feeding was not an appropriate intervention. The NAR did not include other nutrition interventions recommended or attempted. A section of the NAR, titled Rate of Unplanned Weight Loss, documented Resident #14 lost "less than 7.5%" of her body weight over the past 3 months, which was inconsistent with Resident #14's 8.6% weight loss documented in her 9/26/17 WCPN.
* A 10/18/17 WCPN documented Resident #14 experienced an 11.8% decrease in her body weight over the past 3 months and related Resident #14's weight loss to her being on comfort measures.

Resident #14's clinical record did not contain Nutritional Risk Assessments, Weight Change Progress Notes, or Nutrition/ Dietary Progress Notes between 6/28/17 and 9/17/17 when she experienced a 9.3% weight loss.

Resident #14's Nutrition Assessments did not include interventions for the use of fortified foods, snacks, meal alternatives, or consistent use of nutritional supplements.

On 1/24/18 at 9:29 AM, Resident #14 was assisted with her breakfast. Resident #14 consumed 3 bites of her pureed eggs and about 1/2 of her cereal. Resident #14 was not offered an alternative or a supplement.

On 1/25/18 at 4:11 PM, the Registered Dietitian (RD) stated she did not know what interventions were in place prior to the comfort measure orders. The RD stated Resident #14's orders did not include supplements as snacks, and that Resident #14 did not need them due to her comfort measures order. The RD stated if a

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resident refused meals or consumed less than 25% of meals, the staff should offer an alternative. The RD stated the facility did not prepare an alternate meal for residents with diet orders of pureed or mechanical soft. The RD stated for these individuals, the facility would provide supplements, such as Ensure, without doctors' orders, when residents refused or consumed less than 25% meals.

The RD stated Resident #14 should have received supplements, and did not realize Resident #14 was not consistently provided a supplement, when Resident #14 consumed less than 25% or refused meals. The RD stated Resident #14 should have been offered a snack at night. The RD stated Resident #14's weight loss was gradual did not trigger for weight loss, and when she noticed the weight loss, Resident #14's comfort measures were initiated. The RD stated Resident #14 did not want tube feeding and it did not occur to her to initiate enhanced foods or snacks as interventions.

b. Hydration concerns:

According to the Nutrition Care Manual "Methods for Estimating Fluid Requirements" from the Academy of Nutrition and Dietetics, adults within Resident #14's age range should consume 25 ml per kilogram of body weight per day. Using this calculation method, Resident #14 needed a total daily fluid intake of 1397 ml's.

Resident #14's clinical record did not include care plans related to dehydration / hydration or Urinary Tract Infections [UTIs].

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F 692	Continued From page 19 i. Resident #14 experienced multiple UTIs: * Urinalysis [UA] results from 3/28/17, 9/7/17, and 10/27/17 document Resident #14's urine appeared cloudy and contained blood, nitrite, and bacteria. * Resident #14's culture and sensitivity (C&S) results documented the presence of Escherichia Coli (E. coli) (9/7/17 and 10/27/17) and Gram-Negative Rod (3/28/17). Resident #14's UTIs could be signs and symptoms of dehydration. ii. Resident #14 experienced dehydration: *The 1/1/18 through 1/24/18 ADL Documentation Survey Report, Fluid Intake, documented Resident #14's total fluid intake for each day. Resident #14 received the highest total fluid intake of 667 ml on 1/10/18. Resident #14 received the lowest total fluid intake of 100 ml on 1/1/18 and 1/9/18. Resident #14's average fluid intake for the dates above was 339 ml's. Resident #14 refused some fluid offers 7 of 24 days. * Resident #14's ADL Documentation Survey Reports, dated 6/1/17 through 12/31/17, documented similar findings in the Fluid Intake section. *A Basic Metabolic Panel [BMP] result from 9/17/17, documented Resident #14's Sodium (Na) of 155 milliequivalents of solute per liter (mEq/L), Chloride (Cl) of 116 mEq/L, and Bicarbonate (CO2) of 32 millimoles per liter were	F 692		

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F 692	Continued From page 20 elevated. *A BMP result from 1/8/18, documented Resident #14's Na of 149 mEq/L and Cl of 114 mEq/L were elevated. Resident #14's elevated BMP results could be signs and symptoms of dehydration. On 1/23/18 from 9:07 AM to 11:35 AM, Resident #14 was observed in a recliner chair or in her wheelchair in the TV room. Throughout the observation Resident #14 was not offered fluids nor were fluids readily available. On 1/24/18 from 9:04 AM to 11:08 AM, Resident #14 was observed in a recliner chair or in her wheelchair in the TV room, with various staff member contacts. Throughout the observation Resident #14 was not offered fluids nor were fluids readily available. On 1/25/18 at 6:19 PM, the DNS stated Resident #14 had a history of dehydration concerns and the facility ordered IV fluids to correct the imbalance. The DNS stated the BMP results in Resident #14's record demonstrated signs and symptoms of dehydration. The DNS stated UTIs attributed to E. coli was "most likely" due to a lack of proper peri-care and / or dehydration. The DNS stated staff should have offered Resident #14 fluids minimally every two hours, and ideally after every resident contact. 2. Resident #21 was admitted to the facility on 6/24/13 with multiple diagnoses, including arthritis, hypothyroidism, and visual impairment. Quarterly MDS assessments, dated 9/4/17 and 12/5/17, documented Resident #21 was	F 692		

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F 692	Continued From page 21	F 692		

cognitively intact, required supervision for eating, and had no weight loss.

Resident #21's care plan, dated 6/9/17 and 12/6/17, documented Resident #21 had the potential for weight loss related to arthritis and visual impairment. Resident #21's interventions included, "Inform Resident #21 of the location of foods on her plate using the clock method. Provide, serve diet per resident requests and preferences from daily menu... Weights will be reviewed weekly. Dietitian to monitor and report significant wt loss or gain to MD." Resident #21's goals included, "Adequate nutrition and fluids to maintain skin integrity, and weight in 150-160 range."

A Nutritional Risk Assessment, dated 6/14/17, documented Resident #21's most recent weight was 159 pounds with a nutritional goal to maintain weights between 150-160 pounds. The nutritional interventions documented by the dietitian was to review weights weekly, intakes as needed, and labs when available. Resident #21 was not currently receiving a nutritional supplement.

The Weights Summary Report, dated 6/13/17 through 1/23/18, documented Resident #21's weights as follows:

* 6/13/17 - 159 pounds
* 7/14/17 - 160 pounds
* 8/18/17 - 159.5 pounds
* 9/8/17 - 149 pounds
* 9/19/17 - 151.5 pounds
* 10/13/17 - 148.5 pounds
* 10/17/17 - 147 pounds

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F 692	Continued From page 22 * 10/24/17 - 144 pounds * 11/7/17 - 143.5 pounds * 12/8/17 - 143.5 pounds * 12/15/17 - 142 pounds * 12/22/17 - 140 pounds * 12/29/17 - 138 pounds * 1/2/18 - 137 pounds * 1/9/18 - 136 pounds * 1/19/18 - 136 pounds Resident #21 experienced a significant weight loss of 15.00% from 7/14/17 to 1/19/18. There were no Physician Orders for a nutritional supplement for Resident #21 from July 2017 through January 23, 2018. A Nutritional Risk Assessment, dated 9/20/17, documented Resident #21's most recent weight was 151.5 pounds with a nutritional goal to maintain weights between 150-160 pounds. The nutritional interventions documented Resident #21 was receiving Arginaid or Juven supplements to promote wound healing. Resident #21's clinical record did not include Physician Orders for Arginaid or Juven supplements to promote wound healing. Resident #21's care plan did not include interventions for nutritional supplements for wound healing. A Dietitian Progress Note, dated 10/18/17, documented Resident #21's current weight was 147 pounds with a 7.5% weight loss. The Dietitian documented, "Resident #21 was ill last month and had some weight loss, she has not	F 692		

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had continued weight loss." There was no documentation in Resident #21's clinical record that the physician and family were notified of the weight loss.

A Dietitian Progress Note, dated 10/25/17, documented Resident #21's current weight was 147 pounds had some weight loss in the past, will review weights, if weight loss continues, then will notify the physician.

A Nutritional Risk Assessment, dated 12/20/17, documented Resident #21's most recent weight was 138 pounds with a nutritional goal to maintain weights between 140-150 pounds. The nutritional interventions documented to review weekly weights, labs and intakes as needed, and weights affected at times by edema. The Dietitian documented Resident #21 was receiving Ensure for a nutritional supplement. There was no documentation in Resident #21's clinical record that the physician and family were notified of her significant weight loss.

On 1/23/18 at 6:00 PM, Resident #21 was observed eating dinner in her room without a nutritional supplement.

On 1/24/18 at 5:52 PM, Resident #21 was observed eating dinner in her room without a nutritional supplement.

On 1/24/18 at 2:45 PM, the Dietitian stated Resident #21 had been refusing her dinner meal and her Ensure supplement for the past few months. The Dietitian was unable to provide documentation if Resident #21 was receiving and/or drinking the Ensure supplement. The

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F 692	Continued From page 24 Dietitian provided a Skilled Nursing Facility (SNF) Resident's Diet Orders Report, dated 1/24/18, from the kitchen that the dietary staff follows. On the Diet Orders Report had a list of seven resident's including Resident #21, who received supplements. Resident #21 was listed to receive a supplement for the "pm meal." The Dietitian stated the "pm meal" was to be served with dinner. The supplement was Ensure, unless it was listed for a specific kind of supplement next to the resident's name. The Dietitian was unable to provide a physician's order or an updated care plan for the Ensure for staff to provide an Ensure supplement with the dinner meal. The Dietitian stated she did not observe Resident #21 receiving the supplement. The Dietitian stated she initiated a high protein jello for Resident #21's 3:00 pm snack on 1/23/18 and will follow up with Resident #21 if she likes on her quarterly nutritional assessment at the end of February or beginning of March. The Dietitian was aware that Resident #21 was a significant weight loss and was unable to provide documentation that she notified the physician and the family. On 1/24/18 at 3:20 PM, Resident #21 stated, she received jello with banana's yesterday and "loved it and would eat it everyday." Resident #21 stated she did not receive the Ensure supplement with her dinner meal, unless she asked for it. Resident #21 did not recall when the last time she had an Ensure supplement. On 1/24/18 at 3:30 PM, the Dietitian was notified that Resident #21 enjoyed the jello and banana's. The Dietitian was notified Resident #21 had to request an Ensure and did not recall the last time she had an Ensure. The Dietitian was unable to	F 692		

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F 692	Continued From page 25 provide documentation for the staff to offer the high protein jello snack everyday at 3:00 PM. Resident #21's care plan did not include interventions for her significant weight loss. 3. Resident #22 was admitted to the facility on 12/27/16 with diagnoses, including Alzheimer's disease, hypernatremia, and hyperglycemia. A quarterly MDS assessment, dated 10/12/17, documented Resident #22 had a severe cognitive impairment, and was dependent upon staff for eating and drinking. The Nutrition Care Plan, dated 1/13/17, documented staff were "not" to place food or fluids within Resident #22's reach, unless staff were present to supervise. According to the Nutrition Care Manual "Methods for Estimating Fluid Requirements" from the Academy of Nutrition and Dietetics, adults within Resident #22's age range should consume 25 ml per kilogram of body weight per day. Using this calculation method, Resident #22 needed a total daily fluid intake of 1477 ml's. The 12/27/17 through 1/24/18 ADL Documentation Survey Report, Fluid Intake, documented Resident #22's total fluid intake for each day. Resident #22 received the highest total fluid intake of 1001 ml on 1/4/18. Resident #22 received the lowest total fluid intake of 250 ml on 1/7/18. Resident #22's average fluid intake for the dates above was 605 ml's. Resident #22 refused some fluid offers 12 of 29 days.	F 692		

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F 692	Continued From page 26 On 1/23/18 from 9:47 AM to 11:33 AM, Resident #22 was observed in a recliner chair near the nurse's station. Throughout the observation Resident #22 was not offered fluids nor were fluids readily available. On 1/24/18 from 9:14 AM to 11:09 AM, Resident #22 was observed in a recliner chair or in his wheelchair near the nurse's station, with various staff member contacts. Throughout the observation Resident #22 was not offered fluids nor were fluids readily available. On 1/24/18 at 3:06 PM, the DNS stated staff should have offered Resident #22 fluids minimally every two hours, and ideally after every resident contact. 4. Similar findings for Resident #22's hydration concerns were true for Resident #11.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 693		3/21/18

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F 693	Continued From page 27 §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of clinical records and policies, it was determined the facility failed to ensure adequate care and treatment was provided to 1 of 1 sample resident (#17) reviewed for feeding tube use. This created the potential for harm if complications developed from improper tube feeding practices. Findings include: The Facility's Enteral Nutritional Therapy policy and procedure, dated 8/4/10, documented staff were to assess and verify the feeding tube position before each use. The facility's policy and procedure documented, "check physician's order to check gastric residuals." According to Lippincott Manual of Nursing Practice, Ninth Edition, the definition of a PEG was a tube inserted into the stomach. The manual documented for "Long-Term Nutrition Support" use, education was to be provided regarding the "need to assess tube placement and residual before each feeding (for gastric feedings only)." The manual documented the "procedure" for continuous tube feeding, the bag was to be filled with 4 hours ' worth of tube feeding formula. The "procedure" continued on to document, "Flush with 30-60 mL of water every 4 hours and after first checking residual." In	F 693	1. Resident #17□s care plan was updated to include (a) Elevate HOB 45 degrees during and thirty minutes after tube feed (7/29/2015) (b) Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than 250 cc aspirate, recheck residual in 1 hour and proceed with feeding if less than 250 cc aspirate, if greater than 250 cc aspirate notify physician. (2/21/2018) (c) Provide local care to G-Tube site as ordered and monitor for s/sx of infection. Notify MD if s/sx of infection noted, document by exception. (2/21/2018) (d) Tube Feeding order per physician orders. Order to contain type of formula, total volume and calories provided (2/21/2018) (e) PEG tube changed per physician order or as needed. Order to contain frequency of changes and size of PEG tube. (2/21/2018). (f) Evaluate resident for abdominal distention and bowel sounds prior to initiating bolus feedings (2/21/2018). Resident #17 tube feeding orders reviewed by RD Consultant on 2/21/2018, recommendation was made to change order to: Jevity 1.2, 240 cc bolus 6x daily over 24 hr period to provide 1440	

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F 693	Continued From page 28 addition, the "procedure" documented "Nursing action" included a "Follow-up Phase" in which the head of bed (HOB) needed to be elevated for 30 - 60 minutes after non-continuous feedings and during tube feeding administrations. The "procedure" documented nurses were to "document type and amount of feeding, amount of water given, and patient tolerance of procedure." In addition, the "procedure documented nursing were to "monitor, breathing sounds, bowel sounds, gastric distention, constipation..." Resident #17 was admitted to the facility on 8/7/13 with diagnoses, including protein-calorie malnutrition, altered mental status, and gastrostomy. An annual MDS assessment, dated 12/3/17, documented Resident #17 had a moderate cognitive impairment and required nutrition support. Resident #17's Nutrition Support Care Plan, revised 7/29/15, documented he required nutrition support related to dysphagia (difficulty swallowing). Resident #17's Nutrition Support Care Plan did not include: * The need for the head of bed to be elevated during and after medication administration. * The need to verify the feeding tube placement prior to administering the nutrition support. * The need to check residuals prior to the administration of the nutrition support. * The type of formula used to determine the	F 693	cc total volume, 1728 calories and 79 g protein. Resident receives an additional 360 cc fluid from Tube feed flushes before/after med administration and an additional 70 cc from between medication administration. Res also receives 360 cc NS solution x1 daily and would receive 1440 CC fluid from tube feeding for a total fluid volume of 2240 cc which would meet res hydration needs. MD notified of recommendation and TF omissions noted on this report on 2/22/18, per nutrition and hydration evaluation resident is without weight loss and shows no negative effects at this time. New TF order contains prompts for residual documentation, documentation of abdominal distention and bowel sounds prior to initiating bolus feedings. Order to check feeding tube daily, clean and change dressing at insertion site PRN was initiated on 12/13/2016. Order updated on 2/22/2018 to read: Monitor PEG Tube local site for s/sx of infection daily, change dressing every 3 days and PRN. 2. Any resident receiving a tube feeding may be impacted by this alleged deficient practice. There are currently no other residents with a PEG tube or receiving tube feeding. 3. Facility Tube Feeding Policy was updated on 1/29/2018 to meet recommendations based on Fundamentals of Nursing, Potter & Perry, 9th Edition which recommends tube placement to be verified utilizing the following method: (a) Check for gastric	

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F 693	Continued From page 29 volume and calories provided provided to Resident #17. * The size of Resident #17's PEG tube. * The need to clean and monitor for signs and symptoms of infection at Resident #17's PEG tube site. a. Inconsistent physician's orders: Resident #17's January 2018 Physician's Orders were documented in two Electronic Medical Record (EMR) systems PCC and CPSI. EMR #1 (PCC) documented the following active Physician's Orders: * Real Food Blend, mixed with 4-8 oz of fluids, and per gravity feeding, once daily at 12:00 PM, ordered 1/22/18. * Per a tube feeding pump, administer 3 cans of Jevity running at 200 ml/hr during the night, ordered 12/13/16. * Per a tube feeding pump, administer 1000 ml of water running at 250 ml/hr during the night, ordered 12/13/16. * Staff were to flush Resident #17's PEG tube with 60 ml of water before and after medications and nutrition support administrations, ordered 12/13/16. * Staff were to check Resident #17's PEG tube daily, and staff were to clean and change his dressing at the insertion site as needed (PRN), ordered 12/13/16. EMR #1 documented the following discontinued Physician's Order: * Administer 1 can of Jevity at 12:00 PM and 4:00	F 693	residual volume (GRV) before each feeding for bolus and intermittent feedings. (b) Draw up 10-30 ml of air into syringe. Connect to end of feeding tube. Flush tube with air. Pull back slowly to aspirate total amount of gastric contents and measure. (c) Return aspirated contents to stomach unless volume exceeds 250ml. Additionally, Potter & Perry states: Auscultation of insufflated air is not a reliable method for verification of placement of a tube because a tube inadvertently placed in lungs, pharynx or esophagus transmits sound similar to that of air entering the stomach (Kenny and Goodman, 2010; Stewart, 2014). Review of most current Aspen recommendations are consistent with Potter & Perry. Nurses educated on updated Tube Feeding Policy and Procedure, need to document infection monitoring, and need to have more specific dressing change order on or before 3/21/2018. RD consultant from the state of ID with 10 + years experience working with tube feedings in the LTC setting providing guidance and mentoring to the facility RD. RD educated on need to calculate caloric, protein and hydration needs for residents on Tube Feedings on or before 3/21/2018. RD educated that weight changes must be reviewed and trended, MD and responsible party notified and recommendations made to meet resident caloric and hydration needs on or before 3/21/2018. Nurses were educated on new policy, tube feeding formula order requirements (including documentation of	

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F 693	Continued From page 30 PM, discontinued 1/16/18. EMR #2 (CPSI) documented the following active Physician's Orders: * Administer Real Food Blend, once daily at 12:00 PM, ordered 1/20/18. * Mix Real Food Blend with 6 oz of water and administer at 300ml/hr, ordered 1/20/18. * Per a tube feeding pump, administer 3 cans of Jevity running at 200 ml/hr during the night, ordered 2/1/17. * Per a tube feeding pump, administer 1000 ml of water running at 250 ml/hr during the night, ordered 2/1/17. * Staff were to flush Resident #17's PEG tube with 60 ml of water before and after medications and nutrition support administrations, ordered 2/11/17. * Staff were to check Resident #17's PEG tube daily, and staff were to clean and change his dressing at the insertion site PRN, ordered 2/1/17. * Administer 1 can of Jevity 1.0 at 11:00 AM and 4:00 PM, ordered 10/26/17. Physician's Orders were unclear and did not include the type of formula, administration routes, and / or when to begin the nutrition support. b. Inconsistent nutrition support administration: The Nutrition Support Administration Record (NSAR), dated 11/1/17 through 1/24/18, documented Resident #17's nutrition support orders were inconsistently administered: * 15 of 85 opportunities were missed of the 1000	F 693	residual, distention and BS) on or before 3/21/2018. 4. DNS, RD consultant or designee will audit all new tube feeding orders, care plans and required monitoring as new orders are obtained x12 months and report findings to the QAPI committee for review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018.	

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F 693	Continued From page 31 ml of water; * 7 of 85 opportunities were missed of the 3 cans of Jevity; * 55 of 85 opportunities were missed for the 12:00 PM Jevity; * 52 of 85 opportunities were missed for the 4:00 PM Jevity; * 8 of 17 opportunities were missed for the Real Food Blend; and * 336 of 510 opportunities were missed for the water flushes before and /or after nutrition support administration. Resident #17's 11/1/17 through 1/24/18 NSAR did not contain documentation of residual checks being completed, tube placement verification, HOB requirements, dressing changes to the stoma site, watching for signs and symptoms of infection, and monitoring of bowel sounds and abdominal distention. The 11/1/17 through 1/24/18 NSAR documented Resident #14's total nutrition support intake for each day. Resident #17's highest total calories received was 1580 calories on 12/5/17 and 12/8/17. Resident #17 received the lowest total calories of 0 calories on 11/17/17 and 12/25/17. Resident #17's average caloric intake for the dates above was 877 calories. On 1/23/18 from 9:16 AM through 11:15 AM, Resident #17 was observed in his room, and throughout the observation Jevity was not initiated. On 1/24/18 from 8:22 AM through 12:00 PM, Resident # 17 was observed in his room, and throughout the observation Jevity was not	F 693		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 32 initiated. c. Inconsistent nutrition assessments: A Weight Flow Sheet, dated 8/24/17 through 1/22/18, documented Resident #17's weight fluctuated up and down throughout the record included: * 8/24/17 - 159.5 pounds * 8/26/17 - 163 pounds a difference of 3.5 pounds * 9/28/17 - 159 pounds * 9/30/17 - 163.5 pounds a difference of 3.5 pounds * 10/26/17 - 160 pounds * 10/28/17 - 163 pounds a difference of 3 pounds * 11/27/17 - 162 pounds * 11/30/17 - 161.5 pounds a difference of 0.5 pounds * 12/28/17 - 161.5 pounds * 12/30/17 - 163 pounds a difference of 1.5 pounds * 1/20/18 - 162 pounds * 1/22/18 - 162 pounds A BMP result from 4/10/17, documented Resident #17's Na of 132 mEq/L and albumin of 3.1 grams per deciliter were decreased. Resident #17's decreased BMP results could be signs and symptoms of over-hydration. Resident #17's Nutritional Risk Assessments (NAR), dated 3/17/17, 6/14/17, 9/20/17, 12/20/17, and 1/3/18, did not include an assessment of his caloric, protein, or fluid requirements. The assessments did not document how much calories, protein, and fluids	F 693		

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	135070	A. BUILDING _____ B. WING _____	01/26/2018

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Resident #17 received from the current nutrition support order. The assessments did not document when changes were made to the nutrition support orders.

On 1/24/18 at 1:48 PM, the DNS stated Resident #17 was on Jevity and thought it was Jevity 1.0. The DNS stated the orders did not disclose what kind of Jevity Resident #17 received, when he received it, or how much. The DNS stated the tube feeding orders were "messed up," and she had requested the RD correct the issue on several occasions. The DNS stated Resident #17 currently received a bolus of 1000 ml of water, prior to the 3 cans or 711 mL of Jevity at night, 30 - 60 ml of water before and after medication and nutrition support administrations, and 1 packet of Real Food Blend at noon. The DNS stated no other cans of Jevity were administered throughout the day. The DNS stated she would look for documentation of when staff assessed for signs and symptoms of infection, cleaning the stoma site, residual checks, and the size of the PEG tube. The DNS stated it was not facility practice to assess Resident #17's PEG tube placement, prior to use, because Resident #17's PEG tube was well established.

On 1/25/18 at 3:19 PM, the RD stated Resident #17's needs was approximately 1,800 calories, based off of 25-30 calories per kilogram. The RD stated Resident #17's goal weight was 150 - 160 pounds. The RD stated she was unsure if the Jevity being provided was Jevity 1.0 or 1.2. The RD stated Resident #17's previous nutrition support orders included 4 cans of Jevity per day. The RD stated Resident #17 received one of the cans at noon and 3 at night. The RD stated

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Resident #17's interested party complained that Resident #17 was hungry, and she changed the nutrition support order to 1 packet of Real Food Blend and 3 can of Jevity at night. The RD stated the current nutrition support order provided approximately 1,600 calories.

Resident #17's current nutrition support order was calculated, and the 3 cans of Jevity 1.0 plus Real Food Blend, provided 1,080 calories per day, or 60% of his estimated needs.

On 1/25/18 at 3:30 PM, the RD stated she had not calculated Resident #17's nutrition support, because the form she utilized did not request her to assess calories. The RD stated she did not know the current nutrition support order did not meet his estimated caloric needs. The RD stated she had "never" looked at the nutrition support administration records during her assessments to ensure Resident #17 was administered appropriate calories. The RD stated she was not aware that Resident #17 was not consistently receiving his ordered nutrition support. The RD stated 1,080 calories "might be sufficient" if Resident #17's weights and labs were stable. The RD stated anything under 750 calories was "not sufficient." The RD stated she assessed "every" resident "quarterly," and she had not re-assessed Resident #17's nutrition support tolerance, after adjustments or changes were completed. The RD stated labs were completed annually, and she "leaves it up the physician" to assess the labs. She stated the April 2017 decreased Na and albumin levels "did not" concern her. She stated decreased levels "could" indicate over-hydration. The RD stated she did not assess weights for trends, and did not notice

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F 693	Continued From page 35 Resident #17's weights were fluctuating so often. The RD stated when weights fluctuated similar to Resident #17's, it was a sign of fluid imbalance.	F 693		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have a method for evaluating the effectiveness of residents' pain management plans for 3 of 5 residents (#s 12, 17 and 22) sampled for pain. This failure created the potential for harm if residents experienced increased pain and the facility did not identify it. Findings include: The facility's policy, Pain Management Program, revised 5/24/10, directed staff to assess residents' pain level before and after "any" scheduled or PRN pain medications were administered. The policy directed staff to reassess the residents' pain within 60 minutes of administering a medication to assess for effectiveness. 1. Resident #22 was admitted to the facility on 12/27/16 with diagnoses including Alzheimer's disease, muscle weakness, and polyosteoarthritis.	F 697	1. Resident #22 has a new pain evaluation completed on 2/22/2018 and CP was updated. A new order for daily pain monitoring was initiated on 2/22/2018. Resident #17 has a new pain evaluation completed on 2/22/2018 and CP was updated. A new order for daily pain monitoring was initiated on 2/22/2018. Resident #12 has a new pain evaluation completed on 2/22/2018 and CP was updated. A new order for daily pain monitoring was initiated on 2/22/2018. 2. Any resident with pain or pain medications may be impacted by this alleged deficient practice. Nurses educated that when administereing a PRN pain medication they must document indication for medication prior to administration and effectiveness post administration. 3. Facility Policy for pain monitoring updated to include daily pain monitoring	3/21/18

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F 697	Continued From page 36 A quarterly MDS assessment, dated 10/12/17, documented Resident #22 had a severe cognitive impairment and received scheduled and PRN pain medications. Resident #22's clinical record did not contain a care plan related to pain managment. The Resident Skilled Charting Assessment (RSCA), dated 1/15/18, documented Resident #22's pain was assessed, and zero pain was noted or observed. The January 2018 MRR documented Resident #22's pain medications were: * Tramadol 50 mg once daily at 4:00 pm for chronic pain, ordered 8/16/17. * Celebrex 200 mg once daily in the morning for pain, ordered 12/5/17. * Acetaminophen 500 mg twice daily for pain, ordered 12/5/17. * Tramadol 50 mg every 6 hours PRN for pain, ordered 8/25/17. Resident #22's MAR from 11/1/17 through 1/23/18, documented staff routinely administered his scheduled pain medications. Resident #22's clinical record did not contain a daily pain assessment to ensure Resident #22's scheduled pain medications were continually needed and effective. The MAR, dated 11/1/17 through 1/23/18, documented Resident #22 was administered a dose of PRN Tramadol on 1/12/18, and the effectiveness of the medication was not	F 697	for all residents, requirement for pain monitoring with each scheduled pain medication was removed from the Policy. New order for pain monitoring initiated for all residents on or before 2/22/2018. Nurses educated on new policy on or before 3/21/2018. 4. DNS or designee will audit all new admission charts for admission Pain Evaluation and to ensure Q shift pain monitoring order is in place. DNS or designee will audit resident TARs for completion of daily pain monitoring weekly x4, then monthly x3, then quarterly x3 and report findings to the QAPI committee for review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018.	

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F 697	Continued From page 37 assessed. On 1/24/18 at 2:44 PM, the DNS stated it was not facility practice to assess residents' pain levels daily or every shift. The DNS stated staff assessed residents' pain levels when staff administered PRN pain medications. The DNS stated staff would assess the effectiveness of a PRN pain medication, after administered. The DNS stated she could not locate a care plan for management of Resident #22's pain. 2. Resident #17 was admitted to the facility on 8/7/13 with diagnoses, including chronic pain, pain in the ankle and foot, rheumatoid arthritis, deformity of the foot, and altered mental status. An annual MDS assessment, dated 12/3/17, documented Resident #17 had a moderate cognitive impairment and received scheduled pain medication. Resident #17's clinical record did not contain a care plan for pain management. The RSCA, dated 12/6/17, documented Resident #17's pain was assessed, and zero pain was noted or observed. The January 2018 MRR documented Resident #17 received 12 mcg/hr Fentanyl patch every three days for pain, as ordered 12/26/17. Resident #17's MAR from 11/1/17 through 1/23/18, documented staff routinely administered his scheduled pain medication. Resident #17's clinical record did not contain a	F 697		

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F 697	Continued From page 38 daily pain assessment to ensure Resident #17's scheduled pain medication was continually needed and effective. On 1/24/18 at 2:44 PM, the DNS stated it was not facility practice to assess residents' pain levels daily or every shift. The DNS stated staff assessed residents' pain levels when staff administered PRN pain medications. The DNS stated staff would assess the effectiveness of a PRN pain medication, after administered. The DNS stated she could not locate a care plan for management of Resident #17's pain. 3. Similar findings for Resident #12 with lack of pain control management.	F 697		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the	F 756		3/21/18

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F 756	Continued From page 39 attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure pharmacy recommendations were reviewed and followed. This was true for 1 of 11 residents (#24) reviewed for pharmacy recommendations and had the potential for harm if residents' medications and/or supplements were not administered appropriately. Findings include: Resident #24 was admitted to the facility on 9/2/14 with diagnoses, including Steele-Richardson-Olszewskij (degenerative disease of the brain), dementia, and anxiety. The quarterly MDS assessment, dated 12/19/17, documented Resident #24 experienced both short-term and long-term memory impairment,	F 756	1. Resident #24 MD notified and GDR Review for Xanax requested on 2/22/2018. 2. All residents that have a pharmacist recommendation may be impacted by this alleged deficient practice. All current residents most recent pharmacist recommendations will be reviewed and audited to ensure MD response has been received on or before 3/21/2018. 3. Pharmacist recommendations will be updated to include a "Please Respond By Date". Pharmacist recommendations will be referred to attending physicians, if attending physician does not reply by the "Please Respond By Date" the physician will be called. If unable to obtain a	

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F 756	Continued From page 40 severely impaired daily decision-making skills, and required extensive assistance- or was totally dependent on staff for all ADLs. The January 2018 Nursing Orders documented Resident #24 was to receive Xanax 0.5 mg three times a day and two times a day as needed for anxiety secondary to itching. Resident #24's MARs from 5/26/17 through 1/25/18 documented Resident #24 did not receive the Xanax 0.5 mg as needed per physician's order. A Pharmacy Consultant Review, dated 5/9/17, documented, "This resident has an order for Xanax [sic] 0.5 mg orally 3 times a day scheduled and every 8 hours if needed for anxiety secondary to itching. Residents should be reviewed periodically for a gradual dosage reduction. Please review and document if a reduction is warranted at this time." The section on the form for the resident's physician's comments to the recommendation was blank. There was no documentation in Resident #24's clinical record that the as needed Xanax medication had a gradual dosage reduction. On 1/25/18 at 9:45 am, the DNS stated the Pharmacist reviews medications monthly and notified the physician with her recommendations. The DNS stated there was no documentation in Resident #24's clinical record that the pharmacy recommendation was reviewed by the physician.	F 756	response after calling the attending physician the Medical Director will review the recommendation and discuss with the attending physician and provide a response. Pharmacist recommendation form updated to include "Please Respond By Date" on or before 3/21/2018. 4. DNS or designee will audit recommendations for MD response. Results will be reported to the QAPI committee for review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		3/21/18

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F 757	Continued From page 41 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents receiving psychoactive medication had specific target behaviors identified, monitored the efficacy of those medications. This was true for 2 of 8 (# 9 and #15) sampled residents who received psychoactive medications. This deficient practice created the potential for harm if residents received medications that may result in negative outcomes without clear indication of need. Findings include: 1. Resident #15 was admitted to the facility on 11/5/10 with multiple diagnoses, including	F 757	1. Resident #15 CP updated to include resident-specific signs/symptoms of anxiety and depression for staff to monitor on 2/22/2018. Facility has requested attending MD to review resident #15□s orders/chart and provide medical indication to support the need for duplicate therapy on 2/22/2018. Resident #15 behavior monitoring updated to match resident □ specific behaviors as outlined in CP on 2/22/2018. Monitoring for hours of sleep initiated for resident #15 on 2/22/2018. Resident #9 passed away on 02/10/2018.	

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F 757	Continued From page 42 anxiety, major depression, and dementia. Resident #15's annual MDS assessment, dated 10/2/17, documented Resident #15 was cognitively intact with minimal depression and did not experience hallucinations, delusions, or behaviors. Resident #15's current care plan, revised 1/10/18, documented a focus of, [Resident #15] uses psychotropic medications; Zoloft (anti-depressant), Xanax (anti-anxiety) and Restoril (Hypnotic)." "Will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date." Interventions directed staff as follows: * "Monitor/document/report PRN for adverse reactions of psychotropic medications." * "Monitor hours of sleep at night. Report worsening of insomnia to MD." * "Pharmacist to review drug regimen monthly and coordinate with MD to assure the lowest therapeutic dose is given." The care plan did not identify resident-specific signs and symptoms of anxiety and depression for staff to monitor. a. The January 2018 Medication Order documented Resident #15 received Zoloft 200 mg once daily for depression/anxiety, ordered 11/20/17 and Xanax 1 mg twice daily for anxiety, ordered 1/8/18. The Zoloft and Xanax were ordered without documented medical indication	F 757	2. Any resident that is receiving a psychoactive medication may be impacted by this alleged deficient practice. All current residents that are on a psychoactive medication will have CP reviewed for resident specific behaviors and behavior monitoring will be updated to correlate with CP. All current residents receiving a Sedative/Hypnotic will have hours of sleep monitoring initiated on or before 3/21/2018. All residents that are receiving duplicate therapy will be reviewed by attending physician and documentation to support duplicate therapy will be obtained or orders updated/discontinued per MD order on or before 3/21/2018. 3. Nurses educated on the following: resident-specific behaviors must be identified, and care planned for all residents receiving a psychoactive medication. Behavior monitoring must include resident-specific behaviors as outlined in the CP. Hours of sleep must be documented on all residents receiving a Sedative/Hypnotic. Medical Director to provide education to attending physicians on need for documentation of medical indication to support the need for duplicate therapy. Education completed on or before 3/21/2018. 4. DNS or designee will audit CP and behavior monitoring for residents on psychoactive medication and compliance with regulations for ongoing use of PRN psychoactive medication weekly x4, then monthly x3, then quarterly x2. Results will be reported to QAPI committee for	

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F 757	Continued From page 43 to support the need for duplicate therapy. Resident #15's Behavior Monthly Flow Sheet from 11/1/17 through 1/23/18 documented Resident #15 received Zoloft and Xanax. The flow sheet documented staff were to monitor as follows: * "Anxious, Nervous, restless" * "verbally abusive to staff or other residents" The Behavior Monthly Flow Sheets from 11/1/17 through 1/23/18 did not document resident-specific behaviors related to anxiety and depression for Resident #15. Resident #15 exhibited 16 occurrences out of 84 days of nonspecific generic behaviors of anxiety. b. The January 2018 Medication Order documented Resident #15 received Temazepam 15 mg once daily at bedtime for insomnia secondary to anxiety, ordered 8/11/17. Resident #15's Behavior Monthly Flow Sheet from 11/1/17 through 1/23/18 documented, "insomnia: unable to fall asleep or stay asleep." Resident #15 did not experience any occurrences of insomnia out of 84 days. Resident #15's clinical record did not include hours of sleep monitors to evaluate the medication's efficacy. On 1/26/18 at 9:40 PM, the DNS stated the facility did not document resident-specific target behaviors or monitor hours of sleep.	F 757	review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 44	F 757		

Resident #15 was on duplicate therapy. Resident #15 clinical record did not contain assessments, monitoring, clinical indication of use, and evaluations of medication efficacy.

2. Resident #9 was admitted to the facility on 9/11/17 with a diagnosis of depression.

A quarterly MDS assessment, dated 12/19/17, documented Resident #9 was cognitively intact with signs and symptoms of mild depression.

The Depression Care Plan, dated 9/21/17, documented Resident #9's depression presented as feelings of tiredness and statements of depression.

The January 2018 MRR documented Resident #9 received 200 mg of Zoloft once daily for depression, ordered 12/6/17.

Resident #9's MAR from 11/1/17 through 1/23/18, documented staff routinely administered her Zoloft.

Resident #9's Behavior Monthly Flow Sheet from 1/1/18 through 1/24/18 documented staff monitored Resident #9 for sadness, depressed, and tearfulness. The Behavior Monthly Flow Sheet did not include resident-specific signs and symptoms of depression as outlined in her care plan.

On 1/24/18 at 3:47 PM, the DNS stated Resident #9's depression presented as self-isolation tiredness, and statements of depression. The DNS stated Resident #9's current behavior monitors did not match Resident #9's signs and

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	135070	A. BUILDING _____ B. WING _____	01/26/2018

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F 757	Continued From page 45 symptoms.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		3/21/18

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F 758	Continued From page 46 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents received PRN psychotropic medications only when clinically indicated for the treatment of specific conditions. This was true for 1 of 8 residents (#22) sampled for psychotropic medication use and had the potential for harm should residents receive psychoactive medications that were unwarranted, ineffective, or used for excessive duration without benefit to the resident. Findings include: Resident #22 was admitted to the facility on 12/27/16 with diagnoses, including Alzheimer's disease, anxiety, and depression. A quarterly MDS assessment, dated 10/12/17, documented Resident #22 had a severe cognitive impairment with minimal signs and symptoms of depression. The Potential Side Effects of Psychotropic Medication (Buspar) Care Plan, dated 10/23/17, documented Resident #22 was at risk for	F 758	1. Resident #22 CP updated to include resident-specific s/sx of anxiety for staff to monitor on 2/22/2018. CP was reviewed and updated related to Buspar and Xanax on 2/22/2018. Behavior monitoring updated to include resident specific s/sx of depression and anxiety as outlined in CP on 2/22/2018. PRN XANAX usage reviewed by attending MD and based on usage and documented behaviors the medication was discontinued on 2/22/2018. 2. All residents who have psychoactive medication orders may be impacted by this alleged deficient practice. All current residents that are on a psychoactive medication will have CP reviewed for resident specific behaviors and behavior monitoring will be updated to correlate with CP. All current residents on PRN psychoactive medications will be reviewed every 14 days to ensure appropriate physician documentation and visit is completed or medication	

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F 758	Continued From page 47 adverse side effects related to the use of an antianxiety medication, but did not identify resident-specific signs and symptom of anxiety for staff to monitor. Resident #22's care plan was not updated when the Buspar was discontinued or when the Xanax was initiated. a. PRN psychotropic medications were ordered for longer than 14 days, and without a physician directly examining and assessing the resident's current condition and progress to determine if the PRN antipsychotic medication was still needed. The evaluation should minimally document in the resident's record, continued needed for a PRN psychotropic medications, the benefit of the medication, and if expressions or indications of distress had improved as a result of the medication. The January 2018 MRR documented Resident #22's received PRN Xanax and or Buspar, an anxiety medication. Discontinued and active orders were as follows: i. Discontinued: * Buspar 10 mg daily as needed for anxiety, ordered 12/12/17 and discontinued 12/14/17. * Buspar 10 mg every 12 hours as needed for anxiety, ordered 12/14/17 and discontinued 12/28/17. The Buspar was ordered for 16 days and increased after two days, without documented medical indication to support the continuation of the medication and the need for an increased dose.	F 758	discontinued. 3. Medical Director will educate attending physicians on psychoactive medication regulations as they apply to the long-term care setting. All new admission orders will be evaluated for compliance with psychoactive medication related regulation. Nurses educated on new psychoactive medication regulations and requirement for cp to include resident-specific behaviors and behavior monitoring must correlate with CP. Nurses educated that indication for use of PRN psychoactive medication must be documented prior to administration and effectiveness must be documented post administration. Education will be completed on or before 3/21/2018. 4. DNS or designee will audit all new psychoactive medication orders daily x5, then weekly x4, then monthly x 3, then quarterly x3. Consulting pharmacist will audit all psychoactive medication orders monthly x12. DNS or designee will audit pre and post documentation for PRN psychoactive medications administered, weekly x4, monthly x3, then quarterly x3. Results will be reported to the QAPI committee for review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018.	

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F 758	Continued From page 48 ii. Active: * Xanax 0.25 mg twice daily PRN for anxiety, ordered 12/28/17. The Xanax's use extended past the 14 day order limit for a PRN psychotropic medication without documented medical indication to support the continuation of the medication. Resident #22's clinical record did not contain and the facility was unable to provide a physician's direct examination and assessment of the continued need for the antipsychotic medications. c. Resident #22 was administered PRN psychotropic medication without consistent indications for use and monitoring of effectiveness: The MAR, dated 11/1/17 through 1/23/18, documented Resident #22 was administered: * Eleven doses of PRN Buspar on 12/14/17, 12/19/17, 12/21/17, 12/22/17, 12/24/17, 12/25/17, 12/26/17, 12/27/17 x 2 doses, and 12/28/17. The effectiveness of the Buspar was not assessed twice, on 12/19/17 and 12/27/17. A resident-specific indication for use was not documented in Resident #22's clinical record for seven of the eleven Buspar doses on 12/14/17, 12/22/17, 12/24/17, 12/25/17, 12/26/17, 12/27/17, and 12/28/17. * Seven doses of PRN Xanax on 12/28/17,	F 758		

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F 758	Continued From page 49 12/31/17, 1/2/18, 1/8/18, 1/15/18, 1/17/18, and 1/22/18. The effectiveness of the Xanax was not assessed on 1/2/18. A resident-specific indication for use was not documented in Resident #22's clinical record for five of the seven Xanax doses on 12/31/17, 1/2/18, 1/8/18, 1/17/18, and 1/22/18. Resident #22's 12/1/17 through 1/23/18 Behavior Monthly Flow Sheet documented Resident #22's behaviors presented as anxious, upset, restless, kicking, hitting, pinching, and biting. The Behavior Monthly Flow Sheet documented Resident #22 exhibited the behavior of kicking, hitting, pinching, and biting on 8 occasions. The Behavior Monthly Flow Sheet documented Resident #22 exhibited the behavior of anxious, upset, and restlessness on 30 occasions. The Behavior Monthly Flow Sheet did not document Resident #22 experienced a behavior on 12/14/17, 12/27/17, 12/31/17, and 1/22/18 and medication was administered. A 12/14/17 Psychosocial Note documented Resident #22 was "happy and alert" throughout the day. The note documented Resident #22 had "no negative behaviors or agitation" noted, and he was administered 10 mg of Buspar. d. Inconsistent behaviors identified: Resident #22's 12/1/17 through 1/23/18 Behavior Monthly Flow Sheet documented Resident #22's behaviors presented as anxious, upset, restless, kicking, hitting, pinching, and biting.	F 758		

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F 758	Continued From page 50 The Behavioral Problems Care Plan, dated 1/2/18, documented Resident #22 was running his wheelchair into other residents, wandering into other residents' rooms, and he was physically aggressive towards staff. A Plan of Care Note, dated 1/2/18 documented Resident #22's care plan was updated to include physical aggression towards staff. The Behavior Problems Care Plan and Resident #22's Behavior Monthly Flow Sheet were monitoring different behaviors. On 1/24/18 at 3:23 PM, the DNS stated she would try and locate the physician's assessment of Resident #22's PRN anxiety medication ordered on 12/12/17 to include a clinical rationale for the medication's use and non-pharmacological interventions attempted prior its initiation. The DNS stated she was unable to locate the missing items requested. The DNS stated staff should be evaluating the PRN antianxiety's effectiveness.	F 758		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		3/21/18

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F 806	Continued From page 51 by: Based on observation, menu review, and interview, it was determined the facility failed to offer a nutritionally comparable alternate meal to residents. This was true for 1 of 2 residents (#14) sampled for altered textured diets. The deficient practice had the potential for harm if residents experienced hunger and/or weight loss from not having complete meals served. Findings include: Resident #14 was admitted to the facility on 1/11/16 with diagnoses including Vitamin D deficiency, anemia, dementia, and gastroesophageal reflux disease (GERD). A quarterly MDS assessment, dated 12/19/17, documented Resident #14 had a severe cognitive impairment, required extensive assistance with eating, lost food and drink from her mouth while eating, and had significant unplanned weight loss. Resident #14's January 2018 Physician's Orders documented Resident #14 was on a pureed diet with thickened liquids, dated 2/11/17. The Nutrition Care Plan, initiated 1/29/16, documented the following interventions for Resident #14: * Resident #14 required a pureed diet with honey thick liquids, initiated 7/22/17. * Resident #14 was dependent on staff for nutritional and fluid intake, initiated 12/20/16. * Resident #14 wore a clothing protector due to excessive loss of foods and fluids during meals, revised 6/27/17.	F 806	1. Resident # 14 cp updated on 2/22/2018 to include: If resident eats <25% of her meals, offer the alternate meal. Kitchen initiated preparing alternates for pureed diets beginning 2/15/2018. 2. Any resident with orders for a therapeutic diet may be impacted by this alleged deficient practice. Dietary department preparing alternate choice for all therapeutic diets starting 2/15/2018. 3. Kitchen will prepare alternates for all therapeutic diets. Nutrition policy updated to include Residents to be offered an alternate meal or nutritional supplement if less than 25% of meal consumed. Supplements that can be purchased over the counter (such as Ensure) may be provided per resident request or as an alternate if it is residents preference. All Dietary staff educated on requirement for alternates to be available for all therapeutic diets on or before 3/21/2018. All Nurses and CNA□s educated on policy update as outlined above on or before 3/21/2018. 4. Dietary manager or designee will audit menu and actual preparation of all alternate meal choices daily x5, then weekly x4, then monthly x 3, then quarterly x2. DNS or designee will audit meal intake % and documentation of alternates offered weekly x4, then monthly x3, then quarterly x3. Findings will be reported to the QAPI committee for review and further recommendations. 5. Facility will be in substantial	

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F 806	Continued From page 52 The 6/1/17 through 9/30/17 ADL Documentation Survey Report, Nutrition Amount Eaten at meal and Nutritional Supplements, documented Resident #14: * consumed less than 25% of her meals for 80 of 366 opportunities; * refused meals 36 of 366 opportunities; * was not offered a meal 13 of 366 opportunities; and * was not offered a meal alternative 129 of 129 opportunities. Resident #14's ADL Documentation Survey Reports, dated 10/1/17 through 1/24/18, documented similar findings in the Nutrition Amount Eaten and Nutritional Supplement sections. On 1/24/18 at 9:29 AM, Resident #14 was assisted with her breakfast. Resident #14 consumed 3 bites of her pureed eggs and about 1/2 of her cereal. Resident #14 was not offered an alternative or a supplement. On 1/25/18 at 4:11 PM, the RD stated if a resident refused meals or consumed less than 25% of meals, the staff should offer an alternative. The RD stated the facility did not prepare an alternate meal for residents with diet orders of pureed or mechanical soft. The RD stated for these individuals, the facility would provide supplements, such as Ensure, without doctors' orders, when residents refused or consumed less than 25% meals.	F 806	compliance as of 3/21/2018.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		3/21/18

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F 812	Continued From page 53 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination of foods stored in the freezer. This was true for 12 of 13 (#s 9, 11, 12, 14, 15, 20-24, 28 and 29) sampled residents and all other residents residing in the facility. This had the potential for harm if residents contracted foodborne illnesses or contagious diseases. Findings include: Initial tour of the kitchen: On 1/22/18 at 3:15 PM, the freezer was observed. The storage of the meat in the freezer was as follows: * Top Shelf: Boxes of unopened frozen	F 812	1. On 1/22/2018 Dietary Manager corrected the organization of the food items in the freezer. 2. All residents have the potential to be impacted by this alleged deficient practice. 3. Dietary Manager will put signs on the freezer shelves to designate the correct placement for food in the freezer on or before 3/21/2018. Dietary Staff was educated on the importance of placement of food in freezer. Bottom shelf is for poultry, second to bottom shelf will be beef and pork, next will be seafood and the top shelf will be ready to eat foods. Cooked items will not be placed next to	

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F 812	Continued From page 54 vegetables. * Next Shelf: A metal bin filled to the top with, 2 packages of raw chicken breasts in bags, Pre-cooked chicken patties in a bag, packaged baloney, cooked chicken breasts in a bag, and raw beef steaks in bags. * Next shelf: Pre-cooked chicken patties in an open box. * Bottom Shelf: Multiple containers of asparagus soup and other leftover soups. On 1/22/18 at 3:27 PM, Cook #1, present during the tour, stated the way the food was currently stored was incorrect and she would correct it.	F 812	raw/uncooked items. Education will be completed on or before 3/21/2018. 5. Dietary Manager or designee will monitor daily x5, then weekly x4, then monthly x3, then quarterly x2. Findings will be reported to the QAPI committee for review and further recommendations. 6. Facility will be in substantial compliance as of 3/21/2018.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity,	F 838		3/21/18

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F 838	Continued From page 55 and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced	F 838		

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F 838	Continued From page 56 by: Based on record review and staff interview, it was determined the facility failed to ensure a facility assessment was completed. This was true for 13 of 13 (#s 9, 11, 12, 14, 15, 17, 20-24, 28 and 29) sampled residents and all other residents residing in the facility. This created the potential for harm if the facility was unable evaluate its resident population and identify the appropriate resources needed to provide the necessary care and services the residents required. Findings include: On 1/23/18 at 8:23 AM, the AIT and the Administrator were unable to provide a facility assessment, and stated the facility assessment was not completed.	F 838	1. Facility assessment completed on or before 3/21/2018 2. All residents may be impacted by this alleged deficient practice. 3. Policy for facility assessment was initiated and approved on 2/19/2018. Administrator, AIT and DNS received additional education on facility assessment requirements and policy on or before 3/21/2018. 4. Administrator or designee will audit facility assessment completeness monthly x12. 5. Facility will be in substantial compliance as of 3/21/2018.	
F 842 SS=F	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		3/21/18

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	135070	A. BUILDING _____ B. WING _____	01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR LAKE MEMORIAL SKILLED NURSING FACILITY	164 SOUTH FIFTH STREET MONTPELIER, ID 83254

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F 842	Continued From page 57 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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F 842	Continued From page 58 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to keep accurate and complete clinical records for each resident. This was true for 13 of 13 sample residents (#s 9, 11, 12, 14, 15, 17, 20-24, 28 and 29), and all other residents in the facility. The deficient practice created the potential for harm when clinical information was not readily accessible and increased the risk for errors and created the potential for complications if inappropriate care and/or treatment was provided. Findings include: On 1/22/18 at 3:32 PM, during the entrance conference meeting, the Administrator stated the majority of residents' clinical records were located in EMR (PCC) #1. The Administrator stated the MARs and TARs were located in EMR (CPSI) #2. On 1/24/18 at 10:28 AM, the DNS stated EMR #1 contained physician and nursing orders, consents, progress notes, blood glucose monitoring, ADL tasks, behavior monitoring, wound assessments, and more. The DNS stated EMR #2 contained physician and nursing orders, Medication Reconciliation Records (MRR), Medication Administration Records (MAR), code	F 842	1. Resident #17 orders clarified on 1/25/2018 and placed in EMR#1 (PCC), orders in EMR#2 were discontinued. 2. All residents may be impacted by this alleged deficient practice. Location of documentation guide will be placed in all resident charts on or before 3/21/2018. 3. Comprehensive assessment of EMR functionality and use completed by an Independent Consultant that specializes in EMR□s. Based on facility and pharmacy requirements and consultant recommendation the EMR Policy was updated on 2/22/2018 to include: (a) All medication orders, laboratory or radiology orders, Therapy orders and dietary orders will be entered and maintained in EMR#2 (CPSI). (b) All other physician orders will be entered and maintained in EMR#1 (PCC). (c) Location of Documentation guide created outlines location of physician orders, order administration documentation and PRN medication effectiveness. Location of documentation guide to be placed in all residents□ physical charts starting upon admission. (d) Physician Order Summary and	

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F 842	Continued From page 59 status, consents, blood glucose monitoring, tube feeding administration and more. The DNS stated the facility had paper documentation in binders labeled behavior monitors, skin "checks," and pharmacy medication recommendation reviews. The DNS stated the facility utilized paper charts which contained physician telephone orders, consents, history and physicals, monthly pharmacy reviews and more. The DNS agreed the multiple systems utilized by the facility created a complex environment for staff to meet residents' needs. Example: Resident #17's January 2018 Physician's Orders were documented in two EMR systems. EMR #1 documented the following active Physician's Order: * Real Food Blend, mixed with 4-8 oz of fluids, and per gravity feeding, once daily at 12:00 PM, ordered 1/22/18. EMR #1 documented the following discontinued Physician's Order: * Administer 1 can of Jevity at 12:00 PM and 4:00 PM, discontinued 1/16/18. EMR #2 documented the following active Physician's Orders: * Administer Real Food Blend, once daily at 12:00 PM, ordered 1/20/18. * Mix Real Food Blend with 6 oz of water and administer at 300 ml/hr, ordered 1/20/18. * Administer 1 can of Jevity 1.0 at 11:00 AM and 4:00 PM, ordered 10/26/17.	F 842	Medication Administration Record from previous month to be attached to Documents portion of the resident chart found within EMR#1 (PCC). Location of Documentation guide to be placed in all current resident charts on or before 3/21/2018. All nurses and IDT managers educated on the policy changes as outlined above on or before 3/21/2018. 4. Administrator/AIT or designee will audit for verification of the Location of documentation guide and correct location of physician orders, order administration documentation and PRN medication effectiveness daily x5, 3x per week x4, weekly x4, then monthly x2 then quarterly x2. Findings will be reported to the QAPI committee for review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018.	

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F 842	Continued From page 60 The two EMR systems had conflicting orders of when to administer the nutrition support and if they were discontinued or active orders. EMR #1 documented the following Physician's Orders: * Per a tube feeding pump, administer 3 cans of Jevity running at 200 ml/hr during the night, ordered 12/13/16. * Per a tube feeding pump, administer 1000 ml of water running at 250 ml/hr during the night, ordered 12/13/16. * Staff were to flush Resident #17's PEG tube with 60 ml of water before and after medications and nutrition support administrations, ordered 12/13/16. * Staff were to check Resident #17's PEG tube daily, and staff were to clean and change his dressing at the insertion site PRN, ordered 12/13/16. EMR #2 documented the following Physician's Orders: * Per a tube feeding pump, administer 3 cans of Jevity running at 200 ml/hr during the night, ordered 2/1/17. * Per a tube feeding pump, administer 1000 ml of water running at 250 ml/hr during the night, ordered 2/1/17. * Staff were to flush Resident #17's PEG tube with 60 ml of water before and after medications and nutrition support administrations, ordered 2/11/17. * Staff were to check Resident #17's PEG tube daily, and staff were to clean and change his dressing at the insertion site PRN, ordered 2/1/17.	F 842		

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F 842	Continued From page 61 The two EMR systems had duplicate orders. Refer to F693. On 1/24/18 at 11:00 AM, the Administrator and the DNS stated the facility utilized two EMR systems that were not compatible with each other and utilized multiple binder paper systems. The Administrator stated the facility was in the process of acquiring one centralized system.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of clinical records and policies and procedures, it was determined the facility's Quality Assessment and Assurance (QAA) committee failed to take actions to identify and resolve systemic problems. This was true for 13 of 13 sample residents (#s 9, 11, 12, 14, 15, 17, 20-24, 28 and 29), and all other residents in the facility. The deficient practice resulted in insufficient direction and control necessary to ensure residents' rights were maintained and quality of life and quality of care needs were met. The failure had the potential to harm residents due to inadequate care and services. Findings include: The QAA committee failed to provide sufficient	F 867	1. Quality assurance Performance Improvement (QAPI) committee convened on 1/26/2018, 2/12/2018, 2/13/2018, 2/14/2018, 2/15/2018, 2/19/2018, 2/20/2018, 2/21/2018 and 2/22/2018 and reviewed areas of alleged deficiencies including F550, F600, F604, F692, F745, F756, F757, F758, F867. QAPI Committee reviewed statement of deficiencies and discussed and created Plan of Correction for all alleged deficiencies initiated; refer to F550, F600, F604, F692, F745, F756, F757, F758, F867. Ongoing monitoring initiated for all alleged deficiencies, refer to F550, F600, F604, F692, F745, F756, F757, F758, F867.	3/21/18

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F 867	Continued From page 62 monitoring and oversight to sustain regulatory compliance as evidenced by the following citations: Refer to F550 as it relates to the facility's failure to ensure resident were treated with dignity and respect. Refer to F600 as it relates to the facility's failure to ensure residents were free from all forms of abuse, including verbal and mental abuse. Refer to F604 as it relates to the facility's failure to ensure residents were free from physical restraints. Refer to F692 as it relates to the facility's failure to ensure residents received nutritional and hydration interventions to prevent unplanned weight loss and dehydration. Refer to F745 as it relates to the facility's failure to provide medically-related social services to advocate for residents asserting their rights. Refer to F756 as it relates to the facility's failure to ensure pharmacy recommendations were reviewed and followed. Refer to F757 as it relates to the facility's failure to ensure residents receiving psychoactive medication had specific target behaviors identified, monitored the efficacy of those medications, and consistent care plans. Refer to F758 as it relates to the facility's failure to ensure residents received PRN psychotropic medications only when clinically indicated for the	F 867	2. All residents may be impacted by this alleged deficient practice. 3. QAPI committee to convene weekly x 8 and then monthly and as needed to review results of monitoring initiated for alleged deficiencies. QAPI policy updated to include (a) QAPI committee to convene monthly and as needed (b) QAPI committee will make recommendations for system changes as needed based on monitoring. (c) QAPI committee will identify systems/processes that will require routine monitoring and recommend frequency of monitoring. (d) QAPI committee will review routine monitoring and make recommendations for system changes as needed. 4. Administrator or designee will monitor QAPI committee meetings, completion of recommended audits/monitoring, and QAPI recommendations monthly x12. 5. Facility will be in substantial compliance as of 3/21/2018.	

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F 867	Continued From page 63 treatment of specific conditions. Refer to F842 as it relates to the facility's failure to keep accurate and complete clinical records for each resident. On 1/26/18 at 10:08 AM, the Administrator and AIT stated the QAA committee identified environmental and nutrition concerns. The Administrator stated the QAA committee had not recently identified respect and dignity, abuse, physical restraints, weight loss, psychoactive medications, social services, and accurate clinical records, identified during the current 1/26/18 survey as resident care concerns.	F 867		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		3/21/18

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F 883	Continued From page 64 and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop and implement policies and processes to minimize the risk of residents acquiring, transmitting, or experiencing	F 883	1. Resident #14, 20, 22 and 23 (and/or Resident responsible party) have been provided with the most recent version of the CDC□s Pneumococcal VIS for both	

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F 883	Continued From page 65 complications from pneumococcal pneumonia. Specifically, 1) The facility failed to ensure residents who were offered the pneumococcal vaccine received information and education consistent with current CDC [Centers for Disease Control and Prevention] recommendations for pneumococcal immunization for 5 of 5 sampled residents (#9, #14, #20, #22, and #23) reviewed for the pneumococcal vaccination. 2) The facility's pneumococcal immunization process and pneumococcal immunization consent form did not reflect current CDC recommendations. 3) The facility did not implement an immunization program to ensure residents' pneumococcal vaccines were being tracked with receiving or declining the pneumococcal vaccines PCV13 the first year, followed by the PPSV23 one year later. Findings include: The CDC website, updated 11/22/16, documented recommendations for pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older: * "Adults 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23." * "If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most	F 883	PCV13 and PPSV23 on or before 3/21/2018, resident #9 passed away. Facility was able to obtain documentation of resident #14□s initial Pneumovax23 vaccination, completed on 10/13/2014 at physician office. Facility was able to obtain documentation of resident #20□s initial Pneumovax23 vaccination, completed on 8/21/2014 at Bear Lake Memorial Hospital. Resident #14 and #20 Resident consent and MD orders will be obtained for the additional Pneumococcal vaccinations per CDC recommendations on or before 3/21/2018. Resident #14 quarterly MDS dated 12/19/17 modified as follows: O0300A = 0 & O0300B = 3 on or before 3/21/2018. Resident #20 quarterly MDS dated 12/12/17 modified as follows: O0300A = 0 & O0300B = 3 on or before 3/21/2018. Resident #22□s responsible party will be provided with the most recent CDC VIS and after reviewing the education will be re-approached on consent status, if consent obtained an order will be requested from MD and vaccination administered per MD orders on or before 3/21/2018. 2. All residents may be impacted by this practice. All current residents immunization records will be reviewed for Pneumococcal vaccinations and next step of the Pneumococcal Vaccination (per current CDC recommendations) will be identified. Consent for the specific vaccination will be obtained, MD order will be obtained and vaccination will be administered per orders on or before 3/21/2018.	

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F 883	Continued From page 66 recent dose of PPSV23." The facility's policy for 13-Valent Pneumococcal Conjugate Vaccine (PCV13), dated 6/20/12, documented, "the Advisory Committee on Immunization Practices recommended routine use of PCV13 all adults are eligible for a dose of PPSV23 at age 65 years, regardless of previous PPSV23 vaccination; however, a minimum interval of 5 years between PPSV23 doses should be maintained. If it is determined that patient has not received this vaccine, and it has been at least 1 year since the patient received the PPSV23 or has not received the PPSV23 vaccine, then: Patient will be screened for contraindications; Order will be obtained from primary physician for administration of vaccine; CDC Vaccine Information Sheet will be provided to the patient, and Consent will be obtained for administration of the vaccine. Once the consent is signed, the patient will then receive a single dose of the vaccine PCV13. Record of immunization will be placed in patients chart." An undated facility's policy for 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23) documented, "PPSV23 is recommended for prevention of invasive pneumococcal disease among all adults >65 years, and for adults at high risk aged 19-64 years (with a follow up dose 5 years after the initial dose for those 19-64 yrs). If it is determined that the patient has never received this vaccine or it has been longer than five years since last dose of PPSV23 (if received prior to age 65) then: Patient will be screened for contraindications, Order will be obtained from primary physician for administration of vaccine,	F 883	3. Facility Immunization policy updated to include the most recent CDC recommendations for the Pneumococcal vaccination on 2/22/2018. Nurses will request an order for vaccination upon admission. Documentation will include the specific immunization that is being provided (or refused if applicable). Immunization consent will be documented in the immunization module within EMR#1 (PCC), the most recent version of the CDC VIS will be provided when attempting to obtain consent and documentation will include the education that was provided. Immunization will be administered when delivered from the pharmacy. Subsequent immunizations will be ordered and scheduled per CDC recommendations. All nurses educated on policy updates on or before 3/21/2018. 4. Infection control nurse or designee will audit new admissions for appropriate consent, MD order and documentation weekly x4 then monthly x3 then quarterly x2. Results will be reported to the QAPI committee for review and further recommendations. 5. Facility will be in substantial compliance as of 3/21/2018.	

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F 883	Continued From page 67	F 883		

CDC Vaccine Information Sheet will be provided to the patient; Consent will be obtained for administration of the vaccine; and Single dose of PPSV23 vaccine will be administered. If it is determined that the patient has received one dose of the PPSV23 vaccine prior to the age of 65 and it has been five years since that dose of PPSV23, and at least eight weeks have past since the PCV13 vaccine has been given then a one time dose of PPSV23 will be given. Record of the immunization will be placed in the patient's chart."

The facility's Pneumococcal Vaccine Consent Form documented, "The Pneumococcal Polysaccharide Vaccine is effective against 23 pneumococcal types which cause 90 percent of all pneumococcal pneumonia and is effective for approximately six years. Anyone 65 years of age or older or having chronic health problems is considered high risk for exposure to and complications from pneumococcal infections such as pneumonia, septicemia, and meningitis. The Advisory Committee on Immunization Practices (ACIP) currently recommends a single dose of the vaccine for persons 65 years and older who have not been previously vaccinated or whose vaccination status is unknown. A one-time revaccination is recommended for persons 65 years and older who have been vaccinated for the first time when they were 60 years of age or younger."

* "Yes, I wish to receive pneumococcal vaccine according to the recommended schedule."

* "No, I do not wish to receive the pneumococcal vaccine at this time."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135070	A. BUILDING _____ B. WING _____	01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR LAKE MEMORIAL SKILLED NURSING FACILITY	164 SOUTH FIFTH STREET MONTPELIER, ID 83254

(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 883	Continued From page 68 1. Resident #9 was admitted to the facility on 9/11/17 with multiple diagnoses including hypertension and anemia. Resident #9's quarterly MDS assessment, dated 12/19/17, documented Resident #9 was "up to date" with the Pneumococcal Vaccination. Resident #9's January 2018 MRR documented Resident #9 received Prevnar 13 on 9/13/17. On 1/26/18 at 9:15 AM, the Infection Control Nurse provided the January 2018 MRR and the Pneumococcal Vaccine consent form for Resident #9. The consent form did not document if the vaccine was the PCV13 or the PPSV23 vaccine. 2. Resident #14 was admitted to the facility on 1/11/16 with diagnoses, including Vitamin D deficiency, anemia, and dementia. Resident #14's quarterly MDS assessment, dated 12/19/17, documented Resident #14 was "up to date" with the Pneumococcal Vaccination. On 1/26/18 at 9:15 AM, the Infection Control Nurse was unable to provide documentation when Resident #14 received the pneumococcal vaccine and if Resident #14 received information and education consistent with the current CDC recommendations. 3. Resident #20 was admitted to the facility on 8/21/14 with multiple diagnoses, including heart failure and diabetes mellitus.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135070	A. BUILDING _____ B. WING _____	01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR LAKE MEMORIAL SKILLED NURSING FACILITY	164 SOUTH FIFTH STREET MONTPELIER, ID 83254

(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 883	Continued From page 69	F 883		

Resident #20's quarterly MDS assessment, dated 12/12/17, documented Resident #20 was "up to date" with the Pneumococcal Vaccination.

On 1/26/18 at 9:15 AM, the Infection Control Nurse was unable to provide documentation when Resident #20 received the pneumococcal vaccine and if Resident #20 received information and education consistent with the current CDC recommendations.

4. Resident #22 was admitted to the facility on 12/27/16 with multiple diagnoses, including Alzheimer's disease, anxiety, and depression.

Resident #22's quarterly MDS assessment, dated 10/12/17, documented Resident #22 was offered and declined the Pneumococcal Vaccine.

On 1/26/18 at 9:15 AM, the Infection Control Nurse provided Resident #22's Pneumococcal Vaccine Consent Form, dated 9/27/16, documented Resident #22 did not wish to receive the pneumococcal vaccine at this time. The Infection Control Nurse was unable to provide documentation if Resident #22 received information and education consistent with the current CDC recommendations.

5. Resident #23 was admitted to the facility on 5/31/17 with multiple diagnoses, including Parkinson's disease and lewy body dementia.

Resident #23's quarterly MDS assessment, dated 12/7/17, documented Resident #23 was "up to date" with the Pneumococcal Vaccination.

Resident #23's January 2018 MRR documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135070	A. BUILDING _____ B. WING _____	01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR LAKE MEMORIAL SKILLED NURSING FACILITY	**164 SOUTH FIFTH STREET MONTPELIER, ID 83254**

(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 883	Continued From page 70 Resident #23 received the Prevnar 13 on 9/26/17. On 1/26/18 at 9:15 AM, the Infection Control Nurse provided the January 2018 MRR and the Pneumococcal Vaccine consent form for Resident #23. The consent form did not document if the vaccine was the PCV13 or the PPSV23 vaccine. These failed practices represented a systemic failure which increased residents' risk for contracting pneumonia with its associated complications of infection of the blood and covering of the brain and spinal cord which could cause death or brain damage.	F 883		