



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 3020 0001 4051 1265

March 1, 2013

James H. Hayes, Administrator
River Ridge Care & Rehabilitation Center
640 Filer Avenue West
Twin Falls, ID 83301-4533

Provider #: 135106

Dear Mr. Hayes:

On **February 15, 2013**, a Recertification and State Licensure survey was conducted at River Ridge Care & Rehabilitation Center by the Department of Health & Welfare, 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, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.

James H. Hayes, Administrator
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After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 14, 2013**. Failure to submit an acceptable PoC by **March 14, 2013**, may result in the imposition of civil monetary penalties by **April 3, 2013**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

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

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [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 **August 15, 2013**, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. 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)

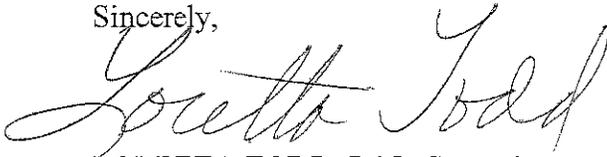
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **March 14, 2013**. If your request for informal dispute resolution is received after **March 14, 2013**, 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, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd". The signature is written in black ink and is positioned above the printed name.

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Linda Kelly, RN Karla Gerleve, RN Monica Nielsen, MEd, QMRP</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BP = Blood Pressure CAA = Care Area Assessment CCD = Change of Condition Documentation CNA = Certified Nurse Aide DM = Diabetes Mellitus DON/DNS = Director of Nursing/Director Nursing Services ESKD = End Stage Kidney Disease IDT = InterDisciplinary Team IDTPN = IDT Progress Notes IE = In Example I&Os = Intake and Output LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS - Minimum Data Set assessment N.O. = New Order POC = Plan of Care RAI = Resident Assessment Instrument RAPS = Resident Assessment Protocol Summary Recap = Physician Recapitulation Orders TAR = Treatment Administration Record UM = Unit Manager</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Ridge Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p><u>225</u></p> <p>Affected Residents:</p> <p>On 03/18/13, the grievance that occurred on 9/27/12 involving resident # 3 was investigated by the Administrator and neglect was unsubstantiated. Resident #3 was assessed for psychosocial and physical injury by the unit manager on 03/13/13 with no signs and symptoms of acute distress or further family concerns identified.</p> <p>Identify Potential Residents</p> <p>On or before 3/20/13, the grievances for the last 30 days will be audited to ensure that allegations of abuse or neglect were investigated.</p> <p>Systemic</p>	03/20/13
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225	On or before 3/20/13, center staff will be reeducated on the facility's grievance and	

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

TITLE

(X6) DATE

Jan H. Nye

Administrator

03.14.2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225

Continued From page 1
ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

F 225

abuse policy including but not limited to the investigation process by the Director of Nursing or designee.

QA Audit

Beginning the week of 03/20/13, grievances will be reviewed at Management morning meeting to ensure various aspects of investigation processes were completed per policy. Findings will result in further investigation to ensure thorough assessment and completion of process per policy.

Beginning the week of 03/20/13, the grievance log will be audited weekly for four weeks and monthly for three months to identify any potential allegations of neglect or abuse by the administrator or designee. The results of these audits will be reported to the Performance Improvement Committee monthly. The Administrator is responsible for monitoring and follows up.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of facility grievances, abuse policy review, record review, and staff interview, it was determined the facility failed to thoroughly investigate a grievance to rule out potential abuse or neglect. This affected 1 of 7 (#3) sampled residents. This failed practice created the potential to negatively impact residents' psychosocial well-being when potential abuse or neglect situations were not thoroughly investigated to prevent or rule out abuse and/or neglect. Findings included:</p> <p>Resident #3 was admitted to the facility on 1/4/09 with multiple diagnoses including vascular dementia.</p> <p>The resident's 12/10/12 significant change MDS coded moderately impaired cognition, minimal depression, no rejection of cares, one person extensive assist for bed mobility, transfers, locomotion on and off unit, dressing, toilet use, personal hygiene, bathing, and supervision and set up help for dining. Did not walk in room or corridor. One sided lower extremity impairment and mobility device was a wheelchair.</p> <p>On 9/27/12, a Customer First Concern/Grievance Report (Grievance) form documented, in part:</p> <ul style="list-style-type: none"> - The individual initiating concern was a family member. - [Resident #3] was... Obviously ... in TV room since lunch. Dirty face, clothes, still had silverware on his lap. He was eating a puzzle piece and was very thirsty. Also wet from head to toe. - Documentation of Facility Follow-up section: IDT 	F 225		

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F 225	<p>Continued From page 3</p> <p>rounding daily units and lobby areas to determine any questionable "neglect." Long term rounding in place.</p> <p>The Grievance form included what actions were taken by the facility after the grievance was brought to the facility's attention. The form did not include what actions were taken by the facility to rule out abuse or neglect.</p> <p>On 2/13/13 at 2:54 p.m., the surveyor asked to review the investigation that ruled out abuse or neglect for Resident #3 on 9/27/12. The Administrator stated, "We should have investigated but did not obtain staff interviews of who, what, where, when or why." The surveyor informed the Administrator not investigating to rule out neglect or abuse was a concern. The Administrator acknowledged by shaking his head. The surveyor then asked for the facility's policy and procedures for investigating potential abuse or neglect.</p> <p>The facility's Abuse & Neglect Prohibition Program documented, in part:</p> <ul style="list-style-type: none"> * "The center must ensure that all alleged violations involving ...neglect ... are reported immediately to the Administrator of the center." * Identification: Identify events, such as ... occurrences ... that may constitute abuse; and to determine the direction of the investigation. * Investigation: "The center must have evidence that all alleged violations are thoroughly investigated." * Signs and symptoms of potential neglect: "...Being dirty or unbathed ... Knowingly leaving a resident wet or soiled ... Failing to provide food or fluids ... lack of monitoring... Inadequate help with 	F 225		

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F 225	Continued From page 4 hygiene or bathing..."	F 225	<u>241</u>	03/20/10
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure dignity was maintained for 1 of 1 (#4) residents reviewed for indwelling urinary catheter use: This was true when the resident's urine leg bag was uncovered and in view from the hallway. The failure had the potential to negatively affect the resident's self-esteem and/or self-worth. Findings included: Resident #4 was admitted to the facility on 1/18/13 with diagnoses that included sacral and bilateral heel pressure ulcers (PU), neurogenic bladder, and hypothyroidism. Note: Upon admission, an indwelling urinary catheter was already in place. The resident's admission MDS assessment, dated 1/28/13, coded, in part: * Intact cognition with a BIMS score of 15; * No signs or symptoms of delirium/mental status changes/behavioral symptoms/rejection of care;	F 241	Identify Potential Residents An audit of residents with indwelling urinary catheters for privacy covers was completed on 2/25/13 by the Unit Manager No other occurrences noted On or before 3/20/13, nursing staff will be reeducated on patient dignity and the need for privacy covers on catheter bags by the Director of Nursing or designee. QA Audit Beginning the week of 3/20/13, residents with catheters will be assessed weekly for 4 weeks then monthly for three months by the Director of Nursing or designee, to ensure privacy covers are in place on catheter bags. The results of these audits will be reported to the Performance Improvement Committee monthly X 3months. The Director of Nursing is responsible for monitoring and follow-up.	

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F 241	<p>Continued From page 5</p> <ul style="list-style-type: none"> * Limited assistance of 1 person for transfers/dressing/personal hygiene * Extensive assistance of 1 person to walk in room/locomotion on and off unit/toilet use; * Walker and wheelchair (w/c) use; and * Indwelling catheter. <p>Resident #4's indwelling catheter care plan, dated 1/21/13, included the intervention, "Privacy cover for catheter bag."</p> <p>The resident was observed in a knee length housecoat with her lower legs bare and an uncovered urinary leg bag strapped to her right lower leg as follows:</p> <ul style="list-style-type: none"> * 2/11/13 at 2:35 p.m. - while seated in her w/c in her room and in view from the hallway; * 2/12/13 from 7:50 a.m. to 8:35 a.m. - while seated in her w/c near the open doorway in her room and in full view from the hallway; and * 2/13/13 at 9:30 a.m. - asleep in her w/c in her room and in view from the hallway. <p>On 2/11/13 at 2:35 p.m., when asked about the uncovered urinary leg bag, Resident #4 stated, "I don't care except I don't want other people to see it."</p> <p>On 2/14/13 at 2:25 p.m., the Medicare Hall Unit Manager (UM) stated, "Isn't it under her clothing?" when asked about Resident #4's uncovered urinary leg bag.</p> <p>On 2/14/13 at 3:30 p.m., the Administrator, DNS, Nurse Consultant, Regional Vice President, and UM were informed of the uncovered urinary leg bag observations. However, no other information or documentation was received from the facility.</p>	F 241		

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F 242 SS=E	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, it was determined the facility failed to ensure residents had the right to choose their schedules and make choices about aspects of their lives that were significant to them for 6 of 6 residents (Residents #3, #5, #10 and #15 - #17) who smoked. This resulted in smoking rules and time limitations being established without residents being fully informed of such. The findings include:</p> <p>1. An interview with the Resident Group was held on 2/12/13 from 1:30 - 2:38 p.m. During that time, dissatisfaction with the facility's smoking rules was expressed; specifically smoking times were limited to six times a day at 15 minute increments and "we have to have a babysitter with us."</p> <p>a. When asked about the facility's smoking rules, the Admissions Director stated on 2/14/13 at 7:45 a.m., that prior to the morning of 2/14/13, the facility's smoking rules were included in a center-specific packet which was given to residents to read upon admission. A center-specific packet was reviewed and</p>	F 242 <u>242</u>	<p>Affected Residents:</p> <p>The facility smoking policy was updated by the Administrator on or before 03/07/13 to include smoking times, smoking time limitations, and required staff supervision.</p> <p>On 03/07/13, the Administrator reviewed the smoking policy with resident's #3, 5, 10, 15 and #17 and answered questions.</p> <p>Identify Potential Residents</p> <p>On or before 3/20/13 a resident council meeting will be held by the Administrator to review the updated facility smoking policy and to identify resident concerns, allow for questions and suggestions including smoking times, time limitations, and required staff supervision.</p> <p>System</p> <p>On 03/18/13, the updated smoking policy was placed in the admission packet. It will be signed and retained in the resident's record.</p> <p>On or before 03/20/13, Center staff will be educated by the Director of Nursing or her designee on the updated smoking policy, including smoking times, time limitations, and required staff supervision.</p> <p>QA Audit</p>	03/20/13

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F 242	<p>Continued From page 7</p> <p>contained an undated document titled Center Rules and Regulations. The document stated a smoking schedule was posted at the nursing station and included information related to assessments "...to determine whether a resident could smoke independently, supervised, or assisted with protective equipment."</p> <p>A posted Smoking Schedule, undated, documented the following times: 9:30 a.m., 11:00 a.m., 2:30 p.m., 5:00 p.m., 7:30 p.m., and 9:00 p.m.</p> <p>The Center Rules and Regulations did not include time limitations and information related to staff supervision.</p> <p>b. The Admissions Director stated on 2/14/13 at 7:45 a.m., revised Smoking Rules were put in place the morning of 2/14/13. Those Smoking Rules stated "Residents desiring to smoke shall be accompanied by a member of the staff." Time limitations were not included in the Smoking Rules.</p> <p>When asked about the Smoking Rules, the Administrator stated during an interview on 2/14/13 from 1:08 - 2:00 p.m., time limitations for smoking were designed by nurses and were based on the availability of staff to supervise residents. The Administrator stated staff supervision was put in place, even for residents who were assessed as safe and independent, due to potential liability issues. When asked, the Administrator stated time limitations were not included in the Smoking Rules. When asked, the Administrator stated the facility did not have documented evidence that residents were</p>	F 242	<p>Beginning the week of 03/20/13, an audit of new admissions who smoke will be completed by the administrator or designee to ensure that they have reviewed and signed the smoking policy. This audit will be completed weekly for 4 weeks and then monthly for 2 months. The results of these audits will be reported to the Performance Improvement Committee for 3 months.</p> <p>Beginning the week of 03/20/13, the smoking policy will be reviewed monthly at resident council to ensure times and frequency continue to meet needs of residents</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301	
(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 242	Continued From page 8 informed and agreed to the Center Rules and Regulations or the Smoking Rules.	F 242	246 Affected Residents: Resident #1's call light was placed within reach of the resident on 2/11/13 by the unit manager. No adverse effect was noted post incident.	03/20/13
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, it was determined the facility failed to ensure residents had access to call lights. This was true for 1 of 11 sample residents (#1) and 1 random resident (#14). This failure created the potential for physical and/or psychological harm for residents whose call light was not available when needed or wanted. Findings included: 1. On 2/13/13 at 12:50 p.m. Random Resident #14 was observed in an electric wheelchair near the foot of the bed. The resident's call light was also observed looped through the siderail on the right side of the resident's bed and clipped to itself at the cord near the wall. Also, an over bed table was in front of the call light and a	F 246	Resident #14's environment was cleared and the call light was placed within reach of the resident on 2/13/13 by the unit manager. No adverse effect was noted post incident. Identify Potential Residents On 2/26/13, an audit of the resident rooms for access to call lights was completed by the administrator or designee. Resident environment was cleared and call lights were moved as needed. Systematic On or before 3/20/13, center staff were reeducated by the Director of Nursing or designee regarding resident safety and the need to maintain call lights within resident reach. QA Audit Beginning the week of 03/20/13 unit rounds will be conducted by the Director of Nursing or designee to check for call light placement to ensure accessibility to resident weekly for 4 weeks, then monthly for 3 months. Any findings will be corrected and on-the-spot re-education provided as needed. The results of	

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F 246	<p>Continued From page 9</p> <p>mechanical lift was next to the over bed table. These two items (table and lift) were parked inbetween the resident's and the roommate's beds. When asked how she would get help if needed or wanted, the resident stated, "I'm not sure. I can't even get to my call light." The resident moved the electric wheelchair and bumped into the over bed table when she attempted to get to the call light. At that, the resident stated, "I can't get to it and that upsets me."</p> <p>At 1:00 p.m., CNA #10 was summoned and accompanied the surveyor to Resident #14's room. Once in the resident's room, it took the CNA several minutes to move the over bed table and mechanical lift out of the way. During this time, the Administrator stopped at the resident's doorway and the CNA told him, "She couldn't get to her call light." CNA #10 then moved the call light and attached it to the blanket near the end of the resident's bed.</p> <p>No other information was received from the facility that resolved the issue.</p> <p>2. On 2/11/13 at 2:55 pm, Resident #1 was observed in his electric wheelchair in his room next, to his bed. The call light was attached to the light above the bed, out of reach to the resident. When asked how he would get assistance from staff, Resident #1 indicated he would usually use his light, but he couldn't reach it.</p> <p>The facility failed to ensure that Resident #1's call light was within reach of the resident.</p>	F 246	Performance Improvement Committee monthly X3 months. The Administrator is responsible for monitoring and follow-up.	

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F 248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, it was determined the facility failed to ensure there was an activity program designed to meet the interests of residents for 6 of 6 residents (Residents #1, and #4 - #8) whose activity assessments were reviewed. This resulted in scheduled activities that did not meet the expressed interests of residents. The findings include:</p> <p>1. An interview with the Resident Group was held on 2/12/13 from 1:30 - 2:38 p.m. During that time, dissatisfaction with the facility's activities and available space for activities was expressed by 5 of 11 residents. Specifically, residents stated activities were limited to movies, Bingo, Dominoes, Yahtzee, and cards. One resident stated "If an activity isn't donated, then there are no activities."</p> <p>Six resident's Activity Assessments were reviewed and compared to the facility's activity calendars, dated 11/2012 through 2/15/13, with the following results:</p> <p>a. Resident #1's Activity Assessment, dated 5/3/12, stated his interests included music,</p>	F 248	<p><u>248</u></p> <p>Affected Residents</p> <p>Resident #1's, activity needs were reassessed by Activity Director on or before 3/20/13 and their individualized activity plan of care was updated to meet each residents needs based on interview and assessment.</p> <p>Resident #4 was discharged on 02/14/13.</p> <p>Resident #5's, activity needs were reassessed by Activity Director on or before 3/20/13 and their individualized activity plan of care was updated to meet each residents needs based on interview and assessment.</p> <p>Resident #6's, activity needs were reassessed by Activity Director on or before 3/20/13 and their individualized activity plan of care was updated to meet each residents needs based on interview and assessment.</p> <p>Resident #7's, activity needs were reassessed by Activity Director on or before 3/20/13 and their individualized activity plan of care was updated to meet each residents needs based on interview and assessment.</p> <p>Resident #8's, activity needs were reassessed by Activity Director on or before 3/20/13 and their individualized activity plan of care was updated to meet each residents needs based on interview and assessment.</p>	03/20/13
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F 248	<p>Continued From page 11</p> <p>spiritual and religious activities, watching television, talking/conversing, trips, reading/writing, reminiscing, nature, home improvement, housekeeping, and grooming.</p> <p>The facility's Activity Calendars, dated 11/2012 - 2/15/13, documented in-house religious services, television, reading, and weekly movies were consistently scheduled. Three community outings were scheduled during the 3 ½ months (1 in November and 2 in December).</p> <p>b. Resident #4's Activity Assessment, dated 1/30/13, stated her interests included spiritual and religious activities, Bingo, hobbies, puzzles/games, celebrating religious holidays, and communion associated with religious services.</p> <p>The facility's Activity Calendars, dated 11/2012 - 2/15/13, documented in-house religious services, Bingo, and puzzles/games were consistently scheduled.</p> <p>c. Resident #5's Activity Assessment, dated 1/3/13, stated his interests included watching television, talking/conversing, reminiscing, and nature.</p> <p>The facility's Activity Calendars, dated 11/2012 - 2/15/13, documented television was consistently scheduled.</p> <p>d. Resident #6's Activity Assessment, dated 1/24/13, stated her interests included music, spiritual and religious activities, watching television, reminiscing, Bingo, hobbies, puzzles/games, intergenerational activities,</p>	F 248	<p>Identify Potential Residents</p> <p>On or before 3/20/13 the Activities Director or designee will review the resident Activities assessments to identify activity and recreation needs and update the plan of care as needed.</p> <p>On or before 3/20/13 residents were interviewed, including the Resident Council, related to preference for activities and facility outings by the Activities Director or Designee. Based on resident comments, requests and assessments, the Activities Director updated the activity calendar to include activities of resident preference.</p> <p>On or before 03/20/13, a monthly facility outing will also be incorporated into the scheduled activities.</p> <p>Systematic</p> <p>On or before 03/20/13, the activity areas and supplies were assessed by the Activity Director or designee. On or before 03/20/13 designated activities areas will be identified and additional supplies will be acquired and made accessible to meet resident activity needs.</p> <p>On or before 3/20/¹³24, nursing personnel will be educated by the Activity Director or designee related to assisting residents to and from scheduled activities and participating in programming as needed.</p> <p><i>Per phone conversation with Jim Hayes - Administrator on 3/19/13 at 11:15 Am. The date was a typo.</i></p>	

He gave me permission to correct date. Bf -surveyor

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F 248	<p>Continued From page 12</p> <p>parties, social/happy hour, special events, celebrating religious holidays, exercise group, arts/crafts, auditory stimulation, pet visits, and draw/color/paint.</p> <p>The facility's Activity Calendars, dated 11/2012 - 2/15/13, documented in-house religious services, television, Bingo, and puzzles/games were consistently scheduled. A Resident Christmas party was scheduled for 12/21/12 and cookie party was scheduled for 2/14/13.</p> <p>e. Resident #7's Activity Assessment, dated 1/24/13, stated her interests included music, spiritual and religious activities, reminiscing, housekeeping, grooming, hobbies, intergenerational activities, parties, social/happy hour, special events, celebrating religious holidays, pet visits, flower arranging, walks, massage, and preparing food.</p> <p>The facility's Activity Calendars, dated 11/2012 - 2/15/13, documented in-house religious services, flower arranging, and "Beautiful Nails" were consistently scheduled. A Resident Christmas party was scheduled for 12/21/12 and cookie party was scheduled for 2/14/13.</p> <p>f. Resident #8's Activity Assessment, dated 10/19/12, stated her interests included music, spiritual and religious activities, watching television, trips, reading/writing, reminiscing, nature, grooming, Bingo, hobbies, intergenerational activities, parties, social/happy hour, arts/crafts, pet visits, draw/color/paint, massage, preparing food, and word games.</p> <p>The facility's Activity Calendars, dated 11/2012 -</p>	F 248	<p>On or before 3/20/13, activities supplies such as games will be re-positioned so as to be readily available to residents.</p> <p>On or before 03/20/13, the Activity Director will be reeducated by the Administrator on activity scheduling, care plan development, and providing needed supplies, and space.</p> <p>QA Audit</p> <p>Beginning the week of 3/20/13 the Administrator or designee will complete an audit of 5 random residents' activity assessments, plan, space and supplies to ensure the residents activity needs are being met. These audits will occur weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee X3 months. The Administrator is responsible for monitoring and follow up.</p>	

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F 248	<p>Continued From page 13</p> <p>2/15/13, documented in-house religious services, television, reading, Bingo and "Beautiful Nails" were consistently scheduled. Three community outings were scheduled during the 3 ½ months (1 in November and 2 in December). A Resident Christmas party was scheduled for 12/21/12 and cookie party was scheduled for 2/14/13.</p> <p>When asked about the facility's activities, the Activity Director stated during an interview on 2/13/13 from 12:05 - 12:20 p.m., activities were "a lot more sparse than I'd like them to be." The Activity Director stated the reasons for the lack of activities included budget, a lack of staff, and available space in the facility. The Activity Director stated her budget was 14 cents per day per resident which did not go very far. The Activity Director stated she was approved to work 35 hours a week, and she was required to run all of the group and one-to-one activities, help in the dining room during meals, and complete all of the resident interviews and assessments, and complete other required paperwork. The Activity Director stated she was also conducting one-to-one spontaneous activities with residents with Alzheimer's disease and dementia. The Activity Director stated the facility had two areas available for activities, a television area and a Bingo area. The Activity Director stated the two areas were not sufficient and no kitchen was available for food and cooking activities.</p> <p>During the initial tour on 2/11/13 from 10:15 - 10:55 a.m., a television area was noted to contain a television, couches, end tables topped with magazines and a newspaper, and two tall bookcases. On top of one bookcase were eight puzzle boxes and a box labeled "Jenga." The</p>	F 248		

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F 248	<p>Continued From page 14</p> <p>items on top of the bookcase were not accessible to residents who used wheelchairs for mobility purposes.</p> <p>Additionally, non-activity staff were interviewed about their involvement with resident activities on 2/14/13 from 5:47 - 6:10 a.m. with the following results:</p> <p>a. LPN #1 stated she did not help with activities and "They need to do more. It would help with wandering."</p> <p>b. LPN #2 stated she helped get residents to activities but did not help with the actual activities. She stated if a resident refused, she would get a movie started for them in their bedroom.</p> <p>c. CNA #3 stated she helped get residents to activities but did not help with the actual activities because she was too busy with feeding residents and putting them to bed.</p> <p>d. CNA #4 stated she did not help with activities because "I'm just a CNA."</p> <p>e. CNA #5 stated she would help if she were asked but "we're usually pretty busy." CNA #5 stated she was only asked for help one time and that was on 2/11/12 and she helped with fingernail painting and poetry reading because the Activity Director had to go to a meeting.</p> <p>f. CNA #6 stated she did not help with the actual activities and "I just take folks to groups."</p> <p>When asked about the facility's activities, the Administrator stated during an interview on</p>	F 248		

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F 248	Continued From page 15 2/14/13 from 1:08 - 2:00 p.m., he had not been satisfied with the activities for a while and had talked with the Activity Director. The Administrator stated diversion and multi-level activities were also needed. When asked about sufficient areas for activities, the Administrator stated the 400 Hall had four or five large rooms that could be used, and he was not sure why the rooms were not being used. When asked about staffing, the Administrator stated they recently added a staff for weekends. The facility failed to ensure activities were based on residents' interests, there was sufficient space to conduct activities, and that there was enough staffing resource allocated to activities to meet the needs of the residents.	F 248		03/20/13
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, it was determined the facility failed to ensure social services were provided for 6 of 11 residents who attended a resident group interview with surveyors and 5 of 5 residents (Residents #18 - #22) whose care plan conference notes were reviewed. This resulted in the potential for medically-related social service needs to go unmet. The findings include:	F 250	<u>250</u> Affected Residents: On or before 03/20/13, resident #18, and their responsible party if applicable, will be invited by the Social Service Director to and attended a care plan conference with the Interdisciplinary team. On or before 03/20/13, resident #19, and their responsible party if applicable, will be invited by the Social Service Director to and attended a care plan conference with the Interdisciplinary team. On or before 03/20/13, resident #20, and their responsible party if applicable, will be invited by the Social Service Director to and attended a care plan conference with the Interdisciplinary team. On or before 03/20/13, resident #21, and their responsible party if applicable, will be invited by the Social Service Director to and attended a care plan conference with the Interdisciplinary team. On or before 03/20/13, resident #22, and their responsible party if applicable, will be invited by the Social Service Director to and attended a care plan conference with the Interdisciplinary team. On or before 03/20/13, resident #23, and their responsible party if applicable, will be invited by the Social Service Director to and attended a care plan conference with the Interdisciplinary team.	

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F 250	<p>Continued From page 16</p> <p>1. An interview with the Resident Group was held on 2/12/13 from 1:30 - 2:38 p.m. During that time, 6 of 11 residents expressed a lack of knowledge about care planning conferences.</p> <p>When asked for evidence of care planning conferences, and family notification and participation from 1/2012 to 2/13/13, the Social Services Specialist provided Interdisciplinary Progress Notes on five residents that contained inconsistent documentation of care planning conferences, and family notification and participation, as follows:</p> <p>a. Resident #18: On 9/27/12, a care plan conference was held with 2 family members. It was not documented whether Resident #18 attended the conference.</p> <p>b. Resident #19: On 9/21/12, a care plan conference was held with Resident #19 and a family member.</p> <p>c. Resident #20: On 7/9/12, a care plan conference was held with a family member. It was not documented whether Resident #20 attended the conference.</p> <p>d. Resident #21: On 6/6/12, a care plan conference was held with a family member. It was not documented whether Resident #21 attended the conference. On 8/16/12, a care plan conference was held with a family member. It was not documented whether Resident #21 attended the conference.</p> <p>e. Resident #22: On 12/15/11, a care plan</p>	F 250	<p>Identify Potential</p> <p>On or before 03/20/13, resident medical records were audited by the Social Service's Director to ensure care plan conference meeting notes included the resident and/or responsible party attendance within the last 90 days.</p> <p>On or before 03/20/13, Meetings will be promptly scheduled and invitations will be made to provide identified residents and/or responsible parties a review of the resident's plan of care. Those meetings will be completed on or before 03/20/13.</p> <p>Systematic</p> <p>On or before 3/20/13, The Social Service department will receive education regarding the timeliness of Care Plan meetings and the necessity to document invitation/notification/attendance of residents and/or responsible parties by Administrator.</p> <p>QA Audit</p> <p>Beginning the week of 3/20/13, 3 random residents records will be audited by the Director of Nursing or designee for care plan conference documentation including resident and responsibility invitation and involvement weekly X4 weeks and then monthly X 2 months. The results of these audits will be reported to the Performance Improvement Committee monthly X3 months. The Administrator is responsible for monitoring and follow-up.</p>	

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F 250	Continued From page 17 conference was held with a family member. It was not documented whether Resident #22 attended the conference. When asked about the facility's social services, the Administrator stated during an interview on 2/14/13 from 1:08 - 2:00 p.m., the facility was without a Social Worker from 2/2012 to 12/2012. The Administrator stated relatives were called about care plan conferences and he was not aware of the documentation issue until 2/13/13. The facility failed to ensure social services were provided to residents.	F 250	<u>252</u> Affected Residents: Resident #1's environment was assessed for odor on 2/25/13 by the unit manager, and found to be clean and presentable and odor free. On or before 03/20/13, the resident #1's plan of care will be updated by the Director of Nursing or designee to include offering resident a shower daily by the assigned CNA and for the room and wheelchair to be cleaned 2x a day.	03/20/13
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined that the facility failed to provide an environment free of institutional odors. This was true of 1 of 11 sampled residents (Resident #1). This had the potential to negatively affect how the resident felt about his environment. Findings included: 1. Resident #1 was admitted to the facility on 6/13/11 with multiple diagnoses including paraplegia, osteomyelitis, anemia, proteinuria. He had a Stage II pressure ulcer on his coccyx.	F 252	Identify Potential Residents On 2/25/13, resident room rounds were made by unit manager to identify any other resident rooms experiencing odor issues and to ensure they were maintained in a clean condition. Findings were promptly addressed, with no adverse effects or further resident complaints noted. Systematic On or before 3/20/13, nursing and housekeeping staff were educated by Administrator regarding identification, and implementation of measures to correct odors.	

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NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301
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F 252	<p>Continued From page 18</p> <p>On 2/11/13 at 3:10 pm, during an interview with Resident #1, he indicated that his electric wheelchair was dirty and the person that normally cleaned it had been on vacation. He stated, "Nobody else cleans it".</p> <p>On 2/12/13 at 7:55 am, the surveyor noted a strong smell of urine when entering Resident #1's room to observe morning cares.</p> <p>On 2/13/13 at 10:15 am in Resident #1's room, while observing wound treatment and transfer, the surveyor again noted a strong urine smell upon entering the room.</p> <p>On 2/13/12 at 10:30 am, CNA #12 was interviewed regarding Resident #1. CNA #12 stated "He always has an odor. It smells like urine, I think it's the bed." She indicated Resident #1 would not allow staff to change the mattress and the mattress moved with Resident #1 when he changed rooms. She also indicated that Resident #1 used a urinal and frequently spilled the urinal on the floor and bed.</p> <p>On 2/13/13 at 2:55 pm, the DON accompanied the surveyor to Resident's #1's room and was asked about the strong urine smell. She stated that Resident #1 had a history of a strong urine smell and she would provide documentation of interventions. She later provided the following documentation: 1) Therapy Inservice Document dated 12/27/12, stated in part "Please make sure to wipe down his scooter if any urine is noted to be on the seat or foot rest." 2) Interdisciplinary Progress Notes:</p>	F 252	<p>QA Audit</p> <p>Beginning the week of 3/20/13, the Administrator or designee will audit rooms for odors and cleanliness of wheelchairs weekly for four weeks and monthly for four months, and plans for odor control will be created as needed. The results of these audits will be reported to the Performance Improvement Committee monthly X 3 months. The Administrator is responsible for monitoring and oversight.</p>	
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F 252	<p>Continued From page 19</p> <p>a) "1/22/13Also discussed issue with toileting, bathing, res[resident] agreeable to take bath & change clothing whenever needed."</p> <p>b) "1/27/13 late entry He self-toilets, has accidents but denies that he needs changed or bathed."</p> <p>3) Physician Progress Notes dated 8/7/12, "2. Strong odor of urine-May trial chlorophyll tabs QD (every day)."</p> <p>4) Care Plan with revision date of 12/18/12: "Urinary incontinence related to: Impaired Mobility, Physical Limitations, hx [history] of proteinuria increased alt[alteration] strong urine 2/1/13 Goal: Will have no skin breakdown related to incontinence. To be clean, dry and odor free Interventions: Medication as per MD order for malodorous urine Offer assistance with toileting before meals, upon rising in the mornings, HS (at bed time), and before activities Incontinence care as needed Provide peri [perineum]-care after each incontinent episode Note any changes in amount, frequency, color or odor. Report abnormalities to Licensed Nurse. Clean room daily"</p> <p>On 2/14/13 at 1:00 pm, meeting was held with DON and nurse consultant regarding the strong urine smell with Resident #1 and his room. They were informed that Resident #1 indicated when the person who cleans his electric wheelchair was not there, his wheelchair did not get cleaned. They both indicated that they were not aware of this, and did not believe this to be true. The DON provided a schedule of showers for Resident #1. The housekeeping supervisor was present and</p>	F 252		

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F 252	Continued From page 20 provided a cleaning schedule for the rooms.	F 252		
F 253 SS=E	<p>The facility failed to provide an odor free environment for Resident #1.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain the tile floor in 1 of 2 shower rooms in good repair. This affected 3 of 11 (#s 2, 9, & 11) sampled residents and had the potential to affect all residents who showered or bathed in the 200 hall shower room. Findings included: On 2/13/13 at 2:55 p.m. 15 tiles were cracked and 3 tiles were missing on the floor of the shower area in the 200 hall shower room. The dimensions of the shower floor area were approximately 6 feet by 8 feet. The Maintenance Supervisor stated, "We put a new floor in the rest of this room but the tiles in the shower floor area need replaced." On 2/15/13 at 11:00 a.m., the Administrator and the DON were informed of the finding. The facility did not provide any additional information.</p>	F 253	<p>253</p> <p>Affected Residents:</p> <p>The damaged floor area in the 200-hall bathroom will be repaired on or before 3/20/13 by the Director of Maintenance.</p> <p>Resident # 2 was discharged on 03/03/13. Resident #9 was discharged on 03/03/13.</p> <p>Resident #11 was assessed by the licensed nurse on or before 3/20/13 without adverse effects or complaints post use of identified shower room.</p> <p>Identify Potential Residents</p> <p>Shower rooms will be inspected for needed repairs on or before 3/20/13. Repairs will be completed as identified by the Director of Maintenance on or before 3/20/13.</p> <p>Systematic</p> <p>On or before 3/20/13, facility Maintenance Director will receive education provided by the Administrator regarding the need to identify and repair damaged floor areas.</p>	03/20/13
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the</p>	F 278	<p>QA Audit</p> <p>Beginning the week of 3/20/13 shower and bath areas will be audited weekly by the Administrator or designee X4 weeks and, then monthly for three months. For needed repairs, the results of these audits will be reported to</p>	

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F 278	<p>Continued From page 21 resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure MDS assessments were accurate. This was true for 1 of 7 sample residents (#4). Resident #4's MDS did not accurately reflect the resident status related to pain, falls, and pressure ulcers. This failure created the potential for inadequate care planning to meet the resident's</p>	F 278	<p>the Performance Improvement Committee monthly X 3 months. The Administrator is responsible for monitoring and Follow up.</p> <p>278</p> <p>Affected Residents:</p> <p>Resident #4 was discharged on 02/14/13.</p> <p>Identify Potential Residents</p> <p>On 3/1/13 the MDS coordinator completed an audit of MDS's completed within the last 30 days for accuracy in coding as it relates to pain, pressure ulcers, and falls Modifications and care plan updates were completed as indicated.</p> <p>Systematic</p> <p>On or before 3/20/13, the MDS Coordinator, Unit Managers, and DON will be educated by Manager of Clinical Operations or designee regarding accuracy of the MDS, Care Plan, and Nursing Documentation</p> <p>QA Audit:</p> <p>Beginning the week of 3/20/13 an audit of 3 random MDSs will be conducted for accuracy by the Director of Nursing or Designee weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the PI committee monthly X3 months. The Administrator is responsible for monitoring and follow up.</p>	03/20/13

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F 278	<p>Continued From page 22</p> <p>needs related to pain, falls, and pressure ulcers which could result in harm to the resident. Findings included:</p> <p>Resident #4 was admitted to the facility on 1/18/13 with diagnoses that included sacral and bilateral heel pressure ulcers (PU), neurogenic bladder, and hypothyroidism.</p> <p>The resident's admission MDS assessment, dated 1/28/13, coded, in part:</p> <ul style="list-style-type: none"> * J0300 Pain Presence - no; * J1800 Any Falls Since Admission - no; and * M0150 Risk of Pressure Ulcers - no. <p>However, review of the Resident #4's clinical record revealed the following documentation:</p> <ul style="list-style-type: none"> * the resident's pain level was 4-5 (on a 0-10 scale) daily during the 5 day look back period and PRN (as needed) pain medications were administered during the same time frame; * a fall on 1/24/13; and * pressure ulcers on both heels and the sacrum were present on admission and a 1/18/13 Norton Plus Pressure Ulcer Scale with a Total Norton Plus Score of 16 (11-15 = moderate risk and 10 and below = high risk). <p>On 2/11/13 at 4:15 p.m., LN #8 was observed as she performed wound care and dressing changes to the pressure ulcers on Resident #4's heels and sacrum.</p> <p>On 2/14/13 at 9:00 a.m., the MDS nurse, was interviewed about Resident #4's MDS coding. Regarding J0300, the MDS nurse stated, "The resident said she did not have pain when I interviewed her. I stopped there." Regarding</p>	F 278		

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F 278	Continued From page 23 J1800, the MDS nurse stated, "That's an error. I will submit a correction." And, regarding M0150, the MDS nurse stated, "I go by the Norton (pressure ulcer risk assessment)."	F 278	279 Affected Residents: Resident #4 was discharged on 02/14/13. Identify Potential Residents On or before 2/28/13, an audit of comprehensive minimum data set assessments completed within the last 30 days will be conducted by the MDS coordinator or Unit Manager to ensure that triggered areas were addressed on the resident's care plan. Plans of care were updated as needed. Systematic On or before 3/20/13, the Case Manager, Unit managers, and DON will be educated by the Manager of Clinical Operations or designee regarding accuracy of the MDS, Care Plan, and Nursing Documentation QA Audit Beginning the week of 3/20/13 3 random comprehensive MDS will be audited by the Director of Nursing or designee to ensure that triggered areas are care planned. The audits will occur weekly x4 weeks and then monthly X 2 months. The results of these audits will be reported to the Performance Improvement Committee monthly X3 months. The Administrator is responsible for monitoring and oversight.	03/20/13
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it	F 279		

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F 279	<p>Continued From page 24</p> <p>was determined the facility failed to ensure all areas triggered by the RAI process and identified by the facility as care planned were actually care planned. This was true for 1 of 7 (#4) sample residents. Specifically, Resident #4's care plan did not include self-care deficit/ADL status, dental status, and psychotropic drug use. This failure created the potential for harm when staff did not have the instructions and direction to meet the resident's needs related to ADL, dental, and hypnotic medication use for insomnia. Findings included:</p> <p>Resident #4 was admitted to the facility on 1/18/13 with diagnoses that included sacral and bilateral heel pressure ulcers (PU), neurogenic bladder, and hypothyroidism.</p> <p>The resident's admission MDS assessment, dated 1/28/13, coded, in part:</p> <ul style="list-style-type: none"> * intact cognitive skills with a BIMS score of 15; * limited assistance of 1 person for bed mobility/transfers/dressing/personal hygiene; * extensive assistance of 1 person for walk in room/locomotion on and off unit/toilet use; * total dependence of 1 person for bathing; * broken or loosely fitting full or partial denture; * no natural teeth or tooth fragment(s) (edentulous); and * received hypnotic 4 of the last 7 days.. <p>Section V, the Care Area Assessment (CAA) Summary, of Resident #4's 1/28/13 MDS included checkmarks in the triggered and care planned columns for ADL Functional/Rehabilitation Potential, Dental Care, and Psychotropic Drug Use.</p>	F 279		

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F 279	Continued From page 25 The resident's CAA Worksheets included the following documentation: * ADL Functional/Rehabilitation Potential - Analysis of Findings: "...needing limited to extensive assist with ADL cares..." Care Plan Considerations: "See self care deficit care plan." * Dental Care - Analysis of Findings: "...no natural teeth or bone fragments. ...upper and lower dentures. Nurses notes 1/24/13 indicate dentures are ill fitting, noted to have lesions in mouth under dentures. Fixadent to be used and if no improvement will request dental consult. Care Plan Considerations: "See self care deficit care plan." * Psychotropic Drug Use - Analysis of Findings: "...order to take ambien [sic] 10 mg [milligrams]... [4 times a week] to treat...insomnia..." Review of Resident #4's clinical record revealed that the care plan, dated 1/21/13 through 2/10/13, did not include self-care deficit/ADL, dental, or psychotropic drug use. On 2/14/13 at 9:00 a.m., when asked about the aforementioned missing care plan areas, the MDS nurse viewed Resident #4's care plan on the computer then stated, "It's not here." The MDS nurse indicated that he would generate care plans for the missing areas right away. On 2/14/13 at 3:30 p.m., the Administrator, DNS, Nurse Consultant, and Regional Vice President were informed of the finding. No other information or documentation was received from the facility that resolved the issue.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	<u>280</u> Affected Residents: On or before 3/7/13, the MDS was reviewed for accuracy and Plan of Care updated to reflect resident# 7's status and care needs by the MDS coordinator Resident #7 was assessed by the Director of Nursing or Designee on 3/7/13 for physical or psychosocial harm related visual impairment.	03/20/13

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F 280	<p>Continued From page 26</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to revise a resident's care plan after a Comprehensive Assessment. This was true of 1 out of 11 sampled residents (Resident #7). The resident's care plan did not indicate that the resident was highly visually impaired and had the potential of causing her physical and or psychological harm from unmet needs.</p> <p>1. Resident #7 was a 93 year old woman diagnosed with Alzheimers, anxiety, bipolar, and mood disorder. She was admitted to the facility</p>	F 280	<p>Identify Potential Residents</p> <p>An audit of comprehensive minimum data sets, and assessment tools which were completed within the last 30 days, was conducted by the MDS coordinator on 2/28/13 to ensure that triggered areas have an associated plan of care. Care plans were updated as indicated.</p> <p>Systematic</p> <p>On or before 3/20/13, the Case Manager, Unit Managers, and DON will receive in-serviced by Manager of Clinical Operations regarding accuracy of the MDS, and updating the plan of care per the triggered CAA and nursing documentation.</p> <p>QA Audit</p> <p>Beginning the week of 3/20/13 an audit of 3 random comprehensive minimum data sets will be completed by the Director of Nurses or designee to ensure that triggered areas have an associated plan of care developed for the resident. These audits will occur weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement committee X3 months. The Director of Nursing is responsible for monitoring and follow-up.</p>	

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F 280	Continued From page 27 on 9/25/07. Resident's #7 Annual MDS assessment, was dated 10/14/2012, and was coded as: * Highly Impaired Vision Note: The CAA (Care Area Assessment) Worksheet dated 10/25/12 indicates that vision was triggered and would be care planned. The Resident's #7 Quarterly MDS assessment, was dated 2/6/2013, and was coded as: *Highly Impaired Vision The facility provided Resident #7's care plan, dated 11/21/12. However, it did not include a vision problem. On 2/14/13 at 9:05 am, the surveyor interviewed the MDS Coordinator regarding the MDS, CAA, and care plan for Resident #7. The MDS Coordinator stated that vision should have been on the care plan but it wasn't. He indicated that he was not present when the Annual MDS was initiated and vision was left off the care plan. He stated that he had recently added the vision problem to the care plan after the MDS was done on 2/6/13. The facility failed to ensure that Resident #7's care plan included a vision problem, after the MDS indicated there was a vision impairment and that vision would be care planned.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	281 Affected Residents: On 2/14/13, the Medication Administration Record for resident #4 was corrected to reflect the ordered dose of Lanoxin which was being administered by the unit manager. There were no adverse effects to Resident #4 as the prescribed medication and dose was actually administered.	03/20/13

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F 281	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility to ensure the dose for Lanoxin (a cardiac medication) was accurate. This was true for 1 of 7 (#4) sample residents. This failure created the potential for the resident to receive double the amount of Lanoxin prescribed which could lead to life threatening toxic effects and require immediate medical attention. Findings included:</p> <p>Note: Potter and Perry's Fundamentals of Nursing, 7th edition, 2009, Medication Administration, page 707 states, "... The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation[.]" In addition, according to Perry & Potter's, Clinical Nursing Skills & Techniques, 7th Edition, 2010, "A medication order is required for any drug you administer to a patient. ...Regardless of how you receive the order, you compare the prescriber's written orders with the MAR when the medication is initially ordered. Also verify medication information whenever new MARs are written...Transcription errors are one of the most common sources of medication errors..."</p> <p>Resident #4 was admitted to the facility on 1/18/13 with diagnoses that included sacral and bilateral heel pressure ulcers (PU), neurogenic bladder, atrial fibrillation, and hypothyroidism.</p> <p>On 2/12/13 at 8:45 a.m., LN #13 was observed as</p>	F 281	<p>Identify Potential Residents</p> <p>On or before 3/20/13, Medication Administration Records will be compared with physician orders to ensure there are no discrepancies. Clarifications completed as needed.</p> <p>Systematic</p> <p>On or before 3/20/13, licensed nurses were reeducated on transcribing physician orders and medication administration.</p> <p>QA Audit</p> <p>Beginning the week of 3/20/13 5 random resident records will be audited by the Director of Nursing or designee to ensure that the physician orders are correctly transcribed on to the MAR. These audits will occur weekly X4 weeks and then monthly X2months. The results of these audits will be reported to the Performance Improvement Committee X3 months. The Director of Nursing is responsible for monitoring and oversight.</p> <p>Beginning the week of 3/20/13 , a medication pass will be audited 1x per week for 4 weeks, and monthly for 2 months. The results of these audits will be reported to the Performance Improvement Committee X3 months. The Director of Nursing is responsible for monitoring and oversight.</p>	

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F 281	<p>Continued From page 29</p> <p>she poured and administered Lanoxin 0.125 mg 1/2 tablet to Resident #4. The medication was 1/2 of a round, yellow tablet.</p> <p>Note: The pharmacy label on the Lanoxin 0.125 mg bubble pack instructed 1/2 tablet every day.</p> <p>The next morning, however, reconciliation with the February recapitulation (recap) of Active Orders, revealed a different order for Resident #4's Lanoxin. The recap order documented, "Lanoxin (Digoxin) 0.125 mg Tablet By mouth (oral) - Before morning meal Everyday: Q [every] day." The order/start date was 1/18/13.</p> <p>Further review of Resident #4's clinical record revealed that the admission orders, dated 1/18/13, documented, "Lanoxin 0.125 mg [milligrams] tabs [tablets] (Digoxin) 1/2 tablet by mouth daily."</p> <p>Note: No other Lanoxin orders were found in resident's clinical record.</p> <p>In addition, the January and February 2013 MARs documented that Lanoxin 0.125 mg was administered to the resident daily from 1/19 to 2/12/13.</p> <p>Note: Somehow, the Lanoxin 0.125 mg dose was changed from 1/2 tablet daily on the admission orders to 1 tablet daily on the February recap orders and both MARs.</p> <p>On 2/13/13 at about 10:00 a.m., when asked about Resident #4's Lanoxin, the Medicare Hall Unit Manager (UM) compared the resident's admission physician orders to the February recap orders and the MARs. The UM acknowledged the discrepancy between the admission and recap</p>	F 281			

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F 281	Continued From page 30 physician orders for Lanoxin and stated she would contact the resident's physician and the pharmacy immediately for clarification. At 11:10 a.m., the UM stated Resident #4's physician's office nurse clarified the Lanoxin order as Lanoxin 0.125 mg 1/2 tablet, or 0.0625 mg, daily and a clarification order was written. The UM also stated the pharmacist confirmed that the Lanoxin bubble pack contained 1/2 tablets of the 0.125 mg strength (yellow) tablets. The UM stated that the Lanoxin order was incorrectly transcribed from the beginning but the resident had received the correct dosage. Later that afternoon, the UM provided a physician's order, dated 2/13/13, and a revised February MAR that documented, "Lanoxin (Digoxin) 0.125 mg tablet by mouth (oral) - daily everyday. Give 1/2 tab to equal 0.0625 mg." The facility failed to compare the pharmacy label for Resident #4's Lanoxin to the MAR and therefore did not recognize the discrepancy between the two when they administered the potentially toxic medication to the resident. On 2/14/13 at 3:30 p.m., the Administrator, DNS, Nurse Consultant, and Regional Vice President were informed of the issue. However, no other information or documentation was received from the facility.	F 281			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	<u>309</u> Affected Residents: Resident# 8's skin, including, but not limited to fingers and hands, was assessed by the Unit Manager on 03/06/13, with no new skin issues noted, and the surgical site healing as expected by the physician. Resident denies any complaints of at this time.	03/20/13	

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F 309	<p>Continued From page 31</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, it was determined the facility failed to perform a physician ordered skin assessment and accurately assess the condition of the resident's skin after the resident's right hand was injured during a fall. This affected 1 of 8 (#8) sampled residents. This failed practice resulted in harm to Resident #8 when the condition of the resident's right ring finger deteriorated and required amputation. Findings included:</p> <p>Resident #8 was admitted to the facility on 11/10/10 and most recently readmitted on 9/21/12 with multiple diagnoses including diabetes, end stage renal disease, muscular wasting and disuse atrophy, cellulitis and abscess of unspecified site, polyneuropathy in diabetes, bipolar disorder, lower limb amputation toe, personal history of methicillin resistant staphylococcus, and ankle and foot osteomyelitis.</p> <p>The resident's 10/19/12 annual and 1/17/13 quarterly MDS assessments both coded cognitively intact and no rejection of cares.</p> <p>Resident #8's All Active Orders for December 2012 (recapitulation) contained, in part, - Skin Assessment (every) Wednesday's - Evening Shift Wednesday</p>	F 309	<p>Identify Potential Residents</p> <p>On 2/28/13, an audit of residents TARS for completed skin checks over the last 30 days were completed by the Director of Nursing or designee. Follow-up was completed as needed.</p> <p>Resident's skin will be assessed by the Director of Nursing or designee on or before 3/20/13. Additional skin checks and follow up will be completed as needed.</p> <p>Systematic</p> <p>On or before 3/20/13, licensed nurses will receive education completed by the Director of Nursing on skin assessments, to include but not be limited to, assessing hands and fingers post incidents for break in skin integrity, and the necessity for thorough and complete documentation of weekly skin checks</p> <p>QA Audit</p> <p>Beginning the week of 3/20/13 high risk residents, and residents with recent incident records, will be audited by the Director of Nursing or designee to ensure timely and accurate completion of skin checks weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee monthly X3 months for review. The Director of Nursing is responsible for monitoring and oversight.</p>	
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F 309	<p>Continued From page 32</p> <p>Resident #8's Care Plan, print date 2/11/2013, documented, in part: Focus area: Alteration in skin integrity. Two of the interventions were, -During cares observe for any changes in skin integrity, ie - bruises, redness, open areas, etc. Report negative findings to licensed nurse. Notify MD prn. Date initiated 12/19/2011. -Weekly skin check by licensed nurse. Date initiated 9/21/2011 Focus area: Abrasion to right ring finger. Res with impaired healing related to ESKD, CHG (may be a typo, Congestive Heart Failure), DM, Neuropathy, occasional non compliance with cares, I&Os, meals, fluid restriction. Date initiated: 12/25/12. Revision on: 2/11/2013. Handwritten entry, 2/11/13, Area determined to begin as small inconspicuous area in bend of right 3rd finger (like paper cut?) and was easily hid by resident due to minute size. Skin check per RN revealed no noticeable skin breaks to fingers when gloves removed.</p> <p>a. According to the facility's Risk Management System (Incident and Accident) reports, Resident #8 was transported to two separate dialysis appointments by a local medical taxi transport company. The same driver drove the transport van for the two appointments, as follows: - On 12/5/12 at 12:45 p.m., the circumstances of the event were documented as, "Resident was at dialysis and on her way back, taxi driver did not tie resident's wheelchair [wc] down appropetiatly {sic} and when she took a turn resident's wc tipped back and resident hit her back on the van door. No injuries noted to resident. Resident</p>	F 309		

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F 309	<p>Continued From page 33</p> <p>denies pain/discomfort. Family and MD notified." The recommendations to prevent further falls section documented, in part, "Taxi driver will be educated on proper way to tie down residents {sic} wheelchair."</p> <p>- On 12/14/12 at 12:00 p.m., "Resident was coming back from dialysis via taxi van, when they took a turn residents wc tipped back and resident hit her back and her head. Taxi driver did not tie residents {sic} wc down properly. Residents neuros [neurological assessments] started and are within normal limits. Family and MD notified." The recommendations to prevent further falls section documented, in part, "Resident will no longer be using taxi company, facility transport will take resident to dialysis. Taxi service was notified of the issue."</p> <p>Resident #8's Change of Condition Documentation form contained, in part, "12/14/12, Was reported to me at 1600 [4:00 p.m.] The res. [resident] was in the taxi [and] it [the taxi] was coming back from dialysis, when the driver went around the corner and res. tipped over back-wards. She hit the back of her head [and] got a skin tear to her [right] knee. Will monitor q day until resolved."</p> <p>Resident #8's InterDisciplinary Progress Notes (IDTPNs), Change of Condition Documentation (CCD) notes, dated 12/14/12 through 2/17/13, were reviewed.</p> <p>- 12/14/12 through 12/24/12, no documentation regarding any injury to Resident #8's right ring finger or right hand as a result of the resident's wc tipping backwards during taxi transport to or from dialysis.</p>	F 309		

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F 309	<p>Continued From page 34</p> <p>- 12/25/12 CCD: Res has an open area between 1st & 2nd phalange of ring finger on right hand... also has a blister on her [right] hand [at] base of index finger both have redness peri wound area & tender to touch. Res stated that wound on right finger occurred during fall while in taxi's care. Area on ring finger 0.5 cm (centimeter) long, 1 cm wide & 0.3 cm deep. Duoderm paste was placed in wound on ring finger & covered [with] steri-gauze [after] being cleansed with NS & gauze. Dressing to be [changed] q 3 days." The MD and Emergency Contact were notified on 12/25/12.</p> <p>NOTE: No documentation on 12/26/12 related to Resident #8's right ring finger or hand.</p> <p>- 12/25/12 1121 (11:21 a.m.) IDTPNs: "... Wound resulted from incident during taxi transport from dialysis, areas found on 12/25/12 at that time resident stated that she got the sore in the taxi and didn't show anybody and kept picking at it..."</p> <p>- 12/27/12 CCD: Wound to in between 1st & 2nd fingers (From mishap "from taxi cab" per resident that occurred on 12/14/12) Has worsened - deep wound base [with] jagged edges - Resident has been encouraged to not propel own w/c [wheelchair] - even though she wear gloves - this still agitates wound." The MD was notified on 12/27/12.</p> <p>- 12/28/12 IDTPNs, in part, UM/DNS reviewed res skin issues to [right] hand. [right] 3rd finger (palm side) proximal knuckle laceration abrasion 1.0 x 0.5 x 0.3 cm, dry [with] slightly macerated edges. Sterile dressing BID [2 times a day] [right] 5th finger (below) on palmside, callous, reddened around, blanches, & tender 0.5 x 0.7 x 0.2 cm [with] dry flaking edges, [no] tenderness. Skin prep to both areas. Res states all 3 areas caused during 'fall' in taxi on 12/14/12 when she suddenly</p>	F 309			

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F 309	<p>Continued From page 35</p> <p>reached & grabbed on to w/c [with] right hand in an attempt to keep from falling.</p> <p>- 12/30/12 0300 (3:00 a.m.) IDTPNs: "... Refused dressing [change] to hand stating she was tired and wanted to go to bed. Existing bandage is D & I [dry & intact]."</p> <p>- 12/31/12 1500 (3:00 p.m.) IDTPNs: "...Finger noted to have lrg [large] area of white macerated {sic} skin, area of yellow/white bed. Unit manager & doctor notified. Orders rec'd [received] to have resident seen in ER & doctor would follow up on Wednesday. Resident transported to ER... @ 1315 [at 1:15 p.m.]."</p> <p>- 12/31/12 1630 (4:30 p.m.) IDTPNs: Resident returned from ER [with] N.O. for ABx [antibiotic] treatment & wet to dry drsg [dressing changes]. Family & doctor notified."</p> <p>- 1/1/13 4:30 a.m. IDTPNs: "... Peri wound macerated [with] yellow white on wound bed ATB [antibiotic] given @ 1800 & 2200 [at 6:00 p.m. & 10:00 p.m.]..."</p> <p>- 1/2/13 1445 (2:45 p.m.) IDTPNs: "... [attending physician's name] in to see resident..."</p> <p>Note: 1/2/13, physician visit, "... right 4th finger lac [laceration] - Staff reports is doing better. Wound care through facility. "</p> <p>- 1/3/13 IDT Cares Review IDTPNs: "... MD in to see res on 1/2/13 for laceration to [right] 4th digit (3rd finger), palm side, which is macerated/ulcerative... Res. is compliant [with] tx & assisting to keep fingers protected... Res also states that she was continually 'picking at her finger' even though she knew she shouldn't have..."</p> <p>- 1/6/13 2200 (10:00 p.m.) IDTPNs: "Finger is red from middle joint to hand. Very tender to touch. Open area extends across whole 'fatty pad' (to palm side) on [right] ring finger. Redness and</p>	F 309		

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F 309	<p>Continued From page 36</p> <p>swelling present. Slough to peri wound. Palm to same hand cont. [continues with] peeling and flaking [with] pink closed skin beneath... Small amount of yellow drainage noted. Center of wound yellow...denies pain to this area."</p> <p>- 1/8/13, Nurse Practitioner visit, "... increased 'dusky' appearance of finger. Continuing 'wet-to-dry' dressing... Right 4th finger - palmar surface [with] eschar, from MIP [metacarpalinterphalangeal joint] to mid finger, several gauze fibers in eschar. No drainage. Cap [capillary] refill [in] 3-5 seconds... Apply moist dressing to soften eschar & remove gauze fibers... Refer to [consultation physician's name] for consult/eval [consultation/evaluation]."</p> <p>- 1/10/13, physician consultation. Open wound [right] 3rd finger (palmar side): Whirlpool daily & sharp debridement daily. Cover with light nonstick dressing. Follow up in office on 1/6/13. NOTE: Resident #8's PT notes provided evidence of daily whirlpool and sharp debridement.</p> <p>- 1/17/13, physician consultation. Wound looks much cleaner, 1.5 x 1.5 cm area of skin has questionable viability. Fingertip still somewhat dusky, capillary refill adequate. Continue daily whirlpool and debridement.</p> <p>- physician Report of Consultation not dated. "Recommendations amputation RRF [right ring finger at surgery center name] 1/29/13 @ 2:00 [p.m.]. Whirlpool every day until surgery."</p> <p>- 1/30/13 attending physician note. "... right fourth finger amputation ... yesterday... reports acceptance of her current condition ..no suicidal ideation and good pain control..."</p>	F 309		

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F 309	<p>Continued From page 37</p> <p>- 1/30/13 IDT Cares Review IDTPNs: "...On initial skin assessment injury was not noted to hand, however res [resident] stated it was just a 'small cut' when injury found wound on 12/25/13 [12/25/12] which was 11 days after 'taxi' fall. Res states she 'hid the area; did not think anything of it, [and] kept picking at it.' When found on 12/25 [2012] had already formed into open wound."</p> <p>On 2/12/13 at 9:00 a.m., Resident #8 stated, "On 12/14/12, I was riding in the taxi and the straps on the front of my wheelchair were not secure. I went over backwards. When I came back in [the facility] I told the nurses my finger hurt. It cut my middle finger and crushed my right ring finger."</p> <p>On 2/13/13 at 10:00 a.m., the surveyor informed the DON of the concern regarding the amputation of Resident #8's finger. The DON stated on 12/25/12 nursing staff observed the condition of the resident's right hand and finger and the facility started treatments as ordered. [Resident's name] has been non-compliant with diet and fluid restriction and that may have been a contributing factor." The DON also stated on 1/17/13 the wound appeared to be improving then the consultation physician decided to amputate the finger due to non-healing.</p> <p>- At 10:06 a.m., the Administrator stated the facility notified the taxi transport company on 12/5/12 and was assured the driver would be provided the required training to properly secure resident's in wheelchairs.</p> <p>On 2/13/13 at 10:30 a.m., the resident's attending physician stated, "Resident did not tell me about a crush injury to the hand on 12/14/12. I was told</p>	F 309			

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F 309	<p>Continued From page 38 about her picking at her finger."</p> <p>On 2/14/13 at 5:41 a.m., LN #2 was interviewed. LN #2 was the LN who completed the taxi incident report on 12/14/12. The LN stated, "On 12/14/12 the resident told me she bumped her knee and then tipped backwards and hit her head. I asked if she hurt anything else. She said no, did not hurt anything else. I looked at her arms, hands, head, and knees. She never told me when it [injury to finger] happened. I found out after she was receiving treatments. I asked her why she didn't say anything to me. She said it happened when she tipped over backwards in the van. She also said it didn't really start bothering her until around 12/18/12."</p> <p>b. Additionally, prior to the 12/14/12 fall during taxi transport, the resident's physician directed nursing staff to observe an abrasion to Resident #8's right index finger and right thumb on a daily basis.</p> <p>During the survey process, Resident #8 was observed self-propelling her wc through out the facility and wearing fingerless gloves while in wc.</p> <p>Resident #8's All Active Order for December 2012 (recapitulation) contained, in part, - 10/9/12, Nursing to observe abrasion to Rt (right) base of index finger q (every) shift until resolved - Night shift, Day Shift Everyday - 10/9/12, Nursing to observe abrasion to Rt thumb q shift until resolved - Night Shift, Day Shift Everyday - Skin Assessment q Wednesday's - Evening Shift Wednesday</p>	F 309		

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F 309	<p>Continued From page 39</p> <p>Resident #8's December 2012 Treatment Record (TR) contained, in part, a treatment sheet that identified in the far right column.</p> <ul style="list-style-type: none"> - "Nursing to observe abrasion to Rt [right] base of index finger q shift until resolved. Start Date: 10/9/2012" and - "Nursing to observe abrasion to Rt thumb q shift until resolved. Start Date: 10/9/2012." <p>The TR also contained handwritten initials for each day of the month and each shift, "Day and Night."</p> <p>NOTE: The documentation indicated nursing staff observed the resident's right hand on a daily basis twice a day for the abrasion to Rt base of index finger and Rt thumb.</p> <p>Another page of Resident #8's December 2012 TR identified in the far right column:</p> <ul style="list-style-type: none"> -Skin Assessment (every) Wednesday's - this includes making sure that nails are clean and trimmed. Skin is intact = Y, not intact = N. Start Date: 12/29/2011. Evening Shift Every Wed (Wednesday). - 12/5/12, initialed and the letter "N" handwritten - 12/12/12, the entire date block was blank - 12/19/12, initialed, handwritten checkmark, a handwritten circle with a line through the circle indicated "[no]" and handwritten "new." - 12/26/12, initialed, handwritten checkmark, a handwritten circle with a line through the circle indicated "[no]" and handwritten entry "new." <p>In addition on 12/31/12 (Monday), initialed, handwritten entry, "N," and "open."</p> <p>Note: The documentation revealed the resident's skin was not assessed on Wednesday, 12/12/12, and no new areas were identified on 12/19/12</p>	F 309		
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F 309	<p>Continued From page 40 and on 12/26/12.</p> <p>On 2/13/13 at 10:00 a.m., the surveyor informed the DON the treatment sheets did not provide evidence the resident's skin was assessed on 12/12/12 and other weekly skin assessments in December 2012 indicated no new issues until 12/31/12. The DON acknowledged a weekly skin assessment was not documented as completed on 12/12/12. The DON also said the October 2012 orders were written due to calluses on the resident's right hand.</p> <p>On 2/15/13 at 11:00 a.m., the Administrator was informed of the finding. The facility provided additional information however the data provided did not resolve the concern.</p> <p>Resident #8 had doctor orders for nursing staff to assess the resident's right hand on a daily and weekly basis beginning 10/9/12. Nursing staff failed to assess Resident #8's skin on Wednesday 12/12/12.</p> <p>On 12/14/12, the resident was transported to dialysis by a local taxi transport company and sustained a fall when not properly secured. Although nursing staff documented Resident #8's right hand was observed every day on each shift, there was no documentation indicating the compromise of the resident's hand or fingers. On 12/25/12, 11 days after 12/14/12, Resident #8's deteriorated skin condition was documented by nursing staff.</p> <p>The condition of the resident's right ring finger deteriorated. The resident was referred for a dermatology consultation and on 1/29/13 the</p>	F 309			

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F 309	Continued From page 41	F 309			
F 314 SS=G	resident underwent right ring finger amputation. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure a resident having pressure sores received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This was true for 1 of 5 sampled residents (#1) reviewed for pressure ulcer prevention and treatment. Specifically, Resident #1 was harmed when he developed a reoccurring Stage II pressure ulcer to the sacral region and the facility failed to provide the wound treatments at the frequency ordered by the physician. Findings include: Resident #1 was admitted to the facility on 06/13/11 with a Stage IV sacral decubitus ulcer and diagnoses of paraplegia, abnormal posture, osteomyelitis, malnutrition, anemia, proteinuria, pleural effusion, hypothyroidism, and pain. The resident's Annual MDS assessment, dated	F 309 314 F 314	Affected Residents: Resident #1 skin was assessed by Director of Nursing or Designee on 02/20/13. Resident #1's treatment plan was clarified with the physician by Unit manager on 02/20/13 and the treatment record and the plan of care were updated. The pressure ulcer was resolved on 3/07/13. Identify Potential Residents On or before 03/20/13, skin assessments and a review of care plans will be completed by the Director of Nursing or designee for residents identified as high risk for pressure ulcer development to assess skin integrity and ensure prevention measures are in place. Physician notification will be made as needed and treatment orders and plan of care revised as applicable. A review of residents TAR's over the last 30 days treatment records were reviewed by the Director of Nursing or Designee on 3/8/13 to ensure treatments completed per physician orders A review of residents with pressure ulcers was completed by Director of Nursing or Designee on 3/8/13 to ensure that an assessment of the pressure ulcer including measurements was completed weekly. Pressure ulcer assessments and measurements were completed as needed.	03/20/13	

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F 314	<p>Continued From page 42 5/3/2012, coded: * BIMS of 14 indicating cognitively intact * No rejection of care necessary to achieve health and well being * Required extensive assistance of two or more persons for bed mobility, transfer, dressing, and toilet use * Bathing- activity itself did not occur * Mobility device-wheelchair * Urinary continence-frequently incontinent * Bowel continence-always continent * Yes on weight gain of 5% or more in the last month or loss of 10% or more in last 6 months. Weight: 198 * Determination of pressure ulcer risk- "clinical assessment" was coded * Risk of pressure ulcer- No * Unhealed pressure ulcer- No * Skin and ulcer treatments, pressure reducing device for chair, pressure reducing device for bed, and nutrition or hydration intervention (indicating the resident received these interventions)</p> <p>The resident's last quarterly MDS assessment, dated 1/1/2013, coded *BIMS of 15 indicating cognitively intact * Behavior of rejection of care necessary to achieve health and well-being, 1-3 days out of the last 7 days *Requires extensive assistance of two or more persons for bed mobility, transfer, dressing, toilet use, and physical help in part of bathing activity with assistance of 1 person *Mobility device-wheelchair *Urinary continence-frequently incontinent *Bowel continence-occasionally incontinent *Yes on weight gain of 5% or more in the last</p>	F 314	<p>Systematic</p> <p>On or before 03/20/13, Licensed staff will be reeducated by the Director of Nursing or Designee on pressure ulcer assessment including measurements every 7 days, and following physician treatment orders.</p> <p>On or before 03/20/13, nursing staff will be reeducated by the Director of Nursing or designee on pressure ulcer prevention, assessment, and documentation.</p> <p>QA Audit</p> <p>Beginning the week of 3/20/13,an audit of 3 residents determined to be at risk for pressure ulcers, or with pressure ulcers, will be completed by the Director of Nursing or designee for pressure ulcer assessment, weekly skin assessment, and care plan updates to prevent pressure ulcers and to ensure treatment provided as ordered weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee monthly X3 months. The Director of Nursing is responsible for monitoring and follow-up.</p>	

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F 314	<p>Continued From page 43</p> <p>month or loss of 10% or more in last 6 months. Weight 249</p> <ul style="list-style-type: none"> * Determination of pressure ulcer risk- resident has stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device, clinical assessment * Is this resident at risk of developing pressure ulcers?, yes * Unhealed pressure ulcer stage 1 or higher- yes * Number of stage 2 pressure ulcer-1 * Date of oldest Stage 2 pressure ulcer-12/05/2012 * Most severe tissue type for any pressure ulcer-None of the above * Skin and ulcer treatments: pressure reducing device for chair, pressure reducing device for bed, pressure ulcer care, application of nonsurgical dressing. <p>The facility provided Incident and Accident report records. Record dated 12/05/12, regarding Resident #1 states in part: " Event: In House acquired pressure ulcer " " Noted an open area to sacrum (1.9 x 0.9 cm) to sacrum over a large area of scar tissue. Occupational therapy states that they have used a slide board for transfers, and may have caused friction to this area. Therapy and staff have been advised not to use slide board for transfers. "</p> <p>The facility provided a Care Plan revised on 12/18/12 which stated in part: "Potential for alteration in Skin Integrity r/t [related to] history of coccyx decubitus ulcer (stage II), and history of multiple abscesses and osteomyelitis. Dermatitis to left hand (11/24/12 cut to right knee) (12/5/2012 stage II pressure ulcer to sacral area) Actual"</p>	F 314			

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F 314	Continued From page 44 "R/[related to] impaired mobility & skin sensitivity r/t paraplegia, Hx [history] of nutritional deficit, malnutrition, hypoalbuminemia, anemia, incontinence, edema" Goals include: "Risk for skin breakdown will be minimized with current interventions.".... "Stage II pressure ulcer open area will close with out s/s [signs and symptoms] of infection" Interventions include:..... "Observe area for s/s of complications or infection and notify MD" "Treatment as per MD orders" "Report new open areas to LN." "Document on Flow Sheet If skin is intact, mark "Y (yes)". If skin is reddened or has open areas, mark "N (no)". "Weekly skin assessment by licensed nurse." "Encourage and assist resident to turn/reposition with cares and prn [as needed] to prevent prolonged pressure (resident can reposition ind [independently]) Assist with care as needed" Physicians orders dated 2/1/2013 to 2/28/2013 stated in part: "Exuderm to open area to sacral region. Change q [every] 3 days et [and] PRN.-Night Shift Every 3 days" "Nursing to observe open area to sacral region q shift until resolved ensure dressing is in place.-Night Shift, Day Shift Everyday" "SKIN ASSESSMENT QWK [week] INTACT (Y/N) INCLUDES CHECKING THAT ALL NAILS ARE CLIPPED AND CLEAN DAY SHIFT MON.-Day Shift Specific days of week: Mon" On 2/13/13 at 10:15 am, RN#7 was observed changing the dressing on Resident#1's coccyx	F 314		

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F 314	<p>Continued From page 45</p> <p>which revealed two open areas on the sacrum, one above the other. The RN stated the top open area measured 1 cm[centimeter] by 1 cm and lower open area measured 1 cm by 0.6 cm. The RN#7 indicated the lower area was the original pressure ulcer and the top area was "new."</p> <p>The December 2012 TAR states "Exuderm to open area to sacral region. Change q 3 days et PRN. Start date:12/5/2012 Night Shift Every 3 Days" It indicates dressing changes occurred on the 12/5, 12/7, 12/9, 12/11, and 12/28/12 (17 days between treatments).</p> <p>The Pressure Ulcer Documentation Form for December 2012 indicates the Coccyx wound was measured on 12/5, 12/19, and 12/26/12. This shows that the wound was not measured from 12/5/12 to 12/19/12 (14 days between measurement of the wound). Note: There were 8 days between the dressing change on 12/11/12 and the wound measurement done on 12/19/12 and 6 days between the wound measurements on 12/19 and 12/26/12.</p> <p>The January 2013 TAR states "Exuderm to open area to sacral region. Change q 3days et PRN. Start Date: 12/5/2012 Night Shift Every 3 Days. It indicates dressing changes occurred on the 1/2, 1/5, 1/16, 1/18, 1/27 (9 days between treatments), and 1/31/13.</p> <p>The Pressure Ulcer Documentation Form for January 2013 indicates the Coccyx wound was measured on 1/2, 1/10, 1/19, and 1/31/13(12 days between measurement of the wound). Note: There were 5 days between the dressing change on 1/5 and the wound measurement on</p>	F 314		

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F 314	Continued From page 46 1/10, 6 days between the wound measurement on 1/10 to the dressing change on 1/16, there were 8 days between the wound measurement on 1/19 to the dressing change on 1/27, and 4 days between the dressing changes on 1/27 and 1/31/13. The February 2013 TAR states "Exuderm to open area to sacral region. Change q 3days et PRN. Start Date: 12/05/2012 Night Shift Every 3 days. It indicated dressing changes occurred on 2/05 and 2/12/13 (7 days between treatments). The Pressure Ulcer Documentation Form for January 2013 indicates the Coccyx wound was measured on 2/6, 2/13, and 2/14/13. Note: There were 5 days between the wound measurement on 1/31 and the dressing change on 2/5/13 and there were 6 days between the wound measurement on 2/6 and the dressing change on 2/12/13. On 2/13/13 at 3:45 pm surveyor informed DON of observation of two open areas on coccyx and requested all documentation regarding treatments. Resident #1 was harmed when he developed a reoccurring pressure ulcer to his coccyx. The facility failed to provide treatments q 3 days et PRN.-Night Shift Every 3 days per Physician orders and failed to provide documentation that resolved the concern.	F 314	<u>323</u> Affected Residents: Resident #1 was evaluated by therapy related to transfer status on 2/15/13. Resident #1's care plan and care card were updated to reflect current transfer status by the Director of Nursing or Designee on or before 3/20/13. On 03/13/13, resident #1 was assessed by Director of Nursing or Designee for injury after use of standing lift. No injury was noted. On or before 03/20/13, the identified staff that cares for resident #1 were reeducated on residents current transfer status by the Director of Nursing or Designee. Identify Potential Residents On or before 3/20/13. An audit will be conducted by the Director of Nursing or designee of residents who use mechanical devices during transfers. Care plans, care cards were reviewed and rounds were made observing transfers to ensure technique and device used were per plan of care. Follow up will be completed as needed. Systematic Nursing staff will be educated on or before 3/20/13 by the Director of Nursing or designee to review plan of care prior to transferring resident and re-educated on the various mechanical devices with emphasis on only using device noted on plan of care.	03/20/13	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323			

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F 323	<p>Continued From page 47</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined that the facility failed to ensure the resident received adequate supervision and assistance devices (proper lift) to prevent an accident. This was true for 1 of 3 residents (Resident #1) reviewed for falls. Resident #1 was transferred using a Sara lift (sit to stand mechanical lift) after the Interdisciplinary Progress Notes recommend to use a Hoyer lift (total mechanical lift) until results from a therapy screen were available. Findings included:</p> <p>Resident #1 was admitted to the facility on 06/13/11 with a Stage IV sacral decubitus ulcer and diagnoses of paraplegia, abnormal posture, osteomyelitis, malnutrition, anemia, proteinuria, pleural effusion, hypothyroidism, and pain.</p> <p>On 2/12/13 at 7:55, Resident #1 was observed receiving morning cares. CNA#11 & CNA#12 were using a Sara lift to transfer the resident from his bed to his electric wheelchair. The resident almost slipped from the bed and was readjusted before continuing the transfer with the Sara lift.</p> <p>Resident#1's medical record contained in Interdisciplinary Progress Notes in part: "2-09-13 (5:30 pm)-Res [resident] was guided to</p>	F 323	<p>QA Audit</p> <p>Beginning the week of 3/20/13 an audit of 5 resident records requiring transfers via mechanical device will be reviewed to ensure care plan and care cards are up to date and observations will be made to ensure correct device is being used by the Director of Nursing or designee to ensure that residents are being transferred safely. This audit will occur weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee monthly X 3 months. The Director of Nursing is responsible for monitoring and oversight.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
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F 323	<p>Continued From page 48</p> <p>his knee while transferring [with] the Sara Lift. No injuries observed."</p> <p>"2/11/13 (3:55 pm)-Screen sent to therapy to re-evaluate xfer [transfer]status & use of sara lift for xfer. Therapy notified."</p> <p>"2/11/13 (3:55 pm)-Also to use Hoyer lift temporarily until results from Therapy screen."</p> <p>On 2/13/13 at 10:15 am, Resident #1 was observed in his electric wheelchair in his room when RN #7 and CNA#12 entered his room to perform a dressing change to his coccyx. Both RN#7 and CNA#12 performed a transfer from chair to bed and bed to chair using the Sara lift. After exiting the room at 10:30 am, the CNA was interviewed regarding the use of the Sarah lift. When asked if the CNA had been informed that Resident #1 was to be transferred with a Hoyer Lift until physical therapy evaluated, CNA #12 replied, "No, that's a problem, they don't tell us these things".</p> <p>On 2/13/13 at 3:45 pm, the DON was informed that Resident #1 was being transferred using the Sara lift. The DON indicated that the PT referral was just sent on the 11th and the PT had requested a physicians order.</p> <p>The DON provided the following documentation:</p> <ol style="list-style-type: none"> 1. A therapy referral for Resident #1, dated 2/11/13 stated "Needs help with transfers, knees buckled during sara lift xfer [transfer]. Please screen xfer status." 2. A physicians order for Resident #1, dated 2/12/13 stated "PT[physical therapy/OT[occupational therapy] to eval (evaluate) and treat related to transfers". 	F 323		
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F 323	Continued From page 49 3. A mandatory in-service training record dated 2/12/13, Time:(2:15) pm for Resident #1 that read, "As of 2/12/13 Res [resident] is to be Hoyer lift transfer until further notice".... Note: RN#7 had signed the attendance sheet of the in-service on 2/12/13. She assisted with the Sara lift transfer of Resident #1 on 2/13/13, the day after the mandatory Hoyer lift in-service. The facility failed to ensure that Resident #1 received adequate supervision and assistance devices to prevent an accident. Resident #1 experienced a fall from the Sara lift and a Hoyer lift was recommended until a therapy screen. The Sara lift continued to be used after it was noted to use a Hoyer lift for transferring the resident.	F 323	441 Affected Residents: Resident #1 was assessed for signs or symptoms of infection on 2/26/13 by the Unit Manager with no adverse effect post incidents noted. Resident #4 was assessed for signs or symptoms of infection on 2/26/13 by the Unit Manager with no adverse effect post incidents noted. Resident #4 was assessed for signs or symptoms of TB on 2/26/13 by the Unit Manager with none noted.	03/20/13
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	Resident #13 was assessed for signs or symptoms of infection on 2/26/13 by the unit manager with no adverse effect post incidents noted. Resident #7 was assessed for signs and symptoms of infection on 2/26/13 by the unit manager follow up was completed as needed. Identify Potential Residents On 3/5/13, rounds during resident care were completed by the Director of Nursing or Designee to ensure infection control measures are being followed. On 3/8/13, a review of residents who required a 2 step PPD in the last 30 days was	

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F 441	<p>Continued From page 50</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff adhered to standard infection control measures. This was true for 2 of 7 sample residents (#1 and #4), 1 random resident (#13), and 1 of 3 LNs (#7) during Medication Pass observations. Specifically: * Resident #4's "2 Step tuberculin Skin Test (TST)" was not completed. Also, a staff member did not wash her hands after she emptied the resident's urine leg bag then handled the resident's call light. * An LN dropped a pulse oximeter on the floor but did not use a barrier or clean the equipment when she placed it on top of a medication cart then into her scrub top pocket. * The same LN did not use a barrier when she sat</p>	F 441	<p>completed by the Director of Nursing or designee with physician follow up for any missed administration completed.</p> <p>Systematic</p> <p>On or before 3/20/13, center staff will be reeducated by Director of Nursing or Designee regarding infection control precautions including hand washing, when to remove gloves, and cleaning equipment.</p> <p>On or before 03/20/13, licensed staff will be reeducated by the Director of Nursing or Designee on administration and reading of TB tests.</p> <p>QA Audit</p> <p>Beginning the week of 3/20/13, infection control rounds will be completed by the Director of Nursing. These rounds will be completed weekly for 4 weeks and monthly for 3 months.</p> <p>Beginning the week of 3/20/13, new admissions will be audited by the Director of nursing or designee for completion of their two step TB test, or follow up per physician order. This audit will be completed weekly for 4 weeks and monthly for 4 months.</p> <p>The results of these rounds and audits will be reported to the Performance Improvement Committee X3 months for review. The Director of Nursing is responsible for monitoring and follow-up.</p>	
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F 441	<p>Continued From page 51</p> <p>on the floor while she removed an ace bandage off Resident #13's leg or when she placed the used bandage on the floor. The LN also rerolled the bandage for later use.</p> <p>* Two staff members failed to perform hand hygiene after they provided personal care for Resident #1.</p> <p>Failure to complete a TB Skin Test placed other residents and staff with whom Resident #4 came in contact at potential risk for TB. Also, failure to implement standard infection control measures, such as hand hygiene after personal care and handling body fluids, and utilization of a barrier and/or cleansing equipment that was in contact with the floor placed other residents at risk for harm from infections due to transmission of microorganisms. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 1/18/13 with diagnoses that included sacral and bilateral heel pressure ulcers (PU), neurogenic bladder, and hypothyroidism.</p> <p>a) Note: The facility's Tuberculosis Screening & Monitoring policy, dated October 2009, included the following, "Admission 2 Step Tuberculin Skin Test (TST)...Step 1 Administer upon admission, Read within 48-72 hours[,] Step 2 Administer 7 days after step 1, Read within 48-72 hours..."</p> <p>Review of the resident's clinical record revealed a 1/19/13 Interdisciplinary Progress Note that documented, "...PPD [purified protein derivative for TST] given in [right] F. arm [forearm]." However, the results of that TB skin test, nor any other documentation about the 2 Step TB Skin Test was found in the resident's record.</p>	F 441		
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F 441	<p>Continued From page 52</p> <p>On 2/14/13 at 7:40 a.m., the Medicare Hall Unit Manager (UM) was interviewed about Resident #4's TST. The UM reviewed the resident's clinical record then stated, "I couldn't find the results."</p> <p>At 2:25 p.m., the UM stated, "We keep it [TST] in the computer but I couldn't find anything there either."</p> <p>On 2/14/13 at 3:30 p.m., the Administrator, DNS, Nurse Consultant, and Regional Vice President were informed of the infection control issue. However, no other information was received from the facility.</p> <p>b) On 2/11/13 at 2:40 p.m., CNA #9 was observed as she emptied Resident #4's urine leg bag, removed her gloves, then handled the push button end of the resident's call light and clipped the call light onto the resident's clothing before she washed her hands.</p> <p>At 3:20 p.m., CNA #9 was asked about the observation. The CNA acknowledged that she had not washed her hands before she handled the resident's call light. She stated, "I'm sorry."</p> <p>On 2/14/13 at 3:30 p.m., the Administrator, DNS, Nurse Consultant, and Regional Vice President were informed of the infection control issue. However, no other information was received from the facility.</p> <p>2. During a medication pass observation on 2/12/13 at 9:10 a.m., LN #7 dropped a pulse oximeter (measures oxygen saturation levels) on the floor outside Resident #13's room. The LN immediately picked up the oximeter. However,</p>	F 441		

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F 441	<p>Continued From page 53</p> <p>she did not cleanse the oximeter or use a barrier before she placed it on top of a medication cart that was parked outside the resident's room. And, moments later, the LN did not cleanse the oximeter or use a barrier when she placed it into her scrub top pocket.</p> <p>At 9:40 a.m., LN #7 was interviewed. The LN acknowledged the pulse oximeter was contaminated when it dropped on the floor and that she had not cleansed it or used a barrier when she placed it on the medication cart and in her pocket.</p> <p>On 2/14/13 at 3:30 p.m., the Administrator, DNS, Nurse Consultant, and Regional Vice President were informed of the observation. However, no other information was received from the facility.</p> <p>3. During a medication pass observation on 2/12/13 at 9:30 a.m., LN #7 administered a breathing treatment to Resident #13 and while it was going, the LN sat on the floor and unrolled a 6 inch ace bandage off the resident's right leg. The LN did not use a barrier underneath herself, nor, when she placed the unrolled bandage on the floor next to her. The LN rewrapped the resident's right leg with two smaller ace bandages. Then, the LN picked up the 6 inch ace bandage off the floor, got up off the floor, rerolled the 6 inch ace bandage and placed on a table in the room.</p> <p>LN #7 was interviewed immediately afterward. When asked about the 6 inch ace bandage, the LN stated that it would be used on Resident #13's left leg. Also, when informed that use of a barrier was not observed, the LN agreed and stated she</p>	F 441		

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F 441	<p>Continued From page 54</p> <p>would discard the used 6 inch ace bandage and get another one for the resident.</p> <p>On 2/14/13 at 3:30 p.m., the Administrator, DNS, Nurse Consultant, and Regional Vice President were informed of the infection control issue. However, no other information was received from the facility.</p> <p>4. Resident #1 was admitted to the facility on 6/13/11 with multiple diagnoses including paraplegia, osteomyelitis, anemia, and proteinuria. He had a Stage II pressure ulcer on his coccyx on 2/13/13.</p> <p>On 2/13/13 at 10:15 am, RN #7 and CNA #12 were observed preparing Resident #1 for a wound treatment. CNA #12 put her gloves on and used the Sara Lift to transfer the resident from his electric wheelchair to his bed. RN #7 completed the wound treatment while CNA #12 stood by with her gloves on. After the RN completed the wound treatment, CNA#12 provided a barrier cream to the residents buttocks, changed the resident's attends, and pulled his pants up; all with the original gloves still on. Then CNA #12 used the Sara Lift and transferred Resident #1 with the dirty gloves on. After the transfer, she removed her gloves, washed her hands and proceeded to take the Sara Lift out of the residents room.</p> <p>The CNA #12 failed to remove her gloves and wash her hands after providing personal hygiene care for Resident #1, and before using the Sara Lift to transfer the resident.</p>	F 441		

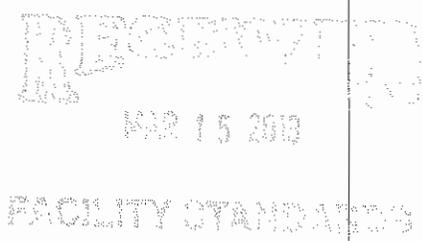
Bureau of Facility Standards

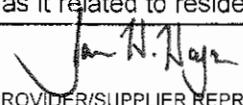
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Linda Kelly, RN Karla Gerleve, RN Monica Nielsen, MEd, QMRP</p>	C 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Ridge Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p>	
C 121	<p>02.100,03,c,v</p> <p>v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; This Rule is not met as evidenced by: Refer to F242.</p>	C 121	<p><u>C121</u></p> <p>See Plan of Correction for F242</p>	
C 125	<p>02.100,03,c,ix</p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it related to resident's dignity.</p>	C 125	<p><u>C125</u></p> <p>See Plan of Correction for F241</p>	


 FACILITY STANDARDS
 MAR 15 2013

Bureau of Facility Standards  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <u>Administrator</u>	(X6) DATE <u>03-14-2013</u>
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C 125	Continued From page 1	C 125		
C 175	02.100,12,f f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F225 as it related to not thoroughly investigating potential abuse or neglect.	C 175	<u>C175</u> See Plan of Correction for F225	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F253 as it related to the floor of the shower area in the 200 hall shower room.	C 361	<u>C361</u> See Plan of Correction for F253	
C 393	02.120,04,b b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The	C 393	<u>C393</u> See Plan of Correction for F246	

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C 393	Continued From page 2 activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F246 as it related to call light accessibility.	C 393		
C 644	02.150,01,a,i a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it related to standard precautions for infection control.	C 644	C644 See Plan of Correction for F441	
C 664	02.150,02,a a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control meeting minutes, it was determined the facility failed to ensure committee members regularly attended Infection Control Meetings. Specifically, the Medical Director and Pharmacist did not sign the attendance record for any of the meetings in 2012; and, the Administrator, Dietary Services Supervisor, Infection Preventionist, a housekeeping representative, and a maintenance representative	C 664	C664 On 03/05/13, an Infection Committee Meeting was held with all attendees present. On 03/05/13, the Infection Control Committee members received in-service regarding the need to maintain regular attendance. Scheduling and notification of Infection Control Committee meetings shall be the responsibility of the Director of Nursing.	03/20/13

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NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CARE & REHABILITATION CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 640 FILER AVENUE WEST TWIN FALLS, ID 83301		
(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) COMPLETE DATE
C 664	<p>Continued From page 3</p> <p>did not sign the attendance records on a regular basis. This had the potential to negatively affect all residents, staff and visitors in the facility when key committee members were not involved in the Infection Control meetings. Findings included:</p> <p>On 2/14/13 at 11:30 a.m., the DNS was interviewed regarding the facility's Infection Control program. The DNS said she shared the Infection Preventionist (IP) position with the Medicare Hall Unit Manager. The DNS also indicated that she had accepted the shared IP position a few weeks ago. When asked about Infection Control (IC) meetings, the IP stated the meetings were conducted quarterly during Performance Improvement meetings. The IP was asked to provide only the minutes and attendance records for the last 4 IC meetings. The IP agreed and said she would inform the Administrator of the request.</p> <p>On 2/14/13 at about 3:45 p.m., the facility's Nurse Consultant stated they realized some of the IC committee members had not signed the attendance records.</p> <p>On 2/15/13 at 11:45 a.m., the Administrator provided a copies of IC meeting minutes and attendance records for 4/26/12, 6/29/13, 7/27/12, and 11/30/12.</p> <p>Review of the attendance records for the aforementioned IC meeting dates revealed the following committee members did not sign as attended as follows:</p> <ul style="list-style-type: none"> * The Medical Director - did not sign any of the attendance records; * Pharmacist - did not sign any of the attendance records; * Dietary Services Supervisor - did not sign 3 of 4 	C 664	<p>Meeting minutes and attendance records shall be monitored by the Administrator at each meeting.</p>	

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C 664	Continued From page 4 attendance records; * Maintenance representative - did not sign 3 of 4 attendance records; * Housekeeping representative - did not sign 3 of 4 attendance records; * Administrator - did not sign 1 of 4 attendance records; and * IP - did not sign 1 of 4 attendance records. No other information or documentation was received from the facility.	C 664		
C 674	02.151.01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248.	C 674	C674 See Plan of Correction for F248	
C 778	02.200.03,a PATIENT/RESIDENT CARE 03. Patient/Resident Care. a. A patient/resident plan of	C 778	C778 See Plan of Correction for F279	

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C 778	Continued From page 5 care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Refer to F279 as it related to initial care planning.	C 778		
C 788	02.200,03,b,iv iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F281 as it related to the professional standards regarding medication administration.	C 788	<u>C788</u> See Plan of Correction for F281	
C 813	02.200,05,a a. The results of a T.B. skin test shall be established for each patient/resident upon admission. If the status is not known upon admission, a T.B. skin test shall be done as soon as possible, but no longer than thirty (30) days after admission. This Rule is not met as evidenced by: Refer to F441 as it related to screening for TB (tuberculosis).	C 813	<u>C813</u> See Plan of Correction for 441	
C 882	02.203,02,a a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service	C 882	<u>C882</u> On 02/27/13, the Health Information Manager secured a cause of death form and set up a book for each nurse's station containing blank forms.	03/20/13

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C 882	<p>Continued From page 6</p> <p>(if applicable); name; address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure that a final diagnosis, or cause of death, was documented in a resident's closed medical record. This was true for 1 of 1 closed records (#12) reviewed. Findings include:</p> <p>Resident #12 was admitted to the facility on 1/7/11 with diagnoses that included malignant neoplasm (cancer) of the bladder and unspecified circulatory disease. The resident died in the facility on 11/2/12.</p> <p>On 2/14/13 at 2:00 p.m., Resident #12's closed record was reviewed. However, a final diagnosis, or cause of death was not found in the record.</p> <p>At 2:15 p.m., the Medical Records Director (MRD) was asked for documentation regarding the resident's final diagnosis, or cause of death. The MRD stated, "The facility does not keep cause of death with physician signature in the medical record."</p> <p>On 2/14/13, at 3:30 p.m., the Administrator, the DNS, Nurse Consultant, and Regional Vice President were informed of the issue. However, no other information was received from the</p>	C 882	<p>On or before 03/20/13, licensed nurses will be inserviced regarding the need to obtain signed cause of death certificates from physicians.</p> <p>The Health Information Manager will monitor the completion of the cause of death certificates and report during the daily clinical stand-up meeting.</p>	

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C 882	Continued From page 7 facility.	C 882		
C 887	02.203,02,f f. Progress notes by physicians, nurses, physical therapists, social worker, dietitian, and other health care personnel shall be recorded indicating observations to provide a full descriptive, chronological picture of the patient/resident during his stay in the facility. The writer shall date and sign each entry stating his specialty. This Rule is not met as evidenced by: Refer to F250.	C 887	<u>C887</u> See Plan of Correction for F250	