



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 4044 7502

March 11, 2013

Julie J. Johansen, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Johansen:

On **March 1, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Prestige Care & Rehabilitation - The Orchards 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should

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sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 25, 2013**. Failure to submit an acceptable PoC by **March 25, 2013**, may result in the imposition of civil monetary penalties by **April 15, 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **April 5, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 5, 2013**. A change in the seriousness of the deficiencies on **April 5, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 5, 2013** includes the following:

Denial of payment for new admissions effective **June 1, 2013**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 1, 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, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

Julie J. Johansen, Administrator

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If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 1, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **March 25, 2013**. If your request for informal dispute resolution is received after **March 25, 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,



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

LT/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135103	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/1/2013
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCF	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 281	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure LNs adhered to professional standards of quality when 2 of 4 LNs pre-initialed medications as administered before the medications were actually administered. This was true for 2 of 8 residents (#17 and #18) during medication pass observations. The failed practice created the potential for medication errors. Findings included:</p> <p>Note: Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."</p> <p>1. On 2/26/13, at 7:25 a.m., LN #1 was observed as she drew up Novolog insulin 2 units for Resident #17 and initialed the medication as administered on the resident's MAR. Then, the LN administered the insulin medication per subcutaneous (SQ) injection into the resident's right arm.</p> <p>2. On 2/26/13 at 11:50 a.m., LN #2 was observed as she drew up Novolog insulin 2 units for Resident #18 and initialed the medication as administered on the resident's MAR. Then, the LN administered the insulin medication, per SQ injection, into the resident's right abdomen.</p> <p>LN #2 was interviewed immediately afterward. The LN confirmed that she had initialed the Novolog insulin as administered before she actually administered it. The LN stated, "Because I knew she would take it."</p> <p>On 2/28/13 at 5:30 p.m., the Administrator and DNS were informed of all of the issue. However, no other information or documentation was received from the facility that resolved the issue.</p> <p>No residents were harmed as a result of this tag. Services provided or arranged by the facility meet profession standards of quality.</p> <p>1) Corrective Action: Licensed Nurses (LN's) were re-educated on the six rights of Administration of Medication by the DNS or designee. Copy of In-service attached as [redacted] In-services will also be scheduled quarterly. A copy of the calendar for the year is attached as [redacted] # 2</p> <p>2) How will other residents affected be identified: Medication Pass Audit has been completed on current LN's by the RCM's or designee. Copy of audits are to be forwarded to the DNS for review and follow up if needed. Copy of Audit is attached as [redacted] # 15</p> <p>3) What measure or systematic change will be put in to place: Medication pass audits and quarterly in services on professional standards of Medication Administration to be done by the DNS or designee.</p> <p>4) Monitoring: Current LN's will be audited in two weeks starting on 3/18/2013. The beginning of the second quarter, April 2013 two LNs will be audited monthly until the beginning of the third quarter July 2013. During the third quarter two LNs will be monitored monthly until October 2013 the beginning of the fourth quarter. For the fourth quarter two LNs will be monitored monthly. The DNS will present findings of the audit results to the QA committee to identify opportunities for performance improvement. The Administrator will ensure compliance.</p>
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Ex #7

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution protection to the patients. (See instructions.) Except for nursing homes, the findings stated above For nursing homes, the above findings and plans of correction are disclosable 14 days following

Date of Correction 3/18/2013

ufficient
is provided.
an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/01/2013
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	The following deficiencies were cited during the annual recertification/complaint survey of your facility.			
	The surveyors conducting the survey were: Sherri Case, LSW, QMRP, Team Coordinator Linda Kelly, RN Karla Gerleve, RN Jim Troutfeter, MEd, QMRP			
	Survey Definitions: BFS = Bureau of Facility Standards CNA = Certified Nurse Aide DM = Diabetes Mellitus DON/DNS = Director of Nursing/Director Nursing Service IDT = InterDisciplinary Team LN = Licensed Nurse MAR = Medication Administration Record MDS - Minimum Data Set assessment CP= Plan of Care RCM = Resident Care Manager TAR = Treatment Administration Record			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157	F157	
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment		No residents were harmed as a result of this tag. The facility promptly ensures a resident's physician is immediately notified when the resident's pain medication is determined not to be effective. 1)Corrective Action: Resident #14 was discharged from the facility on 12/26/2012. On 3/18/2013 Licensed Staff (LN's) were re-educated the assessment of, documentation, and on the Prestige Pain Policy and Procedure that is currently in place since January of 2013. A copy of the in-service is attached [redacted] Quarterly in-services have been scheduled for the assessment.	#1

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

TITLE

(X6) DATE

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 157	<p>Continued From page 1 significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a complaint from the general public received by the Bureau of Facility Standards (BFS) on 1/3/13, staff interview, and record review, it was determined the facility did not ensure a resident's physician was immediately notified when the resident's pain medication was determined not to be effective. This created the potential for inadequate pain management for 1 of 16 (#14) sample residents. Findings include: The complainant stated an identified resident did not have pain medication and only received Tylenol to address pain. Resident #14 was admitted to the facility on</p>	F 157	<p>documentation, understanding and the Prestige Pain P & P. A copy of the in-service calendar is attached [redacted] The Prestige Pain P & P was implemented in January 2013. [redacted] When the resident is admitted to the facility they are placed on alert charting for 72 hours and are monitored for pain on all shifts. If there is <u>no complaint of pain or pain is adequately controlled</u> the resident is removed from alert charting and then monitored by the LN. <u>If pain is not controlled</u> to resident satisfaction the MD will be notified, the resident placed on alert charting and monitored by the Resident Care Manager (RCM) during each morning Managing Acute Condition Change (MACC) Meeting.</p> <p>2) How will other residents which may be affected identified: Audits are completed after admission, quarterly then annually. The resident's entire medical record and plan of care are reviewed. Pain assessment completion and residents current level of pain were added to the audit sheet. The current audit sheet is attached as [redacted] and was put into use on 3/18/2013. MACC meeting takes place every morning. Pain is also addressed and monitored in this meeting. A copy of the policy and procedure is attached as [redacted] Current residents have been interviewed for satisfaction with their pain management and was completed on 3/18/2013. A copy of the in-house check off sheet used for the audit is attached as [redacted]</p> <p>3) What measure or systemic change will be put in place: The implementation of the MACC meeting and the Audit system that is completed 7 days after admission, quarterly and annually; and the complete in house audit completed on 3/18/2013. These systems and policies were addressed in #2 and exhibits are attached.</p> <p>4) Monitoring: The DNS and RCMs will monitor and the Administrator will ensure compliance. MACC meeting takes place five days a week Monday through Friday. Audits of the resident's plan of care and entire chart are done after admission, quarterly, and annually. Attendance at the MACC meeting and changes to the Audit form are in place/use as of 3/18/2013. All findings are reviewed at the monthly Quality Assurance Meeting.</p> <p>Date of Correction: 3/18/2013</p>	#2 #3 #4 #5 #6

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F 157	Continued From page 2 11/23/12 with diagnoses which included pneumonia and chronic pain.	F 157			
	<p>Resident #14's 11/23/12 Physician-Order (recapitulation) included he was to receive Tylenol 325 mg every 4 hours PRN (as needed) for pain.</p> <p>Resident #14's "Admission -PCI-- Initial Pain Questionnaire" documented the observation date was 11/23/12 and the resident was in pain and had a pain level of 4 (with 0 being no pain and 10 being worst pain possible). In the non-verbal expressions of pain the boxes by wrinkled brow and moaning were checked.</p> <p>The resident's PRN Medication Administration Record (MAR) documented the following:</p> <p>11/24/12: 11:30 a.m. - pain level was 7 prior to receiving the Tylenol and 6 after receiving the Tylenol. 7:00 p.m. - pain level was 8 before and 3 after.</p> <p>Resident Progress Notes (PN) document at 8:49 p.m. the resident was medicated with the PRN medication for back pain "with movement." There was no documentation that the resident had been assessed for pain other than the effectiveness of the Tylenol on the MAR.</p> <p>11/25/12: 7:50 pm. - pain level was 8 prior to receiving the one Tylenol tab and 5 after.</p> <p>PN documented "Complains of back pain with movement 8/10 only has Tylenol for pain and this is not helping a lot."</p>				

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F 157	<p>Continued From page 3</p> <p>11/26/12: The PN documented the resident did not complain of pain but did not document he had been assessed for pain.</p> <p>11/27/12: (illegible time) pain level was 10 before Tylenol and effectiveness illegible. (illegible time) - pain level was 7 before Tylenol and 6 after. Noon - pain level was 7 before Tylenol and 6 after.</p> <p>PN documented the resident received the medication for back pain and there were "no further complaint of pain." There was no indication the nurse had actively assessed Resident #14 for pain. The PN only documented the resident had not complained of pain.</p> <p>11/28/12: 3:14 p.m. - 10 before Tylenol and 0 after. (illegible time) -8 before Tylenol and 7 after. Noon - 8 before Tylenol and 7 after. There were initials a fourth medication had been given, however, there was no further documentation (pain level, time etc.).</p> <p>PN at 5:25 a.m. documented the resident received the medication for back pain and there were no further complaints. There was no indication the nurse had assessed the resident for pain. The PN only documented the resident had not complained of pain. A 7:32 p.m. PN documented the resident returned from the physician with a new PRN order for hydrocodone 5/325 mg.</p>	F 157		

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F 157	Continued From page 4 On 2/28/13 at 11:45 a.m. RCMs #11 and #12 were asked when the physician was notified regarding Resident #14's pain medication not being effective. They both agreed that for Resident #14's pain to go for three days was an issue. They stated a fax had been sent to the resident's physician on 11/26/12, a day after the the medication was identified as not effective. The facility was aware the resident's pain medication was not effective on 11/25/12 as documented in the PN. The facility did not inform the resident's physician the resident was in pain until 11/26/12. Additionally, the facility had marked the physician did not need to respond for 24 hours even though the resident's pain level had only decreased to 5 on 11/25/12 after receiving the Tylenol. The resident did not receive an order to address his pain until he went to his physician on 11/28/12, three days after the pain was identified as an issue. The DON and the Administrator were informed of the above concerns on 2/28/13 at 5:30 p.m. On 3/1/13 the facility provided a copy of the 11/26/13 fax sent to the Physician.	F 157	Staffs have been in re-educated on checking the appropriate box at the top of the fax form on 3/18/2013 a copy of the in service has been attached as [redacted] #7		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private	F 164	F164 There were no residents harmed as a result of this tag. The facility does ensure privacy is maintained when a resident receives cares. 1)Corrective Action: Resident # 18 remains in the facility and her privacy is being protected during personal care. Staff were re-educated on privacy by the DNS or designee on 3/18/2013 A copy of the in-service is attached as [redacted] In-service was a reminder to staff that while doing cares they must close the door, pull the privacy curtain between residents, and lower the window blind before performing any resident cares.	#8	

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F 164	Continued From page 5 room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure privacy was maintained when a resident received a subcutaneous (SQ) injection in the abdomen. This was true for 1 of 2 residents (#18) who received SQ injections during medication pass observations. This failure created the potential for a negative effect on the resident's psychosocial well-being. Findings included: On 2/26/13 at 11:50 a.m., during a medication pass observation, Resident #18 was observed seated in a wheelchair (w/c) in front of her bed facing the opposite wall and open doorway. In addition, the resident's roommate was in bed and facing the door. The privacy curtain between the	F 164	<p>2) How will other residents affected be identified: An in house audit of current residents receiving SQ insulin injections was completed, while their LN gave the injections, by the RCM's. The list of residents and the form used for the audit is attached as [REDACTED]</p> <p>3) What measure or systematic change will be put in place: Quarterly in-services are scheduled for staff on privacy. The schedule calendar is attached as [REDACTED]</p> <p>4) Monitoring: The DON and RCMs will monitor, the Administrator will ensure compliance. All medication nurses will be audited in two weeks starting 3/18/2013. The beginning of the second quarter, April 2013 two LNs will be audited weekly until the beginning of the third quarter July 2013. During the third quarter two LNs will be monitored monthly until October 2013 the beginning of the fourth quarter. For the fourth quarter two LNs will be monitored monthly. All findings are reviewed by the Quality Assurance committee which meets monthly.</p> <p>Date of correction 3/18/2013</p>	<p><i>How are SQ Doc</i></p> <p>#9</p> <p>#8</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 164	Continued From page 6 two residents was pulled only about 2 feet from the wall. Also, the window blind was pulled up all the way which created the potential for anyone standing outside the building to see Resident #18 in her w/c. After introductions and the resident's permission for the surveyor to observe, LN #2 did not close the door, pull the privacy curtain between the 2 residents, or lower the window blind before she pulled down the front of the resident's pants and administered the Novolog insulin 2 units per SQ injection into the right side of Resident #18's abdomen. Immediately afterward, when informed of the aforementioned observation regarding the lack of privacy during the SQ injection in the abdomen, LN #2 stated, "She doesn't like her door closed." The LN indicated the resident did not like the door closed even temporarily and stated, "But I could have pulled the curtain." On 2/28/13 at about 5:30 p.m., the Administrator and DNS were informed of the privacy issue. However, no other information or documentation was received from the facility that resolved the issue.	F 164	F-164 RSDT#18 Plan of correction done at this time to prevent any re-occurrences.		
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	F 241	F241 No residents were harmed as a result of this tag. The facility promotes 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.		

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F 241	<p>Continued From page 7</p> <p>by:</p> <p>Based on observation, it was determined the facility failed to ensure residents' dignity was maintained during dining. This was true for 2 random residents (#s 20 and 24) whose meal was interrupted when they were pulled backward in their wheelchairs away from the dining table. This failure created the potential for a negative effect on residents' self esteem. Findings included:</p> <p>1. On 2/26/13, at 8:05 a.m. during a breakfast meal observation, Resident #20 was observed in her wheelchair (w/c) at the first dining table on the left as one would enter the Annex Assisted Dining Room. This table was against the wall by the entrance into the dining room. The table protruded into the entrance into the dining room about 1 foot and Resident #20, in her w/c, protruded into the entrance about another 2 1/2 feet. The entrance into the dining room was approximately 8 feet wide.</p> <p>At about 8:07 a.m., Resident #20's breakfast tray was served and CNA #3 set-up the meal and began to feed the resident.</p> <p>At 8:10 a.m., another staff brought Resident #21 into the assisted dining room in her w/c. At that point, CNA #3 stood up and told Resident #20, "We're gonna move you back." CNA #3 then pulled Resident #20 backward in her w/c about 2 feet, away from her meal and farther into the entrance into the dining room. The 2 CNA's then moved the table 2 feet toward Resident #20 and the other CNA wheeled Resident #21 around to the table to the side opposite of Resident #20.</p>	F 241	<p>1)Corrective Action: The space in the annex assisted dining room was reevaluated and rearranged to be more conducive in meeting the needs of the resident. The dining rooms in the annex are now arranged in a way that allows uninterrupted meal times for the residents. Staffs were in-in serviced on 3/18/2013 on passing trays to all residents at the table at the same time, and not interrupting the resident's meal with moving of other residents in the dining area, and reporting of concerns with dining space immediately. The copy of this in-service is attached as [redacted] #8</p> <p>2)How will other residents affected be identified: The dining rooms in the annex will be reviewed weekly and then monthly by the dietary services supervisor to assess for sufficient use of dining pace to ensure all residents in the dining area are being allowed uninterrupted meals. Additional residents will not be added to the dining room without assessing the dining room for adequate space in advance. A copy of the dining room assessment tool used by the DSM is attached as [redacted] #10</p> <p>3)What measure or systematic change will be put in place: The dining room experience has been added to the audit that is completed after admission, quarterly and annually. A copy of this audit is attached and is referred to as [redacted] #4</p> <p>4) Monitoring: Audits of the dining room will be completed weekly for two weeks by the DSM</p> <p>starting 3/18/2013, then monthly for the remainder of the year. The IDT team will assess each residents dining experience as they come up for audit after admission, quarterly and annually. All findings are reviewed by the quality assurance committee that meets monthly.</p> <p>Date of Correction 3/18/2013.</p>	

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F 241	Continued From page 8 Resident #20's meal was interrupted when she was pulled backward away from the table. 2. a) On 2/27/13 at 11:35 a.m., during a lunch meal observation, the first dining table on the left as one would enter the Annex Assisted Dining Room was observed against the wall and protruded about 1 foot into the entrance into the dining room. At 11:55 a.m., CNA #14 wheeled Resident #24 to the Annex Assisted Dining Room and parked him at the first table on the left as one would enter the dining room. The resident, in his w/c, protruded about 3 feet into the room's entrance. Liquids were served to the resident a few minutes later. At about 12:32 p.m., Resident #24's meal was served and set-up and he began to eat. At about 12:40 p.m., staff brought other resident's into the assisted dining room and CNA #3 pulled Resident #24's w/c backward about 3 feet from the table, and his meal. Resident #24 was farther into the entrance in the room and part way in hallway. Resident #24 reached toward the table and said loudly that he wanted his food. LN #2 then moved the table about 2 feet toward Resident #24. However, Resident #24 still could not reach his meal and CNA #3 said to the resident, "Hold on big guy, we're just gonna get a few more people squeezed in here." About that time, LN #2 wheeled Resident #21 around the table to the side opposite of Resident #24. At about 12:48 p.m., CNA #3 moved Resident #24 back up to the table and the resident resumed eating his meal.	F 241			

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F 241	Continued From page 9	F 241			
	<p>Resident #24's lunch meal was interrupted about 8 minutes when he was moved away from the table in order for staff to get other residents into the crowded dining room.</p> <p>b) On 2/27/13 at 12:55 p.m., during the same lunch meal observation, CNA #3 asked CNA #15, "Can I get you to move [Resident #24's name]?" CNA #15 told Resident #24, "Just going to get you back a minute." CNA #15 then pulled Resident #24 backward in his w/c, away from his table and his meal again, and back into the doorway, while CNA #16 wheeled another resident through the dining room entrance and in front of Resident #24. After that, CNA #15 pushed Resident #24 back to the table and his meal.</p> <p>Note: Refer to F464, Dining and Resident Activities, regarding insufficient space in the Annex Assisted Dining Room.</p> <p>On 2/27/13 at approximately 7:00 p.m., the Administrator and DNS were informed of the observations. However, no other information was received from the facility.</p>				
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>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.</p>	F 246	<p>F-241</p> <p>RSDT#20,#21,#24,</p> <p>For all RsdT's affected the dining room was re-arranged to prevent interruptions of meals. <i>Exhibit # 19</i></p> <p>F246</p> <p>No resident's were harmed as a result of this tag. The facility ensures the resident's 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.</p>		

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F 246	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident interview, it was determined the facility failed to ensure the resident's call light was accessible. This was true for 1 (resident #6) of 16 sampled residents. The failed practice created the potential for physical and emotional harm for the resident whose call light was not accessible. Findings included:</p> <p>Resident #6 was admitted to the facility on 7/09/12 and readmitted on 12/13/12 with diagnoses of AFib (atrial fibrillation), insomnia, dementia, pain, anxiety, Alzheimer's, and hypertension.</p> <p>During an observation in the resident's room on 2/26/13 at 8:55 AM, Resident #6 was assisted to the bed by RN #7. The call light was on the floor, under the bed, up against the wall and out of reach of the resident when the RN left the room. The surveyor asked Resident #6, "What would you do if you needed help?" Resident #6 stated "I'd scream bloody murder until someone comes."</p> <p>On 2/26/13 at 9:40 AM, Resident #6 was observed laying in bed with her eyes closed. The call light was on the floor, under the bed, up against the wall, and not accessible to the resident.</p> <p>On 2/26/13 at 10:40 AM, Resident #6 was observed laying in bed, eyes closed. The call light was still on the floor, under the bed, up against the wall, and not accessible to the resident.</p>	F 246	<p>1) Corrective Action: Resident #6 remains in the facility and has a call light within reach to notify staff of needs. Call light audits will be done to ensure that resident's will have access to call lights while they are in their rooms. Staff re-education on call lights being accessible and within residents reach was done by the DNS or designee on 3/18/2013. See attached as Exhibit # 8 . The In-service calendar showing when quarterly in-service's, on call light placement ,is attached as [redacted] # 2</p> <p>2)How will other residents affected be identified: Call lights will be audited to ensure that the residents have access to their call lights by the RCM's or designee. (See below for frequency) If a resident is found to be without their call light, staff on the floor will be counseled. If incidents continue and the same staff member(s) are found to be delinquent they will be counseled and the disciplinary policy will be followed. A copy of the disciplinary policy is attached as [redacted] # 11</p> <p>3)What measure or systematic changes will be put in place: Call light audits, In- servicing, and disciplinary action as deemed appropriate. A copy of the audit sheet is attached as [redacted] # 12</p> <p>4) Monitoring: Audits will be completed daily for two weeks starting 3/18/2013 by the RCM's or designee. Audits will continue two times weekly in the month of April, then weekly for the month of May, then twice quarterly. Copies of the audits will be forwarded to the DNS for review and follow up, if needed. All findings will be reviewed by the quality assurance committee that meets monthly. The Administrator will ensure compliance.</p> <p>Date of Correction 3/18/2013</p>		

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F 246	Continued From page 11 On 2/26/13 at 11:30 AM, Resident #6 was observed ambulating up and down the hallway with her merry-walker. The call light in Resident #6's room was observed on the floor, under the bed, and up against the wall. On 2/26/13 at 2:20 PM, Resident #6's call light was observed on the floor, under the bed, up against the wall and not accessible to the resident. CNA #6 assisted Resident #6 to bed, picked up the call light off the floor, and placed it within reach of the resident. On 2/28/2013 at 5:30 PM, the administrator and DON were informed of the call light issue and no other information was provided by the facility.	F 246			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility failed to provide Resident #6 with a call light that was accessible to her. The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a sanitary environment. This was true for 1 of 13 (Resident #4) sampled residents. The failed practice created the potential to cause illness related to an unsanitary environment when the resident's telephone was placed on the floor and then placed back on her over bed table. Findings included:	F 253	F253 No Residents were harmed as a result of this tag. The facility ensures that a sanitary environment is provided for all residents. 1) Corrective action: Resident # 4 remains in the facility and is provided a sanitary environment. Staff were re-educated on a sanitary conditions and infection control practices, not placing a resident's phone on the floor and then on the over the bed table before sanitizing on 3/18/13 by the DNS or designee. A copy of the in-service is attached as [redacted] A copy of the yearly in-service calendar is also attached as [redacted] which reflects quarterly in-service training.	#7 + #8 #2	

*Pen Ink Change
4/2/13 at 10:30
Administrator stated
LN's attended initial
training as observation
was 2. But CNA's will
attend future training
Sherril Case*

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F 253	<p>Continued From page 12</p> <p>Resident # 4 was admitted to the facility on 4/22/11 with diagnoses of Congestive Heart Failure, bronchitis, open wound, anemia, Clostridium Difficile, shortness of breath, and pain.</p> <p>On 2/26/13 at 8:30 AM in Resident #4's room, the resident indicated she had eaten a yogurt and banana for breakfast in her room.</p> <p>On 2/26/13 at 11:50 AM in Resident #4's room, the resident stated that she ate her meals in her room. A banana was observed on her over bed table.</p> <p>During an observation on 2/27/13 at 4:00 PM in Resident #4's room, LN #10 cleared the resident's over bed table, and prepared for wound care. LN #10 removed the resident's phone from the over bed table and placed it on the visibly dirty floor. When finished with the wound care, the LN #10 picked the phone up from the floor and placed it back up on the over bed table. The LN did not use a barrier when she placed the phone on the floor or on the over bed table and she did not clean the phone.</p> <p>After leaving the resident's room, LN #10 was informed of the issue of placing the phone on the floor and then placing it back up on the resident's table. The LN #10 stated, "I had no where else to set it."</p> <p>The facility failed to provide a safe and sanitary environment for Resident #4 by placing her telephone on the floor and then placing it back on her table over her bed.</p>	F 253	<p>2) How will other resident affected be identified: Other residents will be identified through audits of both the care givers and the LN's by the RCM's or designee. Copies of the audits will be forwarded to the DNS for review and follow up if needed. A copy of the audit sheet to be used is attached as [redacted]. If a resident is found in an unsanitary environment the staff on the floor will be counseled. If incidents continue and the same staff member(s) are found to be delinquent they will be counseled and the disciplinary policy will be followed. Copy of the disciplinary policy is as attached as [redacted].</p> <p>3) What measure or systematic changes will be put in place: Audits, in servicing and disciplinary action as deemed appropriate.</p> <p>4) Monitoring: Audits will be completed daily for two weeks starting 3/18/2013. Audits will continue two times weekly in the month of April, then weekly for the month of May, then twice quarterly. The Administrator will ensure compliance. All findings will be reviewed by the quality assurance committee that meets monthly.</p> <p style="text-align: right;"><i>Date of Completion</i> 3/18/2013</p>	# 12 # 1)	
			<p>F-253</p> <p>RSMT#4</p> <p>Phone and bedside table have been disinfected, and plan of correction update to prevent re-occurrences.</p>		

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F 272 No residents were harmed as a result of this tag. The facility ensures that all restrictive devices are assessed as safe for the resident. 1) Corrective Action: Resident # 5 and #6 have had their medical devices assessed and Care Plan updated as needed. RCM's were re-educated that residents must be assessed for safety/entrapment when adaptive equipment (restrictive devices) are initiated and then reassessed with change of condition and at least quarterly, on 3/18/13 by the DNS. A copy of the in-service provided to the RCM's is attached as [REDACTED] #13 2) How will other residents affected be identified : Current residents with use of restrictive devices have been reviewed to ensure that they have been assessed for use of the least restrictive devices. Audits are completed after admission, quarterly and annually by the Interdisciplinary Team (IDT). The resident's entire medical record and plan of care are reviewed. "Assessment of all adaptive/restrictive devices" was added to the audit sheet. Please refer to [REDACTED] #4 3) What measure or systematic change will be put in place: The change to the audit system which is done after admission, quarterly and annually will ensure that all adaptive/restrictive equipment will be assessed routinely. 4) Monitoring: The RCMs and IDT team will forward copies of the audit forms to the DNS for review and follow up if needed. The Administrator will ensure compliance. All findings will be reviewed by the Quality Assurance committee that meets monthly. Date of Correction: 3/18/2013		

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F 272	Continued From page 14	F 272			
	<p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure restrictive devices were assessed as safe for resident use. This affected 2 of 13 (#s 5 and 6) sampled residents. This practice placed the residents at risk for entrapment and potential harm should the residents become entrapped in the restrictive devices. Findings included:</p> <p>1. Resident #5 was admitted to the facility 5/31/12 with diagnoses of multiple sclerosis, depressive disorder, and pain.</p> <p>The most recent quarterly MDS, dated 12/4/12, documented the resident:</p> <ul style="list-style-type: none"> * was cognitively intact with a BIMS of 15, * did not have any behaviors, * required total assistance with bed mobility, transfers, dressing, and personal hygiene. <p>Resident #5's Care Plan (CP), dated 11/5/12, identified the problem as the resident was at risk for falling. The Approach section documented the use of side rails for bed mobility.</p> <p>The resident's medical record included a 2/25/13 "Restraints/Adaptive Equipment - PCI - Enabler/Physical Restraint Consent PCI." The form identified the risk and benefits but did not include the resident had been assessed to be safe with the bedrails.</p> <p>On 2/28/13 at 11:45 a.m. RCMs #11 and #12 were asked for documentation that Resident #5</p>				

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F 272	Continued From page 15 had been assessed to be safe with the side rails. They stated the risk and benefit statement did not include any statement the resident had been determined safe to use the side rails. 2. Resident #6 was admitted to the facility on 7/9/12 and then readmitted on 12/13/2012 with diagnoses of atrial fibrillation, insomnia, pain, dementia, Alzheimer's disease, muscle weakness, and abnormal gait. The "Restraints/Adaptive Equipment -Enabler/Physical Restraint Quarterly Assessment" dated 1/16/13 was reviewed, but did not indicate if the resident was safe with the use of the merry-walker or not. Resident #6's Physician Orders dated 2/1/2013 - 2/28/2013 stated in part: "1/03/13 - open ended - Resident to use merry-walker when out of bed for ambulation continuous" Resident #6 Care Plan in part: "Problem Start Date: 12/27/2012 - [Resident #6] at risk for falling R/T[related to] decreased balance and mobility. Goal target date: 3/27/13: Resident will remain free from injuries requiring out of facility interventions. Approach start date 10/29/12: Resident uses merry-walker for ambulation and pressure alarm on bed for safety." Physical Therapy Evaluation and Plan of Treatment dated 12/14/2012 stated in part: "Previous Treatment - Previous Treatment Outcome: Resident had been able to be	F 272	F-272 RSDT#5,#6, Rsd#5 adaptive/enabler observation was updated and re-assessed to be deemed safe to have side-rails, and RSDT#6 was deemed safe to have a merri-walker. <i>Exhibit #20 & #21</i>		

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F 272	Continued From page 16 advanced to use of Merry walker in facility with observation of staff independent in getting up and standing in walker and functional with ambulation with walker." Note: This referred to previous treatment and not since the most recent admission. On 2/28/13 at 5:30 PM, the administrator and DON were informed of the safety assessment for the merry-walker issue. No other information was provided by the facility. The facility failed to provide documentation that Resident #6 was evaluated for the safe use of the merry-walker.	F 272		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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	F 278	F 278 No residents were harmed as a result of this tag that involved Resident's #1,2,4 and #6. The facility ensures the MDS assessments are accurate and complete. 1) Corrective Action: Staff involved with completion of the MDS have been re-educated to sign the MDS assessment at the time of completion per the RAI Manual by the DNS or designee. The IDT will audit MDS signature completion during the IDT Review which occurs after Admission, Quarterly and Annually. See attached as [redacted] Re education of all individuals who complete sections of the MDS was completed on 3/18/2013. 2) How will other residents affected be identified: Current resident's MDS's were audited to ensure presence of signatures for those who completed a section of the assessment by the RCM's. 3) What measure or systematic change will be put in place: To ensure ongoing compliance, signature of the individual sections of the MDS will be checked during the IDT Review after Admission, Quarterly and Annually. Copies of the IDT Review Audit Form will be forwarded to the DNS for review and follow up if needed. 4) Monitoring: The DNS will track and trend results of the Audits and report findings to the QA committee to identify opportunities for performance monthly. The Administrator will ensure compliance Date of Correction: 3/18/2013	# 4 Exhibit B

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F 278	<p>Continued From page 17</p> <p>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 record review and staff interview, it was determined the facility failed to ensure MDS assessments were accurate and complete. This was true for 4 of 10 sample residents (#s 1, 2, 4, and 6). Specifically, the RN Assessment Coordinator certified that MDS assessments for Residents #s 1, 2, 4, and 6, were completed before all sections of the assessments were signed as complete and accurate by authorized staff. This created the potential that the assessments were not accurate and/or not complete, which could lead to care plans not being developed, or revised, to meet the residents' needs. In addition, Resident #2 developed a stage 2 pressure ulcer on the right heel on 9/12/12. However, pressure ulcer was incorrectly coded as "0" on the resident's 2/13/13 MDS assessment. The failure created the potential for harm because the pressure ulcer was not reflected in the resident's care plan. Findings included:</p> <p>1. Note: Probes at §483.20(g)(h) in F278, Accuracy of Assessment, states, "... On an assessment or correction request, the RN Assessment Coordinator is responsible for certifying overall completion once all individual</p>	F 278			

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F 278	<p>Continued From page 18</p> <p>assessors have completed and signed their portion(s) of the MDS. When MDS records are completed directly on the facility's computer, (e.g., no paper form has been manually completed), the RN Coordinator signs and dates the computer generated hard copy, or provides an electronic signature, after reviewing it for completeness, including the signatures of all individual assessors..."</p> <p>On 2/26/13, the facility provided printed versions of MDS assessments for most of the sample residents, including Residents #s 1, 2, 4, and 6. Review of these MDS assessments, revealed there were no signatures in Section Z (Assessment Administration) at Z0400 (Signature of Persons Completing the Assessment or Entry/Death Reporting) or Z0500A (Signature of RN Assessment Coordinator Verifying Assessment Completion). However, a date was documented at Z0500B (Date RN Assessment Coordinator signed assessment as complete) on all of the MDS assessments.</p> <p>On 2/27/13 at 3:45 p.m., RCMs #8 and #9 were interviewed about the missing signatures at Z0400 and Z0500A on the aforementioned MDS assessments. Both of the RCMs stated there were signatures at Z0400 and Z0500A on the facility's printed versions of the MDS assessments.</p> <p>A few minutes later, RCM #12 joined the conversation and showed 2 surveyors a printed version of Section Z of the following MDS assessments: 2/8/13 for Resident #1, 2/13/13 for Resident #2, and 1/14/13 for Resident #4. Review of these printed versions revealed that the RN</p>	F 278			

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F 278	Continued From page 19 Assessment Coordinator had signed these MDS assessments as completed, but, that not all sections of these MDS assessments had been certified as accurate and complete. When asked about the missing certifications, all 3 of the RCM's acknowledged there was only 1 signature at Z0400 and that all of the MDS sections were not listed in Z0400. They all stated, however, that all of the sections were completed or the MDS assessment could not have been submitted to the CMS database. RCM #8 and #9 stated, however, that they did not realize the RN Assessment Coordinator's signature meant that all of the sections of the MDS assessment were accurate and complete. At that time, a copy of Section Z of the aforementioned MDS assessments and for all other sample residents was requested. The next day, RCM #12 provided Section Z of MDS assessments for all sample residents. Additional names of individual assessors and the sections they completed were listed at Z0400 in Section Z of the MDS assessments for Residents #s 1, 2, and 4, as well as for Resident #6's 12/20/12 MDS assessment. RCM #12 stated that all sections of the MDS assessments had been completed but they did not know that all individual assessors must certify their sections as accurate and complete before the RN Assessment Coordinator signed the MDS as completed. RCM #12 confirmed that the additional individual assessor names, sections, and dates were added to the MDS assessments for Residents #s 1, 2, 4, and 6. On 2/28/13 at 5:30 p.m., the Administrator and DNS were informed of the issue. However, no other information or documentation was received	F 278			

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F 278	Continued From page 20 from the facility.	F 278			
F 279 SS=D	<p>2. Resident #2 was admitted to the facility on 5/9/12 with diagnoses that included recurrent dislocation of the pelvis and thigh.</p> <p>Review of a Wound Alert document, dated 9/12/12, revealed Resident #2 developed a stage 2 PU to the right heel on 9/12/12. (Note: Refer to F314, Pressure Ulcers, for additional information.)</p> <p>Review of the the resident's clinical record revealed: * The admission and most recent quarterly MDS assessments, dated 5/16/12 and 2/13/13 respectively, both coded no healed or unhealed pressure ulcers (PU); and, * The right heel pressure ulcer was not addressed in the resident's care plan.</p> <p>On 2/27/13 at 3:45 p.m., RCM #9 was informed of the 9/12/12 Wound Alert regarding the stage 2 PU on the resident's right heel asked about the PU coding on resident's 2/13/13 MDS assessment. The RCM reviewed the 2/13/13 MDS then stated that M0210, Unhealed Pressure Ulcer(s), should have been coded as "1," which meant "yes."</p> <p>On 2/28/13 at 5:30 p.m., the Administrator and DNS were informed of the issues regarding MDS assessments. However, no other information or documentation was received from the facility.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment</p>	F 279	<p>F-278</p> <p>RSDT#2</p> <p>Plan of correction done at this time to prevent re-occurrences</p> <p><i>page 22</i></p>		

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F 279	Continued From page 21 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 observation, record review, and staff interview, it was determined the facility failed to ensure the resident's care plan included her bathing needs. This was true for 1 of 16 (Resident #6) sampled residents. This failed practice had the potential for the resident's bathing needs not being met. Findings included: Resident #6 was admitted to the facility on 7/9/12 and then readmitted on 12/13/12 with diagnoses of atrial fibrillation, insomnia, pain, dementia, Alzheimer's disease, muscle weakness, and abnormal gait. The Resident #6's MDS Assessment dated	F 279	F279 No residents were harmed as a result of this tag. The facility does develop a comprehensive care plans for each resident that includes measurable objectives and timetables to meet a residents medical nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan does describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. 1) Corrective Action: Resident # 6 has had the Care Plan updated to reflect bathing needs . Current residents Care Plans have been reviewed to ensure they reflect the ADL needs of each resident. A copy of the audit form that is in use is attached as  # 4 2) How will other residents affected be identified: Current residents have had their Care Plans reviewed and updated to reflect their current ADL needs. 3) What measure or systematic change will be put in to place: The facility audit has been updated to reflect bathing and ADLs. Bathing and all ADLs will be checked during the audit (done by the IDT team after Admission, Quarterly and Annually) to ensure compliance in obtaining the resident's highest practicable physical, mental and psychosocial well being. Copies of the audits will be forwarded to the DNS for review and follow up if needed. 4) Monitoring: The DNS will track and trend the audit results and present findings to the QA Committee monthly, to identify opportunities for performance improvement. The administrator will ensure compliance Date of Completion 3/18/2013.	

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F 280	Continued From page 23 comprehensive assessment, prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility did not revise care plans for 2 of 10 sampled residents (#s 3 & 8). Care plans did not reflect revisions for pressure sore treatments or diet/nutritional orders. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings include: 1. Resident #8 was admitted to the facility on 12/5/11 with diagnoses that included dementia, dysphagia and diabetes mellitus II. The significant change MDS, dated 12/6/12, documented the resident as cognitively moderately impaired but needing extensive assistance to transfer, ambulate and for use of the toilet. Additionally the assessment documented the resident was at risk for pressure ulcers.	F 280	F 280 No residents were harmed as a result of this tag. All facility resident's have the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, to participate in planning care and treatment or changes in care and treatment . A comprehensive care plan must be developed with 7 days after the completion of the comprehensive assessment; prepared by the IDT 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' needs and to the extent practicable, the participation of the resident, the resident's family or the residents legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 1)Corrective Action: MACC meeting which meets five day a week the policy and procedure for MACC meeting is attached as [redacted] # 5 Also on Exhibit #4 Braden Scores are discussed and the intervention to go along with them which in includes nutrition. 2)How will other residents be identified: During the audit process that is done after admission, quarterly and annually any and all residents will be identified that may have been missed. 3)What measure or systematic change will be put in to place: Interventions that go with the Braden score have been added to the audit process. 4)Monitoring: Audits are completed after admission, quarterly and annually to ensure that all residents needs are being met. The DNS, RCM's , IDT team will monitor. The administrator will ensure compliance. All findings will be reviewed by the monthly quality assurance committee which meets monthly.		

Date of Correction 3/18/2013

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F 280	Continued From page 24 Resident #8's 2/13 Physician Orders (recapitulation) included she was to have, "Care Booties on at all times." During multiple observations on 2/26/13 through 2/28/13 Resident #8 was observed with blue booties on her feet. The resident's 10/9/12 care plan identified in the "Problem" section, the resident was at risk for impaired skin integrity. The "Approach" section did not include the resident was to wear care booties at all times. On 2/28/13 at 11:30 a.m. RCM #12 stated the Care Plan had not been revised to include the care booties. 2. Resident #3 was admitted to the facility on 4/8/11 with diagnoses that included dementia with behaviors, dysphagia and abnormal symptoms of weight loss. The quarterly MDS, dated 12/25/12, documented the resident as cognitively moderately impaired and needing extensive assistance for eating. Resident #8's medical record included a 12/31/12 order for TwoCal (high calorie liquid food) and a 1/10/13 order for Mighty Shakes. Each were to be offered three times a day. The resident's 10/15/12 care plan identified in the "Problem" section, the resident would leave 25% or more of food uneaten at most meals. The "Approach" section identified the resident was to receive high calorie meals but did not include the above supplement ordered by the physician.	F 280	F-280 RSDT#3,#8 Care plans updated to reflect new changes, please see exhibits #16 & #17		

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F 280	Continued From page 25	F 280			
F 309 SS=D	<p>On 2/28/13 at approximately 12:30 p.m. the Dietary Manager stated the care plan needed to be revised to include the nutritional supplements.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a public complaint received by the BFS on 1/3/13, record review, and interview, it was determined the facility failed to ensure assessments for pain and timely physician response for ongoing pain control for a resident admitted with chronic pain. This was true for 1 of 13 sampled residents reviewed for pain and created the potential for inadequate pain management. Findings included:</p> <p>The complainant stated an identified resident did not have pain medication and only received Tylenol to address pain.</p> <p>Resident #14 was admitted to the facility on 11/23/12 with diagnoses which included pneumonia and chronic pain.</p> <p>Resident #14's 11/23/12 Physician Order (recapitulation) documented he was to receive</p>	F 309	<p>F 309 No residents were harmed as a result of this tag. Each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility promptly ensures a resident's physician is immediately notified when the resident pain medication is determined not to be effective.</p> <p>1)Corrective Action: Resident #14 no longer resides in the facility. Licensed Nurses were re-educated on the assessment of, documentation , and on the Prestige Pain P & P, by the DNS or designee, on 3/18/13. [REDACTED] is attached. Quarterly in-services have been scheduled on pain, the assessment of, documentation, understanding and the current pain policy. A copy of the calendar is attached as [REDACTED]. When the resident is admitted to the facility they are placed on alert charting for 72 hours and are monitored for pain on all shifts. If there is not a complaint of pain or pain is adequately controlled, the resident is removed from alert charting and is monitored by the licensed nurse. If pain is not controlled to the resident satisfaction the MD will be notified by the RCM. At any time for all residents if the pain of the resident is not controlled the resident is placed on alert charting and is followed by the RCM.</p>		

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F 309	<p>Continued From page 26</p> <p>Tylenol 325 mg every 4 hours PRN (as needed) for pain. There was also an 11/28/12 Physician order for Hydrocodone 5-325 mg three times a day as needed.</p> <p>Resident #14's "Admission -PCI-- Initial Pain Questionnaire" documented the observation date was 11/23/12 and the resident was in pain with a pain level of 4 (0 being no pain and 10 being worst pain possible). In the non-verbal expressions of pain the boxes by "wrinkled brow" and "moaning" were checked.</p> <p>The resident's PRN Medication Administration Record (MAR) documented on 11/24/12 the resident's pain level was still 6 and 3 after receiving the Tylenol on 11/24/12 and his pain level was 5 on 11/25/12 (after Tylenol).</p> <p>Resident Progress Notes (PN) document on 11/24/12 at 8:49 p.m. the resident was medicated with the PRN medication for back pain "with movement." There was no documentation that the resident had been assessed for pain other than the effectiveness of the Tylenol. PN documented on 11/25/12 the Tylenol was not effective.</p> <p>Additionally PN from 11/24/12 through 11/28/12 did not document the facility had assessed the resident for pain even though his admitting diagnosis was chronic pain. The only documentation on the PN was the resident did not "complain" of pain.</p> <p>On 2/28/13 at 11:45 a.m., RCMs #11 and #12 were asked about Resident #14's pain. They both agreed Resident #14's pain going for three days</p>	F 309	<p>2) How will other residents affected be identified: Attached is a copy of prestige Pain policy and procedure as [redacted] Pain assessment completion and residents current level of pain were added to the audit sheet. The current audit sheet is attached as [redacted] Audits are completed after admission, quarterly and annually by the IDT team. Copies of these audits are to be forwarded to the DNS for review and follow up if needed.</p> <p>3) What measure or systematic change will be put in to place: MACC meeting takes place every morning . Pain is also addressed and monitored in this meeting. A copy of the policy and procedure is attached as [redacted] To ensure current residents are having their pain addressed to their satisfaction, interviews with the residents were completed by 3/18/2013. A copy of the in-house check off sheet used for the audit is attached as [redacted]</p> <p>4) Monitoring: The DNS will track and trend the audit findings and report results to the QA Committee to identify performance improvement opportunities. The Administrator will ensure compliance.</p> <p style="text-align: right;"><i>Date of Correction</i> 3/18/2013</p>		

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F 309	Continued From page 27 was an issue. They stated a fax had been sent to the resident's physician on 11/26/12 (1 day after the the medication was identified as not effective). The facility was aware the resident's pain medication was not effective on 11/25/12 as documented in the PN. The resident did not receive an order to address his pain until he went to his physician on 11/28/12, three days after the pain was identified as an issue. The DON and the Administrator were informed of the above concerns on 2/28/13 at 5:30 p.m. On 3/1/13 the facility provided a copy of the 11/27/13 fax sent to the Physician.	F 309			
F 314 SS=D	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 that a resident who entered the facility without a pressure ulcer did not develop a pressure ulcer. This was true for 1 of 6 sample residents (#2) reviewed for pressure ulcers.	F 314	F-309 RSDT#14 Rsd is no longer at facility and plan of correction done at this time to prevent re-occurrences. F314 No residents were harmed as a result of this tag. The facility ensures 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 service to promote healing, prevent infection and prevent new sores from developing. 1)Corrective Action: Resident #2's Care Plan has been reviewed by the IDT and updated to reflect remains in the facility While doing chart audits [redacted] the resident's Braden score will be reviewed along with all necessary intervention. Interventions will be assessed and enhanced as contraindicated. A copy of the interventions that go along with the different scores that can be achieved on the Braden score is now a part of our audit process that is done after admission, quarterly and annually. Nutritional interventions are also reflected on the attachment. Please see [redacted].		# 4

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F 314	<p>Continued From page 28</p> <p>Failure to implement an intermittent air mattress for 47 days after the pressure ulcer was discovered, to provide evidence that care boots were used and the resident's heels were off-loaded, and to revise the care plan to include a stage 2 right heel pressure ulcer placed Resident #2 at risk for further skin breakdown, pain, and infection. Findings included:</p> <p>Resident #2 was admitted to the facility on 5/9/12 with diagnoses that included recurrent dislocation of the pelvis and thigh.</p> <p>Resident #2's admission and most recent quarterly MDS assessments, dated 5/16/12 and 2/13/13 respectively, both coded, in part:</p> <ul style="list-style-type: none"> * Moderate cognitive impairment; * Adequate hearing and vision; * Able to understand others and to be understood; * Extensive assistance of 1 person for bed mobility, transfers, walk in room/corridor, locomotion on unit, dressing, toilet use, personal hygiene, and bathing; * Walker and wheelchair use; and, * No healed or unhealed pressure ulcers (PU). <p>Note: Refer to F278, Accuracy of Assessment, regarding inaccurate coding of pressure ulcers.</p> <p>A "Skin-Braden Scale For Prediction of Pressure Sore Risk" assessment, dated 8/20/12, documented Resident #2 had slightly limited sensory perception, occasionally moist skin, walked occasionally, slightly limited mobility, probably inadequate nutrition, and a potential problem with friction and shearing. The assessment scored the resident "At Risk" for PU.</p>	F 314	<p>2)How will other residents being affected be identified: Braden accuracy and scores will be assessed and reassessed as necessary. The appropriate interventions will be identified and put into the plan of care achieving the optimal level of care for the resident.</p> <p>3)What measure or systematic change will be put into place: The audit template [redacted] has been change to identify y the area in concern. #9</p> <p>4) Monitoring: The DNS, RCM's, IDT will monitor. The Administrator will ensure compliance. All findings of the audits will go to the Quality Assurance committee for review. Audits are completed after admission, quarterly and annually.</p> <p>Date of completion 3/18/2013</p>		

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F 314	Continued From page 29 Resident #2's care plan identified the problem, " ...at risk for impaired skin integrity, " on 10/19/12. Approaches, all implemented on 10/19/12, included: * "Conduct a systematic skin inspection per facility schedule. Pay particular attention to the bony prominences." * "Keep clean and dry as possible. Minimize skin exposure to moisture." * "Keep linens clean, dry, and wrinkle free." * "... Avoid hot water, and use a mild cleansing agent..., avoid friction..." * "Report any signs of skin breakdown (sore, tender, red, or broken areas)." * "Use cushion for pressure reduction...in chair and IMT [intermittent air] mattress." Other care plan identified problems for Resident #2 included: * "...requires 1 assist with ADL's [sic]," dated 10/19/12. Approaches included, "...full weight bearing and requires 1 assist with transfers and ambulating with FWW [front wheeled walker]." * "...at risk for falling R/T [related to] hx [history] of hip dislocations and weakness," dated 10/19/12. Approaches included, "Uses wheelchair for mobility" and "Provide proper, well-maintained footwear." A "Wound Alert" document, dated 9/12/12, was found with the Incident and Accident reports. This wound alert documented that Resident #2 developed a stage 2 PU to the right heel on 9/12/12. Other documents attached to the wound alert included, a "Comments/Concerns/Info[mation]" page with a section for Physician Orders, dated 9/12/12; a "Short Term Acute Care Plan-Skin," dated	F 314			

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F 314	Continued From page 30 9/12/13; a "Wound Assessment Flow Sheet," dated 9/12/12; and, an "In-Service Training Report, dated 9/17/12. The documents attached to the wound alert included the following documentation: * Comments/Concerns/Info - "Resident c/o [complains of] pain to (R) [right] heel, upon inspection, stage 2 pressure ulcer found measuring 1.0 cm [centimeters] [by] 1/5 cm. No s/sx [signs or symptoms] of infection present and no drainage. May we please have orders to tx. [treat] per facility protocol and to apply care boots to off-load heels when resident is not ambulating?..." Respond Within 24 hrs [hours] was marked. * Physician Order - "1) Cleanse wound to (R) heel [with] NS [normal saline], 2) Apply tegaderm [with] pad, 3) [change] Q 3 days & PRN [change every 3 days and as needed], 4) Notify MD [physician] if s/sx of infection are present, 5) Resident to wear care boots at all times when not ambulating." Note: The order was not dated or signed by anyone. * Short Term Acute Care Plan-Skin - "Problem[:] Pressure Stage II (R) heel[,] Objective[:] Resident will heal without complication." Note: None of the 9 typed approaches were checked and there were no handwritten approaches. * Wound Assessment Flow Sheet - Right heel stage 2 PU, onset date 9/12/12, heel protection "yes." Note: It was not clear if the heel protection was in place before or after the PU was discovered. * In-service Training Report - "Employee group(s) present: NSG [nursing]/CNA. Topic [resident's name]. Contents or summary of training	F 314			

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F 314	Continued From page 31 session... RSDT [resident] to be up in wheelchair for all meals." Note: A record of who attended was not included. The resident was observed in bed, on her back and with her heels resting on the mattress on 2/26/13 at 7:50 a.m., 9:00 a.m., and 10:30 a.m.; 2/27/13 at 9:00 a.m., 9:15 a.m., and 10:40 a.m.; and, 2/28/13 at 9:00 a.m. On 2/27/13 at 3:45 p.m., RCM #9 was asked about Resident #2's right heel PU. The RCM acknowledged that the PU developed in the facility and indicated that she needed to review the resident's clinical record. The RCM agreed to provide documentation regarding assessment, interventions, and monitoring that was in place before and after the PU developed on 9/12/12. She indicated, however, that finding the documentation would take time because it could be in multiple places, including the electronic medical record, the chart, and/or thinned records. On 2/28/13 at 2:45 p.m., RCM #9 provided the following documentation regarding Resident #2's right heel stage 2 PU : * A Progress Note, dated 9/12/12 at 3:54 p.m. - "...c/o pain to R heel...pressure ulcer stage 2 present. ... Peri-wound skin is intact, MD faxed... Care boots implemented...to float heels, and wound care done per facility protocol. Resident aware of wound and understands need to wear care boots." * September and October 2012 Treatment Flowsheets documented wound care with NS and tegaderm was done every 3 day from 9/12 through 10/29/12; and, wound resolution on 10/29/12.	F 314			

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F 314	Continued From page 32 * Wound Assessment Flow Sheet included assessments dated 9/12, 9/20, 9/27, 10/4, 10/12, and 10/18/12. Note: The wound base was noted as, "scabbed" on 9/20 and 9/27/12. And, the wound size did not change until 10/12 when it was noted as 0.25 by 0.25 cm. * Risk for impaired skin integrity care plan, dated 5/22/12. Note: Other than the approach start date of 5/22/12, the only difference in the approaches on this care plan from the 10/19/12 impaired skin integrity care plan, was the addition of the IMT mattress on 10/19/12, approximately 47 days after the onset of the PU. In addition, there was no evidence that the care plan was revised to include the 9/12/12 right heel PU, wound care, care boots at all times when not ambulating, off-loading the heels when not ambulating, and up in wheelchair for all meals. Also, there was no evidence that the resident's heels were off-loaded or care boots were in place when the resident was not ambulating, or she was up in the wheelchair for all meals. On 2/28/13 at 9:00 a.m., RCM #9 accompanied the surveyor to Resident #2's room. With the resident's permission, the RCM removed the non-slip sock off the resident's right foot. This revealed an intact, approximately 2.0 by 1.0 cm oblong reddened area on the medial (inside) aspect of the resident's heel. The area blanched when the RCM applied pressure to it. The resident denied any pain or discomfort at the right heel. The RCM stated, "We will monitor the area." The RCM did not provide any other information or documentation regarding Resident #2's stage 2	F 314	F-314 RSDT#2 Rsd't's care plan updated to reflect updated skin conditions. Exhibit # 23		

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F 314	Continued From page 33 right heel pressure ulcer.	F 314			
F 323 SS=E	<p>On 2/28/13 at about 5:30 p.m., the Administrator and DNS were informed of the pressure ulcer issue. However, again, no other information or documentation was received from the facility.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure the environment was free from accident hazards. This was true for any mobile resident residing in the facility. The deficient practice had the potential to cause more than minimal harm if a resident accessed potentially hazardous substances. Findings included:</p> <p>On 2/28/13 at 4:47 PM, the surveyor checked an unmarked and unlocked closet located between the Activity Director's office and the Health Information office. A shelf in the closet had a 1 gallon container of DMQ disinfectant on the on the shelf that was approximately half full.</p> <p>The Health Hazard Data section of the MSDS, dated 9/23/10, stated DMQ</p>	F 323	<p>F323 No residents were harmed as a result of this tag. The facility ensures that the resident environment remains as free of accident hazards as possible ; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>1) Corrective action: Facility wide check was completed on 3/18/2013 to ensure that no chemicals were in an inappropriate location which was not locked. The audit which was completed is attached as [redacted] #12 Re-education was given on 3/18/2013, informing staff of the importance of locks and locked areas for all chemicals. Copy of the in-service is attached as [redacted] #7 + #8</p> <p>2) How will other residents affected be identified: Rounds will be completed of all rooms to ensure that there are not chemicals in inappropriate locations or that are not in a locked area.</p> <p>3) What measure or systematic changes will be put in place: Environmental rounds audits will be completed by the Environmental staff daily for two weeks starting 3/18/2013. Audits will then continue weekly in the month of April, then weekly for the month of May, then twice quarterly. Copies of the audits will be forwarded to the Administrator for review and follow up if needed.</p> <p>4) Monitoring. The Administrator will report audit findings to the Quality Assurance Meeting which meets monthly, to identify opportunities for performance improvement. The Administrator will ensure compliance.</p> <p>Date of Correction 3/18/2013</p>		

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F 323	Continued From page 34 may cause irreversible eye damage that may include pain, redness, swelling of the conjunctiva and tissue damage, skin irritation, possible chemical burns, and nausea or vomiting if swallowed.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure proper respiratory treatment and care was provided. This was true for 1 of 16 residents (Resident #4). The failed practice created the potential for harm for the resident requiring oxygen, and could have resulted in low oxygen levels. Findings included: Resident #4 was admitted to the facility on	F 328	F328 No residents were harmed as a result of this tag. The facility ensures proper respiratory treatment and care is provided. 1) Corrective Action: Resident # 4 remains in the facility and her Physician orders reflect the ordered Oxygen flow rate. 2) How will other residents affected be identified: An in-house audit of current residents on oxygen have been checked to ensure that all oxygen orders include the flow rate. The audit form is attached as _____ #6 3) What measures or systematic changes will be put in place : When a resident comes to the facility, the RCM checks the hospital discharge orders against the facility admission orders. To ensure that flow rates will not missed the facility audit sheet has been updated to specifically check the flow of the oxygen if ordered. The facility audit is completed after admission, quarterly and annually by the IDT team. Copy of the IDT audit form will be forwarded to the DNS for review and follow up if needed. The audit is attached as _____ #9 4) Monitoring: The DNS will track and trend audit findings and report results to the QA Committee that meets monthly to identify opportunities for performance improvement. The Administrator will ensure compliance. Date of Correction 3/18/2013.		

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F 328	Continued From page 35 4/22/11 with diagnoses of CHF (congestive heart failure), bronchitis, wound, anemia, Clostridium Difficile, shortness of breath, and pain. Resident #4's physicians order, dated 2/1/13-2/28/13 stated in part: "O2[oxygen] to maintain SATS [saturation] = or [less than] 90% (probable typing error) Special Instructions: O2 SAT Q[every] shift [DX (diagnosis): Obstruction, chronic airway] Q shift - Every Shift; Day, Evening, Night" During an observation on 2/26/13 at 6:00 PM in Resident #4's room, Resident #4 was observed with O2 on at 2 L (liters) per n/c (nasal/cannula). During an observation on 2/27/13 at 8:40 AM in Resident #4's room, Resident #4 was observed with O2 on at 2 L per n/c. During interview on 2/28/13 at 2:40 PM with LPN #1, one surveyor informed LPN #1 of the physicians order for O2 but did not mention a flow rate or range. LPN #1 stated, "We usually start at 2 L and titrate it up. I see there is no flow rate." On 2/28/13 at 5:30, the administrator and the DON were informed of the Oxygen issue. No other information was provided by the facility. The facility failed to provide a oxygen flow rate on the physicians order which had the potential for harm to the resident.	F 328	 F-328 RSDT #4 An order was obtained for the RsdT's O2 to state RsdT is to be on 2 liters of oxygen to main an oxygen saturation of greater than 90% <i>Exhibit #24</i>		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	F431 No residents were harmed as a result of this tag. The facility employs a licensed pharmacist who establishes a system of record of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. The facility provides separately lock permanently affixed compartments for storage of controlled drugs.		

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F 431	<p>Continued From page 36</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure schedule IV, controlled, medications were stored under double lock; opened, time-sensitive</p>	F 431	<p>1) Corrective Action: The identified Medication Cart in the Annex Hallway, has been replaced and all drawers are secured when the lock is engaged. The RCM's or designee will do audit (per schedule below) to ensure that all medication are dated appropriately and that LNs are locking medication carts when not in use. The identified refrigerator is locked with a padlock and a second box is kept inside that also has a lock on it which contains controlled drugs. LN's re-educated on 3/18/2013, by the DNS addressing accuracy of dates of medications, when medications are to be given, and the necessity to have refrigerated controlled drugs under double lock..</p> <p>2) How will other residents affected be identified: Medication cart audits will be completed. If medication are found to be expired and in need of replacement, or if medications are being given incorrectly, LN will receive on the spot in-servicing by the auditor.</p> <p>3) What measure or systematic change will be put in to place LN's and medication carts will be audited in two weeks starting 3/18/2013. The beginning of the second quarter, April 2013 two LNs will be audited monthly until the beginning of the third quarter July 2013. During the third quarter two LNs will be monitored monthly until October 2013 the beginning of the fourth quarter. For the fourth quarter two LNs will be monitored monthly. Copies of the audits will be forwarded to the DNS for review and follow up if needed. Please see [redacted] # 15</p> <p>4) Monitoring: The DNS will track and trend audit results and present findings to the QA Committee monthly to identify performance improvement opportunities. The Administrator will ensure compliance.</p> <p>Date of Completion: 3/18/2013</p>		

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F 431	Continued From page 37 medication was not available for resident use after it expired; medications were labeled according to physician orders; and, medication carts were secured when not in sight of staff. This was true when: * Two bottles of Ativan Intensol and 1 vial of Ativan for injection were not secured in 1 of 2 medication refrigerators. The failure created the potential for diversion of the medications and the potential for harm if the controlled medications were not available to treat medical conditions, such as anxiety and insomnia, for 1 of 13 sample residents (#7) and any resident for whom Ativan Intensol or Ativan for injection may be prescribed. * An open bottle of Calcitonin-salmon nasal spray was still available for 1 random resident (#25) after 35 days. Failure to discard the medication after 35 days created the potential for decreased effectiveness of the medication. * Two medications (Glyburide, an anti-diabetic, and Plavix, an anti-blood clot) were not labeled according to physician orders for 1 random resident (#17). Failure to label the medications as ordered created the potential for the medications to be administered a time different than the physician intended which could affect the medications' efficacy. * Two drawers in 1 of 3 medication carts were easily opened when no staff were in sight. The failure created the potential for harm for any independently mobile resident or residents who moved about the Annex Nurses' Station and the Annex Assisted Dining Room hallway. Findings included: 1. On 2/28/13 at 9:30 a.m., the locked refrigerator in the Annex Nurses' Station was inspected with RCM #9 in attendance. LN #2 and CNA #3 were	F 431	F-431 RSDT #7 RSDT #25 RsdT #7 medication "Ativan intensol" was placed in a double lock and placed in a locked box inside the locked refrigerator. RsdT #25 Calcitonin was discarded and was replaced with a new bottle of Calcitonin <i>Exhibit #25</i>		

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F 431	Continued From page 38 present.	F 431		
	<p>The following was found in the refrigerator:</p> <ul style="list-style-type: none"> * A 30 milliliter (ml) bottle of Ativan Intensol 2 milligrams (mg)/ml prescribed for Resident #7 was on a shelf in the refrigerator; and * Another 30 ml bottle of Ativan Intensol 2 mg/ml and a 1 ml vial of Ativan 2 mg/ml for injection, both for emergency use, were in a clear white plastic container with a closed lid and a red zip tie through the lid and the container. <p>When asked about a double-lock for the controlled medications, RCM #9 said the zip tie was considered to be the second lock. She acknowledged, however, that the Ativan prescribed for Resident #7 was loose in the refrigerator. When asked about the security of the zip tie, the RCM indicated the zip tie could not be broken. However, when the RCM applied pressure to the zip tie on the clear white plastic container, it broke. At that point, RCM #9 stated that she would take all of the Ativan medications out of the refrigerator and talk to the DNS about the storage issue.</p> <p>Later that day, RCM #9 stated that the 3 Ativan medications would be stored in the refrigerator in the medication room at the Main Nurses' Station.</p> <p>2. On 2/27/13 at 11:00 a.m., the Main Hall medication cart was inspected with LN #17 in attendance. A bottle of Calcitonin-salmon nasal spray prescribed for Resident #25, was noted as opened on 12/25/12. The LN confirmed the open date.</p> <p>Regarding storage of Calcitonin-salmon nasal</p>			

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F 431	<p>Continued From page 39</p> <p>spray, Medline Plus, a National Institutes of Health website, states, "What storage conditions are needed for this medicine? ... Store unopened Calcitonin salmon nasal spray in the refrigerator; do not freeze. Store opened bottles at room temperature in an upright position. ... Opened Calcitonin salmon stored at room temperature should be thrown away after 35 days. ..."</p> <p>3. On 2/28/13 at 10:30 a.m., during a medication pass observation, LN #1 poured 10 oral medication for Resident #17. The pharmacy label on 2 of these medications read: * Glyburide 5 milligrams (mg) 1 by mouth before breakfast; and * Plavix 75 mg 1 by mouth every evening.</p> <p>When asked if the resident had eaten, LN #1 stated, "Yes, just a few minutes ago." At that point, the LN was asked to reread the label on the Glyburide, and she did.</p> <p>LN #1 then locked the medication cart and walked toward the resident's room. At that point, she was asked to reread the label on the resident's Plavix. The LN reread the Plavix label and stated, "It's scheduled for the morning."</p> <p>Reconciliation of the 2 aforementioned medications with Resident #17's current physician orders revealed Glyburide was ordered as "daily" and Plavix was ordered as "every morning."</p> <p>On 2/28/13 at approximately 11:30 a.m., RCM #8 was informed of the labeling issue and asked to provide the original orders for both medication.</p> <p>At 12:35 p.m., RCM #8 provided Resident #17's</p>	F 431		

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F 431	Continued From page 40 admission orders, dated 10/2/12. These orders included Glyburide 5 mg by mouth daily and Plavix 75 mg by mouth every morning. When asked if there were any interim orders for either of the medications, RCM #8 stated, "No." Note: Regarding administration of Glyburide, the Nursing 2013 Drug Handbook, states, "Give drug with breakfast or first main meal." On 2/28/13 at about 5:30 p.m., the Administrator and DNS were informed of the medication storage and labeling issues. No other information or documentation was received from the facility that resolved the issue.	F 431			
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well	F 464	F464 No residents were harmed as a result of this tag. The facility does provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with non smoking areas identified, be adequately furnished and have sufficient space to accommodate all activities.		

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F 464	<p>Continued From page 41 ventilated, with nonsmoking areas identified; be adequately furnished, and have sufficient space to accommodate all activities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and review of the seating chart for the Annex Assisted Dining Room, it was determined that the facility failed to provide sufficient space to accommodate resident dining. This was true for 3 of 10 sampled residents (#'s 1, 6, and 7) and 6 random residents(#'s 18, and 20-24) who ate in the Annex Assisted Dining Room. The crowded dining room created the potential for a negative effect on the self esteem of the residents who dined there. Findings included:</p> <p>1. On 2/26/13, at 8:03 AM, during a breakfast meal observation in the Annex Assisted Dining Room, Resident #20 was observed in her wheelchair at a table in the dining room entrance. Trays had started being served.</p> <p>At 8:10 AM, a staff member brought Resident #21 to the dining room in her wheelchair. CNA #3 stated "We're gonna move you back". CNA #3 pulled Resident #20 back in her wheelchair away from the table and her meal. Two CNAs moved the table toward Resident #20 and then pushed Resident #21 in her wheelchair to the other side of the table, across from Resident #20.</p> <p>2. On 2/27/13, at 11:55 AM, during a lunch meal observation, CNA #14 wheeled Resident #24 in his wheelchair to the table in front of the doorway at the entrance to the Assisted Dining Room.</p>	F 464	<p>1)Corrective Action: The space in the annex assisted dining room was reevaluated and rearranged to be more conducive in meeting the needs of the residents. The dining rooms in the annex are now arranged in a way that allows uninterrupted meal times for the residents who eat there, including the identified residents # 1,6,7,18,20-24. The rearrangement and moving of tables to the other dining room has resulted in a more pleasant dining space and experience. Staff were in- serviced on 3/18/2013 by the DNS or designee of the new seating arrangements which contribute to the resident's dining experience.</p> <p>2) How will other residents affected be identified: The dining room in the annex will be reviewed weekly and then monthly by the dietary services supervisor to assess for sufficient use of dining space and ensure all residents in the dining are being allowed uninterrupted meals. Results of the Dietary Services Dining Room review will be forwarded to the Administrator for review and follow up if needed. See [redacted] # 10</p> <p>3) What measure or systematic change will be put in place: The dining room experience has been added to the audit that is completed after admission, quarter and annually by the IDT team. A copy of this audit is attached and is referred to as [redacted] # 4</p> <p><i>Monitor</i> [redacted] Audits of the dining room will be completed weekly for two weeks by the DSM starting 3/18/2013, then monthly by the DSM. The IDT team will assess each resident dining experience as they come up for audit after admission, quarterly and annually. The Administrator will review the audit findings and present the results to the QA Committee monthly to identify opportunities for performance</p> <p style="text-align: right;">3/18/2013</p>

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F 464	<p>Continued From page 42</p> <p>CNA #15 entered the Assisted Dining Room scooting by Resident #24 in the doorway. CNA #13 also squeezed by Resident #24, and sat at a table with other residents.</p> <p>At 12:12 PM, a visitor walked sideways behind Resident #24 to enter the Assisted Dining Room.</p> <p>At 12:32 PM, CNA #15 wheeled a resident into the Assisted Dining Room, and almost ran into Resident #24, who was in a wheelchair at the table in the doorway. Staff entered and exited the room while serving trays from the cart that was parked outside the dining room.</p> <p>At 12:40, CNA #3 pulled Resident #24 backwards in his wheelchair away from his table and his meal which he was eating. RN #2 pulled the same table away from the wall so Resident #21 could be placed behind it and across from where Resident #24 had been sitting. Staff continued to walk around and in front of Resident #24 and served other residents their trays. CNA #3 wheeled Resident #20 to Resident #24's table and told Resident #24 who was still sitting in the doorway, "Hold on big guy we're just going to get a few more people squeezed in there."</p> <p>At 12:48 PM, CNA #3 wheeled Resident #24 back to his table. Resident #24's wheelchair was sticking out into the doorway, blocking two thirds of the Assisted Dining Room entrance when he was sitting at his table.</p> <p>At 12:55 PM, CNA #3 asked CNA #15, "Can I get you to move [Resident #24's name]?" CNA #15 told Resident #24, "Just going to get you back a minute." CNA pulled Resident #24 backward in</p>	F 464			

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F 464	Continued From page 43 his wheelchair away from his table and his meal again and into the doorway so that CNA #16 could get a resident through the dining room entrance, in front of Resident #24. CNA #15 then pushed Resident #24 back up to his table and his meal. LN #1 assisted Resident #6 out of the dining area and told her "Let us get thru here", as they walked single file thru the entrance behind Resident #24. The entrance to the dining room was reduced to 12-18 inches, while Resident #24 was sitting at his table.	F 464		
F 514 SS=D	On 2/27/13 at 7:00 PM, the Administrator and the DON were informed of the crowded space in the Annex Assisted Dining Room. The facility failed to provide sufficient space to accommodate resident dining in the Assisted Annex Dining Room. 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	F514 No residents were harmed as a result of this tag. The facility maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 1)Corrective Action: The facility promptly ensures a resident physician is immediately noticed when the resident's pain medication is determined not to be effective. An in-service for licensed staffs on 3/18/2013 on pain, assessment of, documentation and the policy and procedure that is currently in place since January of 2013. Both are attached as [redacted] When a resident comes to our facility from the hospital the RCM checks the admit orders against the admission order. To ensure all orders are in place medical records inputs the orders then the RCM double checks and signs the POS to ensure that no orders have been missed.	

F-464

RSDT #1,#6,#7,#18,#20,#21,#22,#23,#24

For all Rsd'ts affected the dining room was re-arranged

to prevent interruptions of meals.

Exhibit # 19

1 + 2

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F 514	Continued From page 44 by: Based on record review and staff interview, it was determined the facility failed to ensure residents' clinical records were complete and accurate. This was true for 1 of 15 sample residents (# 14). Failure to maintain complete and accurate medical records placed residents at risk for medical decisions based on incomplete or inaccurate information and at risk for complications related to inappropriate care. Findings included: Resident #14 was admitted to the facility on 11/23/12 with diagnoses which included pneumonia and chronic pain. The admitting Physician Orders, dated 11/23/12 documented the Resident was to receive oxygen at 2 liters per minute if needed. "Resident Progress Notes" (PN) documented the resident had received oxygen on 2/25/12. Resident #14's recapitulation orders, dated 11/23/12-11/30/12 and 12/01/12-12/31/12 did not include an order for oxygen. On 3/1/13 at 10:15 a.m. RCM #12 stated the order for oxygen should have been on the above recapitulation orders. Resident #14's PN documented the resident's pain medication was not effective. A fax, dated 11/26/12, requesting an order for a pain medication did not document the physician had responded to the order. The PN did not document the physician had responded to the order.	F 514	This has been in place since January of 2013. <u>Resident #14 was discharged from the facility on 12/26/2012.</u> 2)How will other residents affected be identified: Attached is copy of physician order review policy and procedure. The policy is [redacted] Also chart audits of the complete medical record are done after admission, quarterly and annually. The audit sheet that is used is attached as [redacted] 3)What measure or systematic change will be put in place: The audit system is completed on each resident after admission, quarterly and annually. Also a new policy [redacted] is in place. Medical records check the orders while doing the input and then the RCM or RN signs off that the POS is correct. 4)Monitoring: The DNS and RCMs will monitor and the Administrator will ensure accuracy. MACC meeting takes place five days a wee Monday through Friday [redacted] Also in addition the residents' plan of care and entire chart are audited after admission, quarterly, and annually. The audit form is [redacted] All finding are reviewed by the Quality Assurance Committee which meets monthly. Date of Correction 3/18/2013	18 4 18 5 4

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/01/2013
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501		
(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 514	Continued From page 45 On the side of the 11/26/12 fax was a handwritten statement, "11/27/(illegible) re-faxed MD office called stated will call back." The medical record did not document if the physician called back or any other information regarding the request for pain medication. The physician did order pain medication on 11/28/12 when the resident had an appointment, however, there was no documentation if the order or the appointment were in response to the fax.	F 514	F-514 RSDT#14 RsdT is no longer in facility plan of correction in place to prevent any re-occurrences.		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE OF	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501
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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 recertification/complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Sherri Case, LSW, QMRP, Team Coordinator Linda Kelly, RN Karla Gerleve, RN Jim Troutfetter, 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 Service IDT = InterDisciplinary Team I&Os = Intake and Output LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS - Minimum Data Set assessment POC = Plan of Care RAI = Resident Assessment Instrument RAPS = Resident Assessment Protocol Summary Recap = Physician Recapitulation Orders TAR = Treatment Administration Record</p>	C 000		
C 125	02.100,03,c,ix Treated with Respect/Dignity	C 125	C125- Refer to plan of correction for F164	3/18/2013

Bureau of Facility Standards

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

STATE FORM

TITLE

(X8) DATE

3/22/2013

68899

22T441

If continuation sheet 1 of 8

Bureau of Facility Standards

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C 125	Continued From page 1 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 F164 as it related to privacy during personal care.	C 125		
C 173	02.100,12,d Immediate Notification of Physician of Injury d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please see F 157 as it pertains to physician notification.	C 173	C173- Refer to plan of correction for F157	3/18/2013
C 295	02.107,04,d Current Diet Manual d. A current diet manual approved by the Department and the patient's/resident's physician shall be available in the kitchen and at each nursing station (the Idaho Diet Manual is approved by the Department). This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility did not ensure a current approved diet manual was available at the nurse's station. This affected all residents residing in the facility. Findings included: On 2/28/13 at 10:29 AM, the facility's main nursing station was checked for a current and	C 295	C295 - A diet manual placed at each nurses station	3/18/2013

Bureau of Facility Standards

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C 295	Continued From page 2 approved dietary manual. At that time, the LN at the main nurse's station stated there was no dietary manual at the nurse's station. When asked about the dietary manuals on 2/28/13 at 3:45 PM, the Dietary Manager stated it was the policy of the facility to keep a copy in the Dining Services department and it was not required to have them at the nurse's stations. The Dietary Manager provided a copy of the policy, revision dated 01/2013, to the surveyor at that time. On 3/6/13 at 9:42 a.m., the Administrator was notified the facility's current dietary manual was not approved by the state by voice mail. During a meeting on 2/28/13 from 5:30 - 5:45 PM, the Administrator was made aware of the requirement to have dietary manuals at nurses' stations and directed the Dietary Manager to place them there. The policy contained the the name of an unapproved dietary manual the facility was using and the procedure stating "A copy of the diet manual is available in the dining services department where it will be available any time of the day."	C 295		
C 422	02.120.05,p,vii Capacity Requirments for Toilets/Bath Areas vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror	C 422	<i>please refer to Page #5</i>	

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C 422	<p>Continued From page 3</p> <p>for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not provide one bathtub or shower for every twelve licensed beds. This had the potential to affect 13 of 13 sample residents (#s 1 through 13) and all other residents who lived in the facility. The failure created the potential for a negative affect on residents' psychosocial well-being related to bathing. Findings included:</p> <p>Note: At the time of the survey process, on 2/25/13, the facility was licensed for 127 beds and 77 residents lived in the facility.</p> <p>On 2/28/13 from 11:10 a.m. to 12:00 p.m., during a tour of the facility environment, the Maintenance Director pointed out 6 working bathing areas for resident use to two surveyors. He also pointed out a shower area near the kitchen and stated it was for staff, and occasionally, visitor use. He stated, however, that the staff/visitor shower did not have a call system. The Maintenance Director also stated that a shower area in the Therapy Department was used for training purposes only because the hot and cold running water had been disconnected. When asked if there were any other bathing areas in the facility or in resident rooms, the Maintenance Director stated, "No."</p> <p>The working bathing facilities for resident use were:</p> <ul style="list-style-type: none"> * One shower area in the Shower room across the hall from the Main Hall Nurses' Station; * Two bathing areas in the Shower/Tub room next 	C 422		

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C 422	Continued From page 4 to the Social Services office; * Two bathing areas in the Shower/Tub room between rooms 304 and 308; and, * One shower area in the Shower room next to room 323. On 2/28/13 at 12:50 p.m., when informed of the bathing facility issue, the Administrator stated, "We only use 79 beds and the other rooms are used for offices." No other information or documentation was received from the facility that resolved the issue.	C 422	C422 - Administrator will contact Bureau of facility standards for a waiver of facility being set up for 79 beds. The other beds listed on the license are used for office spaces only. <i>See fax 3/26/2013 Pg 5a dmy</i>	<i>3/25/2013</i>
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it related to the revision of care plans.	C 782	C782 - Refer to plan of correction for F280	<i>3/18/2013</i>
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F300 as it related pain. <i>dy</i> F 309	C 784	C784 - Refer to plan of correction for F309 <i>dy</i>	<i>3/18/2013</i>
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers	C 789	C789 - Refer to plan of correction for F314	<i>3/18/2013</i>

3/28/2013 Administrator notified of correction via email @ 2:41 pm dmy

25/13

C422 On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds. The current license is for 127 beds requiring there be 10.58 showers or tubs

To accommodate 127 licensed beds. Currently the facility has 6 shower/tubs available. In order to meet the state requirement the following will be completed:

- The shower area near the kitchen will be designated for residents and the call light will be reconnected to the system.
- The shower in the therapy department will have the hot and cold running water reconnected and will also be made available for residents.
- The shower area across from the main nurse's station originally had two shower areas in the room. The shower will be reconnected and a privacy curtain will be installed.
- The shower area next to room 323 originally had two showers in the room. The second shower that was removed will be reinstalled.
- The hall on the way to therapy will have the original two showers in the room reconnected and a privacy curtain installed. The shower room will also be made available for the residents use.

In order to complete the above tasks I would like to request a waiver on the time limit of the current plan of correction for this tag only (C422) and request a completion date May 15th 2013.

Maintenance Director to monitor, The Administrator will ensure compliance.

Date of completion May 15, 2013

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FACILITY STANDARDS

Bureau of Facility Standards

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C 789	Continued From page 5 or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it related to pressure ulcers.	C 789		
C 794	02.200,03,b,x Respect and Kindness x. Treatment of patients/residents with kindness and respect; This Rule is not met as evidenced by: Refer to F241 as it related to treatment of residents.	C 794	C794 – Refer to plan of correction for F241	3/18/2013
C 797	02.200,03,c Documentation of Nursing Assessments c. Nursing staff shall document on the patient/resident medical record, any assessments of the patient/resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a monthly summary of the patient's/resident's condition and reactions to care shall be written by a licensed nursing staff person. This Rule is not met as evidenced by: Refer to F281 as it related to pre-initialing	C 797	C797 – Refer to plan of correction for F281	3/18/2013

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C 797	Continued From page 6 medications.	C 797		
C 832	02.201,02,f f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F431 as it related to pharmacy labels on medications.	C 832	C832 – Refer to plan of correction for F431 <i>3/18/2013</i>	
C 838	02.201,02,l l. All medications in the facility shall be maintained in a locked cabinet located at, or convenient to, the nurses' station. Such cabinet shall be of adequate size, and locked when not in use. The key for the lock of this cabinet shall be carried only by licensed nursing personnel and/or the pharmacist. This Rule is not met as evidenced by: Refer to F431 as it related to medication storage.	C 838	C838 – Refer to plan of correction for F431 <i>3/18/2013</i>	
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;	C 882	C882 – Cause of death will be added in red to discharge paperwork Along with discharge diagnosis as well as specific mortuary with address. Address of where resident discharged to, and condition on discharge, Will also be added to discharge papers <i>3/18/2013</i>	

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C 882	Continued From page 7 branch and dates of military service (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. This Rule is not met as evidenced by: Based on closed record review and staff interview, it was determined the facility failed to ensure a final diagnosis, or cause of death, was provided by the attending physician and documented in the medical record. This was true for 1 of 3 closed records (#15) reviewed. Findings include: Resident #15 was admitted to the facility on 11/8/07. The resident died in the facility on 1/1/13. On 2/28/13 Resident #15's closed record was reviewed. However, a final diagnosis, or cause of death, was not included. The Administrator and the DON were informed on 2/28/13 at 5:30 p.m. a final diagnosis or cause of death was not included in the record. The Administrator stated the facility would contact the physician to provide a final diagnosis for Resident #15.	C 882		

Exhibit # 20



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

March 28, 2013

Julie J. Johansen, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Johansen:

On **March 1, 2013**, a Complaint Investigation survey was conducted at Prestige Care & Rehabilitation - The Orchards. Sherri Case, L.S.W., Q.M.R.P., Linda Kelly, R.N., Karla Gerleve, R.N. and Jim Troutfetter, Q.M.R.P. conducted the complaint investigation.

The complaint investigation was conducted in conjunction with the annual Recertification and State Licensure survey. The records of fourteen residents were reviewed and interviews were conducted with a variety of facility staff including the Administrator, Director of Nursing, Licensed Nurses and Certified Nurse Aides (CNAs). Residents and their families were interviewed as well.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005855

ALLEGATION #1:

The complainant stated a resident was in pain and the only pain medication ordered was Tylenol.

FINDINGS:

Based on records reviewed and staff interviewed, it was determined the facility failed to ensure assessments for pain and timely physician response for ongoing pain control for a resident admitted with chronic pain. The facility was cited at F157 and F309 related to these deficient practices. The facility

Julie J. Johansen, Administrator
March 28, 2013
Page 2 of 3

was also cited at F514 for failure to ensure documentation was complete.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the resident required oxygen.

FINDINGS:

Although it could not be determined through records reviewed that there was deficient practice related to the identified resident, other issues involving oxygen were identified and the facility was cited at F328.

Additionally, the facility was cited at F514 for failure to ensure a resident's physician recapitulation orders included an order for the use of oxygen.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated a white tablet was observed on a resident's bedside table.

FINDINGS:

Medications were not observed to be left unattended in residents' rooms. However, the facility was cited at F431 for failure to ensure schedule IV, controlled, medications were stored under double lock; opened, time-sensitive medication was not available for residents use after it expired; medications were labeled according to physician's orders and medication carts were secured when not in sight of staff.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant stated a resident was observed slouched down in bed.

FINDINGS:

Observations were conducted at various times of the day between February 25 and March 1, 2013, to

Julie J. Johansen, Administrator
March 28, 2013
Page 3 of 3

determine if residents were appropriately positioned in their wheelchairs or beds. The observations took place in residents' rooms, dining rooms and in the hallways. CNAs were noted to reposition residents when needed or if the resident requested to be repositioned. During these observations, there were no documented incidents of residents being positioned incorrectly in their beds or wheelchairs.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated the facility had been requested to provide a smoking patch for the resident.

FINDINGS:

The identified resident's November 23, 2013, physician orders included a diagnosis of personal use of tobacco.

Staff interviewed at the facility stated that the resident did not smoke. There was no evidence in the resident's record that documented the resident smoked or had requested a patch to help with nicotine withdrawal.

The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj