



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: 7009 0820 0000 2798 6178

April 9, 2012

Shon L. Shuldberg, Administrator
Ashton Living Center
700 North Second Street, PO Box 838
Ashton, ID 83420

Provider #: 135097

Dear Mr. Shuldberg:

On **March 30, 2012**, a Recertification and State Licensure survey was conducted at Ashton Living Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency 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 sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 23, 2012**. Failure to submit an acceptable PoC by **April 23, 2012**, may result in the imposition of civil monetary penalties by **May 14, 2012**.

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 **May 4, 2012 (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 **May 4, 2012**. A change in the seriousness of the deficiencies on **May 4, 2012**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 4, 2012** includes the following:

Denial of payment for new admissions effective **June 30, 2012**. [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 30, 2012**, 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.

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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 30, 2012** 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:

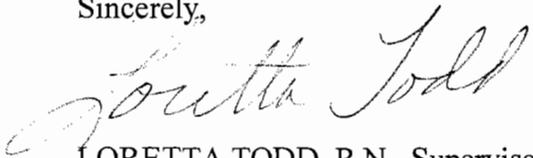
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **April 23, 2012**. If your request for informal dispute resolution is received after **April 23, 2012**, 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 # 135097	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 3/30/2012
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 838 ASHTON, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 204	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on closed record review and staff interview, it was determined the facility failed to maintain an accounting of a resident's belongings upon discharge. This was true for 1 of 1 residents (#10) reviewed for discharge. Findings included:</p> <p>Resident #10 was admitted to the facility on 3/14/11 with diagnoses including malaise and fatigue. The resident expired on 2/15/12.</p> <p>The resident's closed clinical record provided evidence that the resident was admitted with belongings. However, the record did not provide evidence that the resident's belongings were accounted for.</p> <p>On 3/29/12 at 4:18 p.m., Resident Services (RS) stated, "The family took some belongings and donated some other belongings to the facility." The surveyor requested where that was documented in the clinical record. The RS indicated "not sure."</p> <p>On 3/30/12 at 10:00 a.m., the DON was informed of the finding. The facility did not provide any additional information.</p>		
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: Based on observation and staff interview, it was determined that the facility failed to ensure their nurses followed Idaho State Nursing Board rules when administering medications. This was true for 1 of 2 nurses (LN #4) observed administering medications. This failure in practice had the potential to result in medication errors for Resident #2 and any resident whose medications were signed before administration. Findings include:</p> <p>The Bureau of Facility Standards Information Letter #97-3, dated 4/16/97 states, "...long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually had taken the medication. ...the Board's [of Nursing] expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."</p>		

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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

The above isolated deficiencies pose no actual harm to the residents

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F 281	<p>Continued From Page 1</p> <p>During a medication pass observation on 3/28/12 at 8:15 am, LN #4 was at her medication cart by the nurses station. LN #4 crushed 4 medications, including Fluoxetine, Tramadol, vitamin D, and Ritalin, then added liquid Tylenol and liquid Omeprazol to the crushed medications in preparation of administering them to Resident #2 through her peg tube. After preparing the medications for administration, LN #4 signed the medications and then took the medications to the resident's room to administer them. After LN #4 administered the medications she was asked why she signed them before administering them. LN #4 acknowledged that she pre-signed Resident #2's medications. LN #4 stated she did not generally pre-sign other resident's medications because she was not sure, until they took them, that they would take them, but she was sure she would be administering Resident #2's medications through her peg tube and thought it would be okay to pre-sign them.</p> <p>On 3/30/12 at 8:30 am, the DON and the acting Administrator were notified of the deficient practice. The facility provided no further information.</p>		
F 465	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain 1 of 1 walk-in freezer in a safe operating condition. This related specifically to a build-up of what appeared to be water on the ceiling that had dripped onto the floor and then froze both on the floor and the ceiling. There was also a build-up of ice located where the condenser unit pipes entered the freezer ceiling. This had the potential to affect the frozen food stored in the freezer. Findings included:</p> <p>On 3/26/12 at 2:45 p.m. during the initial tour of the facility kitchen, what appeared to be frozen water was observed on the ceiling and floor of the walk-in freezer. In another location where the condenser pipes entered the freezer, the build-up of ice covered an area approximately 7 by 10 inches. There was no evidence of water or ice dripping onto any frozen food items. Also, there was no evidence of frozen food thawing and refreezing. The CDM accompanied the surveyor during the initial tour.</p> <p>- At 2:50 p.m., the surveyor, CDM, DON, and Maintenance Supervisor (MS) reviewed the ice build-up in the freezer. The MS indicated that a refrigeration professional would be contacted.</p> <p>On 3/27/12 at approximately 3:00 p.m., the CDM said that a refrigeration professional evaluated the freezer. The surveyor observed that the same ice build-up, 7 by 10 inches, was still at the same ceiling location. The CDM stated, "We will call and have the unit looked at again."</p> <p>On 3/28/12 at approximately 5:00 p.m., the CDM said the determination was that the freon level was low in</p>		

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NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 838 ASHTON, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 465	<p>Continued From Page 2</p> <p>the condenser unit. The surveyor did not observe any ice build-up in the freezer after the second evaluation by the refrigeration professional.</p> <p>On 3/30/12 at 10:00 a.m., the DON was informed of the finding. The facility did not provide any additional information.</p> <p>F465 -Specific Resident - There was no harm for a specific resident. Other Residents - All residents have the potential to be affected. As stated in summary statement but not listed in POC the refrigeration professional determined the Freon was low and add Freon to the freezer. There was no longer any ice build up in the compressor that was observed. Systemic Changes - The kitchen staff were inserviced on concerns of ice build up in the freezer and potential causes for the ice build up how it could affect the residents. CDM will do daily checks on the freezer and check for build up. If build up is observed she will contact Administrator and MS to discuss how to resolve the ice build up. Monitor - CDM will monitor the freezer 2 X a week to check for ice build up for one month. She will check freezer once a month for 11 months to track any build up and report findings to the QA committee. Audits Starting 4/25/2012</p> <p>F204 A Administration Treatment Discharge of resident #10 - no belongings list check off completed. Specific Resident - # 10 (deceased) was contacted and they confirmed all the resident's belongings were accounted for when they removed his things from his room. Other Residents - Day shift LCNAs inventoried each existing patients belongings and downloaded the list onto Matrix electronic medical record system using the form entitled inventory of personal items. This list is now available for all subsequent discharges or deaths when they occur. Systemic Changes - The LCNAs will be responsible for the belongings lists on all admissions. DNS created an addition to Discharge Plan of Care and Nursing Packet for Deceased that reads "Has the Resident Belonging List been checked off with family members?" as a requirement on these checklists. Monitor - DNS has reviewed this checklist with charge nurses in a nursing inservice on April 18, and will monitor all discharges for 6 months weekly as evidenced by written documentation of this QA. Audits Starting 4/25/2012</p> <p>F281 refer to C804</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/30/2012
NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 838 ASHTON, ID 83420	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Lorraine Hutton, RN, QMRP Survey Definitions: ADL = Activities of Daily Living BFS = Bureau of Facility Standards BIMS = Brief Interview for Mental Status BP = Blood Pressure CAA = Care Area Assessment CNA = Certified Nurse Aide DON = Director of Nursing DX = Diagnosis LN = Licensed Nurse MAR = Medication Administration Record MDS - Minimum Data Set NPO = Nothing by Mouth PO = By Mouth POC = Plan of Care RAI = Resident Assessment Instrument RAPS = Resident Assessment Protocol Summary Recap = Physician Recapitulation Orders SpO2 = Pulse Oximeter Oxygen Saturation TR = Treatment Record UTI = Urinary Tract Infection	F 000	Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *[Signature]* (X6) DATE: 4/25/12

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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(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 226	<p>Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on personnel record review, review of the facility's Abuse Policies and Procedures, and staff interview, it was determined the facility failed to: 1) ensure that the State of Idaho CNA abuse registry was checked prior to employing individuals as CNAs. This was true for 2 of 3 CNAs (Staff A & Staff D), and 2) perform reference checks for newly hired employees (Staff B, C & D). This was true for 3 of 5 staff (Staff B, C, & D). Failure to conduct comprehensive employment screenings placed the residents at risk for potential abuse. Findings included:</p> <p>The facility's undated "Operational Policy and Procedure Manual, Background Screening Investigations" documented, "...This facility will conduct employment background screening checks, reference checks...on individuals making applications for employment with this facility...Such investigation will be initiated prior to an offer of employment being made...Will conduct...reference checks...For any individual applying for a position as a certified nursing assistant [CNA], the state nurse aide registry for each state in which the applicant has worked will be(sic) contacted..."</p> <p>Federal Guidance at §483.13(c)(1)(ii) and (iii) states, in part, "...Facilities must be thorough in their investigations of the past histories of individuals they are considering hiring...inquiry of the State nurse aide registry...previous and/or current employers..."</p>	F 226	<p>Specific Residents The CNA registry was checked for staff A & D and comprehensive employment screenings were finished on staff B, C & D. placed in file</p> <p>Other Residents All residents have the potential to be affected. All potential new employees will have the CNA registry checked and a comprehensive employment screening completed before they begin work in the facility.</p> <p>Systemic Changes Department managers and HRD were inserviced regarding the need to complete CNA registry checks and comprehensive employment screenings. The HRD will verify reference checks are completed prior to a newly hired employee beginning work.</p> <p><i>add 5.2.12 see fax for who will verify CNA registry km</i></p>	4/27/12	

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NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 838 ASHTON, ID 83420
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 226	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on personnel record review, review of the facility's Abuse Policies and Procedures, and staff interview, it was determined the facility failed to:</p> <p>1) ensure that the State of Idaho CNA abuse registry was checked prior to employing individuals as CNAs. This was true for 2 of 3 CNAs (Staff A & Staff D), and</p> <p>2) perform reference checks for newly hired employees (Staff B, C & D). This was true for 3 of 5 staff (Staff B, C, & D). Failure to conduct comprehensive employment screenings placed the residents at risk for potential abuse. Findings included:</p> <p>The facility's undated "Operational Policy and Procedure Manual, Background Screening Investigations" documented, "...This facility will conduct employment background screening checks, reference checks...on individuals making applications for employment with this facility...Such investigation will be initiated prior to an offer of employment being made...Will conduct...reference checks...For any individual applying for a position as a certified nursing assistant (CNA), the state nurse aide registry for each state in which the applicant has worked will be(sic) contacted..."</p> <p>Federal Guidance at §483.13(c)(1)(II) and (III) states, in part, "...Facilities must be thorough in their investigations of the past histories of individuals they are considering hiring...inquiry of the State nurse aide registry...previous and/or current employers..."</p>	F 226	<p>Specific Residents</p> <p>The CNA registry was checked for staff A & D and comprehensive employment screenings were finished on staff B, C & D. placed in file</p> <p>Other Residents</p> <p>All residents have the potential to be affected. All potential new employees will have the CNA registry checked and a comprehensive employment screening completed before they begin work in the facility.</p> <p>Systemic Changes</p> <p>Department managers and HRD were inserviced regarding the need to complete CNA registry checks and comprehensive employment screenings. The HRD will verify reference checks are completed prior to a newly hired employee beginning work.</p> <p>HRD will complete, check and Verify the CNA registry. 5/2/12</p>	4/27/12
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NAME OF PROVIDER OR SUPPLIER ASHTON LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 838 ASHTON, ID 83420		
(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 226	Continued From page 2 1. Staff A, CNA Hire date: 1/3/12 No evidence of the CNA registry check prior to or after employment. 2. Staff B, Nurse Aide (NA) Hire date: 3/7/12 No evidence of reference checks were not initiated or completed. 3. Staff C, NA Hire date: 3/14/12 No evidence of reference checks were not initiated or completed. 4. Staff D, CNA Hire date: 1/18/12 No evidence of the CNA registry check prior to or after employment. No evidence of reference checks were not initiated or completed. 5. On 3/28/12 at 1:30 p.m., the personnel records of the above identified staff were reviewed with the Human Resources Director (HRD). a. When the surveyor asked the HRD for verification of the CNA registry check, for Staff A and D, to rule out any abuse findings, the HRD stated, "I cannot check the CNA registry as I do not have access to the CNA registry." The surveyor then requested that the HRD and the surveyor place a telephone call to the BFS to obtain access to the CNA registry. The HRD proceeded to open the Internet connection to the Idaho Department of Health and Welfare website, clicked on the link to the CNA registry. The HRD then printed a copy of Staff A's and D's CNA registry check that provided no evidence of abuse	F 226	Monitor The <u>DON</u> will set up <u>weekly audits</u> of CNA registry checks and comprehensive employment screenings beginning <u>4/4/2012</u> , continuing for at least <u>one month</u> and then upon hire for two months. These audits will be submitted to the Administrator who will follow up with results and submit results to the QA committee for review. Audits Starting 4/25/2012	4/27/12	

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F 226	Continued From page 3 findings for either staff. b. When the surveyor asked the HRD for verification of reference checks for Staff B, C & D, the HRD stated, "Previous surveyors told me that I did not have to do reference checks." The surveyor reviewed with the HRD the Federal Guidance at §483.13(c)(1)(ii) and (iii) and again verified that reference checks were not completed for Staff B, C, & D.	F 226			
F 241 SS=E	On 3/30/12 at 10:00 a.m., the DON was informed of the findings. The facility did not provide any additional information. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain an environment that enhanced residents' dignity and respect. This related specifically to referring to residents who were assisted with dining as "Feeders." This affected 3 of 10 (#s 5, 7, & 8) sample residents and 3 of 3 random residents (#s 11, 12, & 13). This practice created the potential that residents would experience loss of self esteem and or despression. Findings included: Federal guidance at §483.15(a) - Dignity states, "Respecting residents by speaking	F 241	Specific Residents Residents #5,7,8,11,12,13 at the maximum assist table both now and in the future will no longer be referred to as "feeders". Other Residents All maximum assist residents have potential to be affected. DNS has individually counseled with LNs to refer to these residents by name or "the residents at the pink tables" rather than "feeders". Systemic changes DNS has individually counseled with LNs to refer to these residents "the residents at the pink tables" rather than "feeders". DNS attended shift changes at 0600 and 1400 for one week after surveyors left the building and discussed use of the term "feeders" with CNAs leaving shift. Lead CNAs have been trained to continue to inform staff of this change. Issue was reviewed with nurses again at a nursing inservice and with all staff in an all staff meeting April 18		

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F 241	Continued From page 4 respectfully...avoiding use of labels for residents such as "feeders,'..." On 3/26/12 at approximately 4:30 p.m., the surveyor requested to know which residents dined at the different tables in the dining room. When the CDM #1 told the surveyor the names of the residents who sat at the eating assistance table, the CDM referred to the residents as, "Feeders." On 3/27/12 at 8:19 a.m., LN #2 was standing at the doorway to the dining room. The LN referred to the residents who required assistance eating as, "Feeders." On 3/27/12 at 9:56 a.m., RA #3, who was in the dining room, referred to the residents who required eating assistance as, "Feeders." On 3/30/12 at 8:30 a.m., the survey team informed the DON of the above observations. On 3/30/12 at 10:00 a.m., at the exit conference, the DON was again informed of the observations. The facility did not provide any additional information.	F 241	Monitor CDM will monitor dining room for staff use of term "feeder" at meals. 3 x a week for a month. 1 X a week for 1 month and once a month for 4 months and will report finding to QA committee. Audits Starting 4/25/2012	4/27/12	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280	Specific resident - Resident assessment #2, 5, and 6. Care Plan review and revision: All residents injured in a fall will have a Fall Risk Assessment completed to reflect an individualized plan of care based on all new physician orders, assessment findings, and wound care from the fall.		

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F 280	<p>Continued From page 5</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure that residents' care plans were developed and revised based on residents' current needs. This was true for 3 of 6 sampled residents (#2, 5, & 6). Failure to develop and revise comprehensive, individualized care plans to identify potential and current problems and interventions, placed the residents at risk to receive inappropriate and inadequate care to meet their individualized needs. Findings include:</p> <p>1. Resident #5 was admitted to the facility 4/26/10, and readmitted on 10/22/11, after a fall with a fracture. The resident's diagnoses included altered mental status, moderate intellectual impairment, osteoarthritis, depression, and anxiety.</p> <p>The resident's 11/3/11 Significant Change MDS assessment coded a 3 (severe cognitive impairment) on the BIMs and documented the</p>	F 280	<p>#5 New Fall Risk Assessment has been completed on Resident #5 on the electronic medical record. Prerestraining Assessments are in place from the 10-4-11 fall for a lap buddy, but the resident removed the lap buddy on 10-20-11 and fell again resulting in a fracture. On 20-24-11 when resident returned from the hospital lap buddy was placed, as a t-belt was not available. A Prerestraining Assessment was completed at that time for a 72-hour trial of a T-belt, which was placed on 11-10-2011, trialed and deemed safe for this resident. It is still in use. The care plan has been updated to reflect this information.</p> <p>#2 Care Plan needed for Baclofen Pump Comprehensive Care Plan will accurately reflect all aspects of resident care. Baclofen Pump Care Plan created by MDS coordinator with information from the prescribing doctor on signs and symptoms of overdose of baclofen, or other problems that could occur using an intrathecal pump, information on the pump alarm system and what interventions were necessary when alarms sounded, information regarding the dose of baclofen being administered, and interventions in the event the family was unable to take the resident to the clinic for pump refills.</p>	

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F 280	<p>Continued From page 6 resident had a fall with a fracture during the past 30 days.</p> <p>Review of Incident and Accident Reports for May 2011 through March 2012, revealed Resident #5 had 3 falls between 5/7/11 and 10/20/11: * On 5/7/11 at 7:45 am, the resident was found on the floor next to her bed. The resident's floor alarm had not sounded. The resident had a small skin tear as a result of the fall. The Supervisor's Falls Investigation Report indicated that the intervention was to remind the nurses to turn the floor alarm on when the resident was in bed. No other individualized Care Plan changes were documented.</p> <p>* On 10/4/11 at 9:30 am, the resident was again found on the floor by her bed. No injury was noted. The Supervisor's Falls Investigation Report indicated the Care Plan addressed prevention of falls per the facility's Fall Prevention Program and that the "Care Plan was complete." However, the Fall Prevention Program was generic in nature and the Resident #5's care plan was not individualized to address why she was falling and what steps, based on the reason the resident was falling, should be taken to prevent further falls.</p> <p>* On 10/20/11 at 7:30 pm, Resident #5 was by the fireplace in front of the nurses station. Resident #5 removed her lap buddy and attempted to stand. Although the alarm went off and staff immediately rushed to the resident, Resident #5 fell before staff reached her. This fall resulted in a fractured hip which required surgery. The Supervisor's Falls Investigation Report documented again that the Care Plan addressed the fall through the Fall Prevention Program. No</p>	F 280	<p>#6 Lorazepam and Clonazepam (not prescribed) both on care plan. Comprehensive Care Plan will accurately reflect all aspects of resident care. Care Plan on resident #6 updated by MDS coordinator to correctly reflect medication orders.</p> <p>Other residents All residents have the potential to be affected. DNS edited Fall Event report form with addition to DNS follow up reads "has a new Fall Risk Assessment been initiated as a result of this fall? If not why not?"</p> <p>Systemic Changes Nursing staff and MDS coordinator was inserviced regarding the changes to Fall Risk Assessment. Educated on the need to adjust care plans to fit residents changing needs.</p> <p>Monitor In the monthly fall committee all the falls for that month will be reviewed by the committee which includes PT, Administrator, HRD, DON, Environmental Supervisor, MDS Coordinator. Care plans will be monitored for appropriate changes to a residents fall risk. Audits Starting 4/25/2012</p>	4/27/12

*add
5.2.12*

*See pg 8 of fax
far more than
monthly
monitoring* 

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F 280	<p>Continued From page 7</p> <p>Individualized interventions were added to the Care Plan.</p> <p>On 3/29/12 at approximately 2:00 pm, the DON and MDS Coordinator reviewed the resident's Care Plan. When asked if there was a more individualized Fall Care Plan which indicated which interventions were implemented and when, they said "No." They stated once a new Care Plan was developed, it listed the new Care Plan date for all interventions.</p> <p>2. Resident #2 was admitted to the facility on 12/27/11 with diagnoses including gastrostomy, quadriplegia and quadriparesis, and aphasia.</p> <p>Resident #2 was under the care of two physicians. One physician monitored the resident's Baclofen pump and the other physician was the resident's attending physician. For the purposes of this citation, the physician who monitored the Baclofen pump will be referred to as MD #2. The resident's attending physician will be referred to as MD #1.</p> <p>The resident's 12/28/11 Admission Nursing Evaluation documented, in part under the Skin Condition section, "healed scar (baclofen pump)."</p> <p>On 3/27/12 at 1:35 p.m., LN #2 and the surveyor observed a horizontal scar on the resident's lower left abdomen. The LN stated, "As you touch the area, it is hard where the pump is located."</p> <p>The resident's Care Plan identified: * 12/27/11 Pain Management problem, "Muscle Spasms" secondary to quadriplegia. One of the care plan goals was, "Pain will be controlled thru</p>	F 280	<p>5/2/12 Any falls for the previous week will be reviewed weekly by DON and Administrator for 3 months to verify any changes that need to be made to patients care plan.</p>

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F 280	<p>Continued From page 8</p> <p>3/17/12." One of the problem approaches was, "Baclofen implant" for the diagnosis of muscle spasms related to immobility.</p> <p>* Health Conditions/Medications problem, "Baclofen Pump Refilled" dated 1/26/12. The problem approach was, "Next Refill 3-5-12 2 pm."</p> <p>The resident's clinical record contained a "Transport Checklist, dated 3/5/12 0200 pm [2:00 p.m.]" that documented, "Baclofen pump refilled. Next Refill 4/12/12." The refill entry appeared to have been written by MD #2.</p> <p>Note: The Baclofen medication and dose the resident received through the pump was not listed on the Medication Administration Record (MAR). The appointment to refill the Baclofen pump on 3/5/12 at 2:00 p.m. was listed on the Treatment Record (TR).</p> <p>The care plan did not include:</p> <ul style="list-style-type: none"> * any information regarding signs and symptoms of overdose of Baclofen, or other problems that could occur with the use of intrathecal pumps including meningitis, and/or kinking, coiling or breaking of the catheter. * any information on the Baclofen pump alarm system and what interventions were necessary when the alarms sounded. * any information regarding the dose of Baclofen the resident received or that the dose of medication was infused continuously. * interventions in the event the family was unable to take the resident to the clinic for pump refills. <p>On 3/28/12 at 10:02 a.m., the DON stated, "The Baclofen pump will be added to the entire care plan."</p>	F 280		

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F 280	<p>Continued From page 9</p> <p>On 3/28/12 at approximately 4:00 p.m., the MDS Coordinator provided the survey team with an update to the resident's care plan that included the Baclofen pump, the goal of "will have no complications," and 11 different approaches. The MDS Coordinator indicated that the facility was currently "revising" the resident's care plan to ensure the approaches were thorough and comprehensive.</p> <p>3. Resident #6 was admitted to the facility on 1/23/09 with diagnoses including aftercare healing traumatic fracture, anxiety and depressive disorder.</p> <p>The resident's Antianxiety Interdisciplinary Care Plan contained a 1/26/12 updated entry for the medication "Clonazepam 1 mg po q hs [milligram by mouth every day at bed time]."</p> <p>In addition, the resident's Psychosocial Well-being/Mood/Activities Care Plan contained the 8/18/11 approach, "Ativan 1 mg po q am and hs [every morning and hs]."</p> <p>Note: The resident's care plan documented that the resident was currently administered two antianxiety medications; Clonazepam and Ativan (Lorazepam).</p> <p>The 3/12 Physician's Order (recapitulation) included an order for the antianxiety medication "Lorazepam [Ativan]" 1 tablet by mouth each morning and at bedtime for anxiety, however the recapitulation did not include an order for Clonazepam.</p>	F 280			

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F 280	Continued From page 10 The resident's 3/12 MAR provided evidence that Lorazepam (Ativan) was to be administered two times a day. On 3/29/12 at 2:00 p.m., the DON reviewed the resident's clinical record and stated, "I cannot find that there was ever a written order for Clonazepam. The record does include an order for Ativan." The survey team, the DON, and the MDS Coordinator discussed the care plan concerns for Resident #s 2, 5, & 6. The MDS Coordinator stated, "I thoroughly understand [what you are saying]." On 3/30/10 at 10:00 a.m., the DON was informed of the findings. The facility did not provide any additional information.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, it was determined the facility failed to obtain route of administration clarification for physician's orders and entered erroneous route of medication administration on the MAR and the care plan (Resident #2), and did not follow physician orders for medication administration	F 309	Specific Residents #2 All incorrect orders for medications to be administered po, when this patient is npo receiving all medications per her PEG tub, were corrected for route of administration, and MARs and care plan were updated. Corrected orders were signed by the physician on April 18 during his rounds. Nurses individually called by DNS and asked to come into the facility and fill in the MARs and TARs they had been responsible for when they were on shift in January, February and March. #4 TARs received from the pharmacy with incorrect dates were corrected by nursing staff. Nurses individually called by DNS and asked to come into the facility and fill in the MARs and TARs they had been responsible for when they were on shift. #6 Nurses individually called by DNS and asked to come into the facility and fill in the MARs and TARs they had been responsible for when they were on shift in January, February and March. DNS has audited MARs and TARs for January through March 2012 on residents #2, #4, and #6 for any unsigned meds or treatments and none were found.		

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F 309	<p>Continued From page 11 and treatments (Resident #s 2, 4 & 6). This affected 3 of 6 (#s 2, 4, & 6) sample residents. Failure to ensure physician orders were clarified, correct medication route administration was entered on the MAR and care plan, and physician orders were followed created the potential for the residents to not attain and maintain the highest practicable physical, mental, and psychosocial well-being. Findings included:</p> <p>Potter and Perry's Fundamentals of Nursing, 7th edition, 2009, Medication Administration, page 707 states, in part, "...The...rights of medication administration include...The right route...The right documentation[.]"</p> <p>1. Resident #2 was admitted to the facility on 12/27/11 with diagnoses including gastrostomy, quadriplegia and quadriparesis, and aphasia.</p> <p>The resident's 1/7/12 admission MDS assessment coded total dependence on staff for ADLs, did not ambulate, did not speak, and received 51% or more nutrition through parenteral or tube feeding.</p> <p>The 3/12 Physician's Order (recapitulation) documented, in part, * "...continue npo status as risk for...aspiration is high." * Fluoxetine, "Open 1 capsule and give via peg tube once daily for depression and pmdd [by way of percutaneous gastrostomy tube once daily for depression and premenstrual dysphoric disorder]." * Liquid Tylenol 480 mg [milligrams] via peg tube three times a day for pain.</p>	F 309	<p>Other Residents The Ashton Living Center will ensure that all physician orders are clarified when necessary and correctly entered on the MAR and TAR and care plan to ensure that residents will be receiving the highest possible physical, mental and psychosocial well being.</p> <p>Systemic Changes Problems were addressed in the monthly Pharmacy Meeting April 12 held with medical director, pharmacist, administrator and DNS for input. Problems also addressed in nursing staff meeting April 18. Starting April 2, meds are charted via eMAR which will help solve the issue of unsigned MARs as eMAR flags in red all meds that are not addressed. All nurses check the eMAR during med pass for red meds, and resolve.</p> <p>Monitor DNS will QA monthly for unsigned medications for 12 months. DNS will report findings to QA committee. Audits Starting 4/25/2012</p>	4/27/12	

*See fax dtd
5.2.12
for more frequent
monitoring KM*

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F 309	<p>Continued From page 12</p> <p>a. The following medications were written as "po" on Physician's Telephone Orders (PTOs):</p> <ul style="list-style-type: none"> * 2/1/12, Fluoxetine 20 mg "p.o." q d (day) Dx: pmdd and depression * 2/19/12, Levaquin 500 mg [one] "po" q d x 7 days UTI * 3/5/12, Ritalin 10 mg [one] "po" q am, [one] "po" q noon, no diagnosis documented, Note: Please refer to F329 related to a physician's medication order without a diagnosis. <p>b. Further review of the resident's clinical record revealed the following documentation:</p> <ul style="list-style-type: none"> * 3/12 MAR, Fluoxetine administered via peg tube not by mouth * 3/12 MAR, Levaquin administered "po" not by peg tube, for 7 days, 3/19/12 through 3/25/12. * 2/19/12, UTI Care Plan approach, Levaquin 500 mg (one tablet) "po" q d for 7 days * 3/5/12 Health Conditions/Medications Care Plan approach, Ritalin 10 mg (one tablet) "po" q am, (one tablet) "po" q noon <p>On 3/27/12 at 1:35 p.m., LN #2 was observed as she administered medications via the peg tube for the resident. The LN stated, "The medications I just gave the resident were Ritalin and Tylenol."</p> <p>On 4/3/12 at 11:04 a.m., the surveyor spoke with the DON by telephone.</p> <ul style="list-style-type: none"> * The surveyor informed the DON that medications were written as "po" on PTOs but were listed on the recapitulations as "via peg tube." * The surveyor informed the DON that three orders, Levaquin, Ritalin, and Fluoxetine were written to be administered by mouth (po). The DON stated, "When the doctors write orders as 	F 309	5/2/12 DNS will do weekly checks for unsigned medications and then will move to monthly for 12 months.

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F 309	<p>Continued From page 13</p> <p>po and the resident is npo, we obtain clarification orders." The DON stated she would fax the BFS clarification orders.</p> <p>* The surveyor also informed the DON that the care plan documented that Ritalin and Levaquin were to be administered "po." And, the 2/12 MAR documented that the Levaquin was administered "po." The DON stated, "The resident is npo and we do not administer anything by mouth [po] for this particular resident." The DON acknowledged that the documentation was not correct.</p> <p>On 4/3/12 at 12:20 p.m., the BFS received a fax from the facility. The Comments section documented, "...corrected Feb[uary] and March MARs changing po to per peg...changed the care plans...notified the pharmacy of changes to route of administration...faxed clarifications to [doctor's name] for...signature..." Copies of the updated MARs, care plan, recapitulation, and PTOs were included in the fax. The documents were clarified and updated on "4/3/12."</p> <p>c. The 2/12 & 3/12 Physician's Order (recapitulations) contained, in part, the following:</p> <ul style="list-style-type: none"> * Citalopram give 10 mls (milliliters) via peg tube once daily * Docusate give 10 mls via peg tube once daily for constipation * Trentinoin cream apply to affected areas once daily * Check tubing site daily * Tubing: check placement by injecting air into the tube and usculating sic{auscultating} with stethoscope * Elevate head of bed 30 degrees during tube feeding (TF) and leave up for 1 hour after. * Jevity, give 90 mls hourly at night 	F 309		

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F 309	<p>Continued From page 14</p> <ul style="list-style-type: none"> * Give 20 mls free water after each medication pass <p>The resident's 1/12 through 3/12 MARs and TRs were reviewed as follows:</p> <p>1/12 MAR</p> <ul style="list-style-type: none"> * 1/3/12 & 1/30/12, Citalopram not administered (not admin) * 1/3/12, Docusate not admin <p>1/12 TR</p> <ul style="list-style-type: none"> * 1/27/12, Trentinoin cream not applied * 1/27/12, Tubing site not checked * 1/27/12, Head of bed not elevated during TF & not left up for 1 hour after. <p>2/12 MAR</p> <ul style="list-style-type: none"> * 2/18/12, 2/25/12, 2/26/12, & 2/28/12, TF not started at night, no documentation on the MAR of what time the TF was started * 2/18/12, 20 ml free water not provided with morning medication pass * 2/18/12, Liquid Tylenol administered twice, not three times as ordered * 2/18/12, Fluoxetine not admin * 2/29/12, 20 ml free water not provided with 5:00 p.m. medication pass <p>3/12 TR</p> <ul style="list-style-type: none"> * 3/26/12, Tubing placement not checked by injecting air into the tube and auscultating with stethoscope, pm (afternoon) <p>2. Resident #6 was admitted to the facility on 1/23/09 with diagnoses including aftercare healing traumatic fracture, anxiety and depressive disorder.</p>	F 309		

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F 309	<p>Continued From page 15</p> <p>The 3/12 Physician's Order (recapitulation) contained, in part, the following:</p> <ul style="list-style-type: none"> * Senna, Take up to 5 tablets by mouth once daily for constipation * Oxygen: Check, SpO2 (oxygen saturation levels) twice daily and as needed <p>Note: The recapitulation also contained 11 routine medications and a pain assessment was to be completed 4 times a day.</p> <p>The resident's 1/12 through 3/12 MARs and TRs were reviewed as follows:</p> <p>1/12 MAR</p> <ul style="list-style-type: none"> * 1/2/12 and 1/25/12, Senna not admin <p>1/12 TR</p> <ul style="list-style-type: none"> * 1/27/12, oxygen saturations checked once, not twice as ordered <p>2/12 MAR</p> <ul style="list-style-type: none"> * 2/27/12, 13 of 20 (43%) routine medication administration opportunities were blank <p>3/12 TR</p> <ul style="list-style-type: none"> * 3/26/12, oxygen saturations checked once, not twice as ordered <p>3. Resident #4 was admitted to the facility on 2/26/12 with diagnoses including stage III chronic kidney disease and malaise and fatigue.</p> <p>The resident's 2/26/12 admission Physician's Orders contained an order for, Amitriptylene 25 mg po q hs</p> <p>2/12 MAR</p> <ul style="list-style-type: none"> * 2/28/12, Amitriptylene not admin 	F 309			

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F 309	<p>Continued From page 16</p> <p>The resident's 3/1/12 Physician's Telephone Orders contained the order "SpO2 [checks] BID [two times a day]."</p> <p>* The oxygen saturation checks were documented on a TR dated 11/8/11. The TR documented, "Charting for 11/8/11 through 12/07/11."</p> <p>Note: The date of the order was 3/1/12.</p> <p>Note: The 11/8/11 date was prior to the resident's admission and SpO2 order date.</p> <p>* According to the November 2011 dates on the TR; on 11/26/11, the resident's oxygen saturation level was checked once, not two times a day as ordered.</p> <p>Review of the MDS database revealed that this facility was the only facility the resident has resided; no previous admissions to this facility or any other facility.</p> <p>On 3/28/12 at 9:00 a.m., the surveyor informed the DON that Resident #2, #4, and #6's MARs and TRs were not consistently documented for medication administration and treatments. The DON made a note of the missing documentation and indicated she would check the residents' charts. The DON stated, "It is not appropriate that the MARs and TRs indicate that medications were not administered and that treatments were not provided as ordered."</p> <p>On 3/30/12 at 10:00 a.m., the DON was informed of the deficient practice. The facility did not provide any additional information regarding Resident #4 and #6.</p>	F 309			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329			

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F 329	<p>Continued From page 17</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>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 proper medical diagnoses were in place for residents on psychoactive medications. This affected 2 of 6 sampled residents (#2 and 5) reviewed for unnecessary medications. This failed practice had the potential to cause Resident #2 and #5 to be chemically restrained if the psychoactive medications prescribed for them were not necessary for their medical care.</p>	F 329	<p>Specific Residents</p> <p>Resident #5 Xyprexa 5mg without appropriate diagnosis. Correct diagnosis was obtained and signed by the physician during his rounds on April 18, 2012. Care plan and MAR were updated.</p> <p>Resident #2 Ritalin without appropriate diagnosis. Correct diagnosis was confirmed by phone on 3-30-2012, and signed 4-18-2012 by the physician during his rounds. Care plan and MAR were updated.</p> <p>Other Residents</p> <p>All residents have the potential to be affected. All residents in the Ashton Living Center will have current and proper medical diagnoses in place for psychoactive medications.</p> <p>Systemic Changes</p> <p>Nursing staff meeting 4-18-2012 reviewed taking physician's orders for medications. All nurses were instructed to get a diagnosis with the physician's order, and double check it with the F329 information which is now in the P/P Manual under Medications. This document is the state guidance Investigative Protocol for Unnecessary Medications—Medication Regimen Review. Any questions the nurses have will be referred to the DNS for review with the pharmacist and physician. Nurses have reviewed the F329 and signed to confirm they have done so.</p>		

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F 329	<p>Continued From page 18 Findings include:</p> <p>1. Resident #5 was admitted to the facility 4/26/10, and readmitted on 10/22/11, after a fall with a fracture. The resident's diagnoses included altered mental status, moderate intellectual impairment, osteoarthritis, depression with anxiety.</p> <p>The resident's 11/3/11 Significant Change MDS assessment coded a 3 (severe cognitive impairment) on the BIMs, an 8 on the depression scale, delirium, but no behaviors.</p> <p>The resident's current Physician's Orders for March 2012 (recapitulation), documented the resident was to receive Zyprexa 10 mg 1/2 tablet by mouth once daily for mood. The resident also had an order for Citalopram HBR 40 mg daily for depression, and Clonazepam 0.5, 1/2 tablet twice daily for anxiety.</p> <p>Resident #5's last physician visit note, dated 3/7/12, listed only the three active problems; osteoporosis, depression/anxiety, and moderate mental retardation.</p> <p>No diagnosis appropriate for the use of Zyprexa was found in the resident's medical record.</p> <p>Zyprexa is defined in the Federal guidelines at §483.25(l) (F329), as a second generation (atypical) antipsychotic medication. Table 1 of these guidelines defines the circumstances that would warrant the use of an antipsychotic medication in the elderly. The guidelines also define inadequate indications for use as, "In many situations antipsychotic medications are not</p>	F 329	<p>Monitor DNS will review with medication diagnosis with pharmacist monthly. Will report to pharmacy committee. Audits Starting 4/25/2012</p>	4/27/12

*see fax dtd 5.2.12
for monitoring more
frequently than
monthly KM*

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F 329	<p>Continued From page 18</p> <p>Findings Include:</p> <p>1. Resident #5 was admitted to the facility 4/26/10, and readmitted on 10/22/11, after a fall with a fracture. The resident's diagnoses included altered mental status, moderate Intellectual Impairment, osteoarthritis, depression with anxiety.</p> <p>The resident's 11/3/11 Significant Change MDS assessment coded a 3 (severe cognitive impairment) on the BIMs, an 8 on the depression scale, delirium, but no behaviors.</p> <p>The resident's current Physician's Orders for March 2012 (recapitulation), documented the resident was to receive Zyprexa 10 mg 1/2 tablet by mouth once daily for mood. The resident also had an order for Citalopram HBR 40 mg daily for depression, and Clonazepam 0.5, 1/2 tablet twice daily for anxiety.</p> <p>Resident #5's last physician visit note, dated 3/7/12, listed only the three active problems; osteoporosis, depression/anxiety, and moderate mental retardation.</p> <p>No diagnosis appropriate for the use of Zyprexa was found in the resident's medical record.</p> <p>Zyprexa is defined in the Federal guidelines at §483.25(l) (F329), as a second generation (atypical) antipsychotic medication. Table 1 of these guidelines defines the circumstances that would warrant the use of an antipsychotic medication in the elderly. The guidelines also define Inadequate Indications for use as, "In many situations antipsychotic medications are not</p>	F 329	<p>Monitor</p> <p>DNS will review with medication diagnosis with pharmacist monthly. Will report to pharmacy committee. Audits Starting 4/25/2012.</p> <p>DNS will review new orders weekly for 2 months and then review new orders monthly for 12 months.</p> <p>5/2/12</p>	4/27/12

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F 329	<p>Continued From page 19 indicated. They should not be used if the only indication is one or more of the following: 1) wandering; 2) poor self-care; 3) restlessness; 4) impaired memory; 5) mild anxiety; 6) insomnia; 7) unsociability; 8) inattention or indifference to surrounding; 9) fidgeting; 10) nervousness; 11) uncooperativeness; or 12) verbal expressions or behavior that are not due to conditions listed under "Indications" and do not represent a danger to the resident or others."</p> <p>The intent of the Federal guidelines at §483.13(a) (F222) is, "For each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints." Under §483.13, a chemical restraint is defined as, "... any drug that is used for discipline or convenience and not required to treat medical symptoms." "Convenience" is defined as, "any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest."</p> <p>In addition, the manufacturers instructions for Zyprexa stated, "ZYPREXA® (olanzapine) is an atypical antipsychotic indicated [for treatment of] schizophrenia... [and] Disorder and maintenance treatment of bipolar I disorder." Again, Resident #5's medical record contained no diagnosis of schizophrenia or bipolar disorder.</p> <p>On 3/29/12 4:45 pm, the DON was asked if there was another location where the diagnosis for the resident's Zyprexa would be found. The DON</p>	F 329			

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F 329	<p>Continued From page 20</p> <p>stated she would check into it. The next morning, the DON provided several orders for the Zyprexa, none of which had an appropriate diagnosis. The facility did not provide any additional information.</p> <p>2. Resident #2 was admitted to the facility on 12/27/11 with diagnoses including gastrostomy, quadriplegia and quadriparesis, and aphasia.</p> <p>The resident's 1/7/12 admission MDS assessment coded total dependence on staff for ADLs, did not ambulate, did not speak, and received 51% or more nutrition through parenteral or tube feeding.</p> <p>The resident's clinical record contained a Physician's Telephone Order (PTO) for the medication, "Ritalin (methylphenidate) 10 mg #60 [one tablet] po q am, [one tablet] po q noon [10 milligrams #60 one tablet by mouth every morning, one po every day at noon]." Note: The PTO did not contain a diagnosis for the administration of Ritalin.</p> <p>On 3/28/12 at 9:00 am, the surveyor informed the DON that the Ritalin medication did not have a diagnosis identified on the PTO.</p> <p>On 3/29/12 at 9:47 a.m., the DON stated the resident's physician was notified of the missing diagnosis for Ritalin and told her that the diagnosis was to, "Increase LOC [level of consciousness]/alertness." The DON also stated, "The physician will sign a clarification PTO today."</p> <p>On 3/30/12 at 10:00 a.m., the DON was informed</p>	F 329		

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F 329	Continued From page 21 of the finding. The facility did not provide any additional information.	F 329			
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system 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>	F 431	<p>Specific Residents No specific residents were affected</p> <p>Other Residents All residents have the potential to be affected. DNS checked the medication cart and medication room 4-1-2012 and no further outdated meds or supplies were found. The facility will ensure that all medications and biologicals will be in date before patient use. Problem and correction were reviewed in Nursing Staff Meeting held 4-18-2012 to be sure all nursing staff understood.</p> <p>Systemic Changes All nursing staff warned individually by DNS starting 4-1-2012 to never to cut off patient ID from bubble packs, and to never use meds for a resident they were not prescribed for. Problem and proposed correction were reviewed in Pharmacy Meeting held 4-12-2012 which involved the Pharmacist, Medical Director, Administrator and DNS and were deemed adequate. Problem and correction were reviewed in Nursing Staff Meeting held 4-18-2012 to be sure all nursing staff understood.</p>		

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F 431	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure that outdated urine test strips were disposed of and that stock-piled medications had expiration dates. This was true for 1 of 4 bottles of test strips checked and 4 of 4 blister packs that were kept in a stock-pile after residents were discharged. This practice had the potential to provide out of date medications and biologicals to residents which could render the medication ineffective and the test inaccurate. Findings included: During a tour of the main nurses station and medication room on 3/27/12 at 9:30 am, the expiration date listed on a bottle of urine Multistic test strips was 2008. LN #2 was asked about the test strips. She stated that they were used if the machine (Urine Analysis) was not working. When asked if she realized they were outdated, she looked at them and then discarded them. LN #2 was then asked to open the medication cart. Five blister packs that were secured together with a rubber band were stored in the bottom left hand drawer of the medication cart. LN #2 explained that these blister packs were extra medications that a resident may need and they could not get out of their emergency supply box. LN #2 stated, in the case of these blister packs, a resident was discharged and the medication was left behind. The resident's name was cut off the blister pack and they were placed in the cart for general population use. By cutting the name off of the blister packs, the expiration dates were also removed. The five blister packs contained the following; Phenergan 12.5, 23 tablets, two full	F 431	Monitor <u>DNS</u> will check the medication cart weekly for two months then monthly indefinitely for cards or anything else that is outdated or otherwise should not be there. Nurses have been started on a QA program to record checks for outdated medications and supplies in the med room monthly. Audits Starting 4/25/2012	4/27/12	

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F 431	Continued From page 23 packs of Senna 8.6, a second blister pack of Phenergan 12.5 containing 20 tablets, and an unlabeled blister pack containing 18 clear red pills which LN #2 identified as colace. On 3/27/12 at 4:45 pm and 3/30/12 at 10:07 am, these issues were discussed with the DON and Acting Administrator. On 3/30/12 at 10:07 am, the DON stated, as she looked at those from the facility who attended the exit conference, "That will not happen again" and then repeated, "That will not happen again." The facility provided no additional documentation or information that resolved the concern.	F 431			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to Infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	Specific Residents No specific residents were affected. Other Residents All residents have the potential to be affected. The Living Center will ensure that all direct care and housekeeping staff will follow proper sanitary procedures when handling dirty laundry, so that no infections will be spread from soiled uniforms		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 24</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure that direct care and housekeeping staff, who were required to do laundry as part of their assigned duties, were following proper sanitary procedures. This was true for 2 of 2 staff observed doing laundry. This deficient practice created the potential that residents would develop infections spread from caregivers' uniforms. Findings included:</p> <p>During a tour of the laundry facilities on 3/29/12 at 2:30 pm, a housekeeper was observed to bring a large rolling bin of soiled clothing protectors to the laundry room. The housekeeper sanitized her hands and donned gloves before she began reaching into the bin and putting the soiled clothing protectors into the washer. At one point, the housekeeper placed her whole trunk into the bin to reach the last of the bibs at the bottom of the bin. While doing so, the housekeeper's</p>	F 441	<p>Systemic Changes Procedure was discussed in the nurses inservice and All Staff Meeting held April 18. Environmental Supervisor and LCNA placed plastic aprons in laundry and are teaching CNAs and housekeepers individually on procedure to use them in laundry when handling soiled laundry, and also removing the apron before leaving laundry room; Environmental Services Supervisor has updated her checklist used for orientation of new housekeepers and CNAs to include proper infection control in the laundry, and use of the aprons.</p> <p>Monitor <u>Night nursing staff</u> to monitor night CNAs for correct use of aprons in laundry room and record on their QA log. <u>Daily</u>. Audits Starting <u>4/25/2012</u></p>	4/27/12	

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F 441	<p>Continued From page 25</p> <p>uniform top came in contact with the sides of the bin that had carried the dirty laundry. The Supervisor of Environmental Services (SES) accompanied the surveyor during the tour. When asked if the facility employed laundry staff, the SES stated "No." The SES stated that night shift CNAs were responsible for washing residents' personal laundry, blankets, and to help wash the clothing protectors. Day shift housekeeping staff were responsible for washing clothing protectors after the breakfast and lunch meals. The SES stated the majority of the laundry, like sheets, towels, wash cloths, and bedspreads, were sent out to be washed by a professional laundry. The SES was asked what training the CNAs and housekeeping staff were given to do resident laundry. The SES stated they were taught how to use the machines and the washing/drying products, and to clean the lint filter on every shift. When asked about infection control, the SES stated staff were taught to sanitize their hands and put on gloves when handling dirty laundry and before folding/putting away the clean laundry. When asked if staff doing laundry, especially sorting dirty clothes, were taught to put on a clothing barrier to protect their uniforms from contamination. The SES stated no, neither the CNA staff nor the housekeeping staff had been trained to use clothing barriers to protect their uniforms from becoming contaminated with urine, stool, or other soiling when they sorted the dirty clothes.</p> <p>During an observation on 3/30/12 at 5:15 am, CNA #5 stated the laundry was already done for the shift. CNA #5 was asked to walk the surveyors through the laundry process. CNA #5 stated:</p>	F 441		

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F 441	<p>Continued From page 26</p> <ol style="list-style-type: none"> 1. Using gloves, staff first go to the Soiled Linen Room and sorted the dirty laundry (mostly residents' personal clothing) and put it into a basket. 2. After sorting the laundry, they took it to the laundry room. At this point they sanitized their hands and put on a fresh pair of gloves. 3. The next step was to remove the washed clothing protectors (put to wash by day shift) and place them in the dryer. 4. They then placed the dirty laundry into the washer, put soap in, and turned on the washer. 5. Later, they come back and switched the washed clothing to the dryer and continued washing dirty clothes. <p>When asked how she protected her clothing when sorting and washing clothes, CNA #5 stated, "We keep everything away from our body so that it does not touch our clothes." CNA #5 denied using any type of protective equipment or barrier.</p> <p>On 3/30/12 at 8:30 am, the DON, Acting Administrator and SES were informed that the Federal regulations state that facility personnel must handle, store, process and transport linens so as to prevent the spread of infection. Not wearing protective equipment or some type of barrier when sorting and washing dirty laundry and then handling cleaned laundry without any type of barrier, put residents at risk for cross-contamination when the staff doing laundry also provided the residents with personal cares.</p>	F 441		

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C 000	16.03.02 INITIAL COMMENTS 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. The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Lorraine Hutton, RN, QMRP	C 000			
C 159	02.100.09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES 09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request. This Rule is not met as evidenced by: Please refer to F204 as it related to not ensuring a resident's belongings were accounted for.	C 159		Refer to F204	4/27/12
C 191	02.105.05 APPLICABLE IDAHO & FEDERAL LAWS 05. Applicable Idaho and Federal Laws. Applicable Idaho and federal laws shall be observed in relation to employment of any individual. This Rule is not met as evidenced by: Please refer to F226 as it related to not performing CNA registry checks or reference checks for newly hired individuals.	C 191		Refer to F226	4/27/12

Bureau of Facility Standards

[Signature]

Administrative
TITLE

4/27/12
(X5) DATE

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

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C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F465 as it related to ice build-up in the kitchen walk-in freezer.	C 325	Refer to F465 	4/27/12
C 355	02.108,06,b,iii iii. Soiled linen shall be handled and stored in such a manner as to prevent contamination of clean linen. This Rule is not met as evidenced by: Please refer to F441 as it related to sorting and handling dirty linen.	C 355	Refer to F441	4/27/12
C 782	02.200,03,a,iv 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 not updating or revising resident care plans as changes occurred. Please refer to F309 as it related to erroneous medication route administration in the care plan.	C 782	Refer to F309 & F280	4/27/12
C 794	02.200,03,b,x x. Treatment of patients/residents with kindness and respect;	C 794	Refer to F241	4/27/12

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If continuation sheet 2 of 4

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C 794	Continued From page 2 This Rule is not met as evidenced by: Please refer to F241 as it related to treating residents with dignity and respect.	C 794		
C 798	02.200,04,a MEDICATION ADMINISTRATION 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Please refer to F309 as it related to a physician orders for medication route administration not consistent with the resident's diagnosis. Nursing staff not following doctor's orders for medication administration and treatments.	C 798	Refer to F309 F281 Specific Residents #2 medication will be documented before it is administered. Other Residents All residents have the potential to be affected. Medications will be prepared, administered to the resident per facility policy, then documented. Systemic Changes LN involved was counseled by DNS on correct procedure for admin of meds; P&P reviewed. Correct administration from Policy and Procedures Manual policies on administration of meds, and documentation of administration was reviewed in nursing staff meeting April 18. Policies were shown to nurses in the manual for their future reference. Every nurse has reviewed and signed that he/she has reviewed. Monitor DNS will watch a med pass weekly to monitor to make sure medications are given and then documented. Different nurse every week for 4 weeks Audits Starting 4/25/2012	4/27/12
C 804	02.200,04,g g. Each patient's/resident's medication is properly recorded on his individual medication record by the person administering the medication. The record shall include: This Rule is not met as evidenced by: Please refer to F281 as it related to pre-signing medications.	C 804		4/27/12
C 821	02.201,01,b b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal	C 821	Refer to F431	4/27/12

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C 821	Continued From page 3 of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Please refer to F 431 as it related to the expiration date of drugs.	C 821		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F329 as it related to physician orders that did not contain a diagnosis for the medications ordered.	C 881	Refer to F329	4/27/12