



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: 7012 1010 0002 0836 1932

January 28, 2014

Warren "Douglas" Bodily, Administrator
River's Edge Rehabilitation & Living Center
714 North Butte Avenue
Emmett, ID 83617

Provider #: 135020

Dear Mr. Bodily:

On **January 16, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at River's Edge Rehabilitation & 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 an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 10, 2014**. Failure to submit an acceptable PoC by **February 10, 2014**, may result in the imposition of civil monetary penalties by **March 3, 2014**.

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.

Warren "Douglas" Bodily, Administrator
January 28, 2014
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- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

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

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 16, 2014**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

- BFS Letters (06/30/11)

Warren "Douglas" Bodily, Administrator
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **February 10, 2014**. If your request for informal dispute resolution is received after **February 10, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

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

LKK/dmj
Enclosures

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2014
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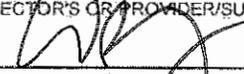
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN and Nina Sanderson, LSW</p> <p>The survey team entered the facility on Sunday, January 12, 2014 and exited the facility on Thursday, January 16, 2014.</p> <p>Survey Definitions: AD = Activity Director ADLs = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing HS = At Bedtime IDT = Interdisciplinary Team LN = Licensed Nurse MD = Medical Doctor MDS = Minimum Data Set assessment MAR = Medication Administration Record OT = Occupational Therapist PN = Progress Note PRN = As Needed TAR = Treatment Administration Record W/C = Wheelchair</p> <p>F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p>	F 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River’s Edge Rehabilitation and Living Center and does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies.”</p> <p>F 226</p> <p>1. Resident #1: Staff has been re-trained on Hoyer lift use, positioning in wheelchair, and application of topical creams.</p> <p>2. All other residents experiencing bruising or other injury requiring investigation for potential abuse could be affected.</p> <p>3. Incident and accident report forms (I&As) will be modified to include areas for documentation of staff interview statements and questions to elicit specific pertinent facts. All staff will be in serviced on timely, comprehensive completion of I&As. Medical Records Director will review</p>	
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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 2/8/14
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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 correction is requisite to continued program participation.

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F 226	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of the facility's Abuse Investigation policy, it was determined the facility did not ensure all injuries of unknown origin were thoroughly investigated as potential instances of abuse and neglect. This was true for 1 of 8 residents (#1) sampled for incident investigations. The deficient practice had the potential to cause more than minimal harm if the root cause of resident incidents was not accurately identified so as to prevent further occurrences. Findings included: Facility Policy Number NARR 04, identified as the facility's Abuse Investigation policy, documented: "2. The investigation will consist of at least the following: *A review of the completed Complaint Report; *An interview with the person(s) reporting the incident; *Interviews with any witnesses to the incident; *An interview with the resident if possible; *A review of the resident's medical record; *An interview with the staff members having contact with the resident during the period/shift of the alleged incident; *Interviews with the resident's roommate, family members, and visitors; *A review of all circumstances surrounding the incident." The Bureau of Facility Standards Informational Letter 2005-1 documented: "A thorough investigation is critical to developing effective prevention strategies...investigators	F 226	all I&As for completion including comprehensive wound/injury description and timeliness of required signatures. 4. The Administrator or DNS will monitor medical records review weekly XX months then monthly ongoing. MDS coordinator will audit Hoyer lift transfers 2X weekly X 2 months then monthly ongoing. Results of the audits will be reported monthly to the QA committee. Audits to start 2/3/14. 5. February 14, 2014 <i>See addendum Pg 2A lt</i>		

F226

1. Resident #1: Staff has been re-trained on Hoyer lift use, positioning in wheelchair, and application of topical creams. Staff has been in serviced on Appropriate transfer interventions to decrease resident anxiety during transfers.
2. All other resident with the potential for bruising or injury will be identified through review of resident medical records, admit skin assessment, weekly skin assessment, written interview of staff members on duty at time the event occurs and observation of mechanical lift transfers. Corrective measures for those residents will include a review of the I & A by the IDT team and an update to the resident POC with the updated interventions.
3. Incident and accident report Forms (I&A0 will be modified to Include areas for documentation of Staff interview statements and Questions to elicit specific pertinent facts. All staff will be in serviced On timely, comprehensive Completion of I & As. Medical Records Director will review all I & As for completion including comprehensive wound/injury description and timeliness of required signatures.
4. The Administrator of DNS will Monitor medical records review Weekly X2 months then monthly Ongoing. MDS coordinator will audit Hoyer lift transfers 2X weekly X2 Months then monthly ongoing. Results of the audits will be reported monthly to the QA committee. Audits to start 2/3/2014.
5. February 14, 2014.

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FACILITY STANDARDS

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F 226	<p>Continued From page 2</p> <p>must ask probing questions to get to the root cause...essential components...include...all pertinent staff (or other witnesses) must be interviewed and the results of the interview documented in some form...in cases of injury of unknown source, all staff having possible contact with the resident over the 24 hour period prior to the injury discovery...in cases of unwitnessed incidents, the facility needs to determine when the resident was last observed by staff and what the resident was doing at the time...the facility must determine whether specific care plan approaches intended to prevent incidents...were being implemented as planned."</p> <p>Resident #1 was originally admitted to the facility on 7/7/09 with multiple diagnoses which included Alzheimer's disease, dementia with behavioral disturbances, muscle weakness, glaucoma, and anxiety.</p> <p>Resident #1's Quarterly MDS, dated 10/4/13, coded: *Unable to complete the BIMS. *Severely impaired decision making skills, per staff assessment. *Extensive assistance of 2 persons for transfers and dressing. *Extensive assistance of one person for eating. *Did not ambulate. *Range of motion deficits for both lower extremities.</p> <p>Resident #1's care plan for ADL's, with a focus date initiation of 7/11/13, documented an approach of, "...dependent assistance with total mechanical lift for transfers and 2 staff..." [NOTE: There was no implementation date documented for the approach.]</p>	F 226		

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F 226	<p>Continued From page 3</p> <p>Facility "Skin Event Investigation" forms for Resident #1 documented:</p> <p>*7/2/13 at 3:00 PM, "[Left] Great toe nail lifted almost completely off." An undated, unsigned handwritten statement on the back of the form documented, "It appears Resident stubbed toe on something causing it to lift off. Resident has no bruising or other marks. Resident unable to communicate what or how it happened. Staff not aware of hitting any walls or the table while pushing her in the wheel chair. Resident does occasionally try to self propel when she needs to use the restroom." The "IDT [Interdisciplinary Team] Team Recommendations" section of the form documented, "MD notified [and] assessed." "Monitor [and treat] until resolved", and "cont POC" [Continue Plan of Care]. Attached to the form was a facility Progress Note [PN], dated 7/3/13 at 11:16 AM, which documented, "...Resident has a history of dementia and poor safety awareness. After interview of staff members they do not recall resident bumping her toe on any object. Mechanical lift for transfers. Resident is total dependent on staff for ADLS...Unknown if resident attempted to self propel [wheelchair] and bumped the toe during this time, or if occurred during, but not witnessed by staff, during transfer..."</p> <p>Neither of the documents specified which staff were interviewed, or when. The content of the staff interviews was not documented. There was no documentation of factors other than the resident stubbing her toe, such as the technique used for Hoyer lift transfers, were considered, investigated, and ruled out as potential causes of her injury. There were no care plan updates to</p>	F 226		

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F 226	<p>Continued From page 4 address prevention of a similar incident in the future for this resident.</p> <p>*7/8/13 at 5:30 PM, "2 cm [centimeter] diameter abrasion on below [sic] [right] gluteal fold." The "Immediate Action Taken" area of the form documented, "...Educated staff on placement of the Hoyer sling and to remove sling from between legs when in [wheelchair]. (There was excessive amount of anti-fungal cream in place over open area.)" The back of the form documented, "Noticed yellow cream covering open area, notified nurse to ensure skin area wasn't accounted for prior to me finding it." The statement was signed by a CNA #1, dated 7/8/13 at 9:35 PM. The "IDT Recommendations" area of the form documented, "MD notified", "Monitor until resolved", "staff education", and "update POC." A facility PN, dated 7/15/13 at 5:36 PM (7 days after the event) documented, "IDT review...After interview of staff it appears resident was found sitting up in her [wheelchair] with straps to mechanical lift sling still located between resident upper legs. It appears the straps of the sling may have contributed to the abrasion...staff education provided."</p> <p>There were no staff statements beyond that of CNA #1. There was no documentation as to how it was determined an "excessive" amount of anti-fungal cream was present, or who may have applied the cream to that extent. There was no investigation as to who may have positioned the sling straps in such a way as to cause the abrasion. There was no evidence of which staff were educated, or what that education had entailed.</p> <p>*8/3/13 at 11:40 AM, open area in the right gluteal</p>	F 226		

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F 226	<p>Continued From page 5</p> <p>fold over an irregular size mass. The back of the form had several spaces for "Investigation Interviews". One space documented, "Assisted [LN name] with skin check with [Resident #1] bottom with measuring", and was signed by a CNA. The rest of the spaces were blank. A 8/5/13 PN attached to the form documented, "IDT review...Upon investigation and assessment of area resident is noted to have approximately a 3 cm X 2 cm mass located just above the abraded area. The skin above and around the mass is red and blanchable with a slightly protruding core. It appears the mass is pulling on the skin which could be causing friction from the sling strap during transfers..."</p> <p>There was no documentation as to whether the sling strap placement was investigated, in terms of the education done following the 7/8/13 incident. There were no further updates to Resident #1's care plan regarding mechanical lift sling placement or transfer technique. Please see F280 as it pertains to care plan revisions.</p> <p>* 8/24/13 at 2:45 PM bruising to the right upper thigh, and 8/27/13 at 9:50 AM multiple bruises to bilateral upper extremities (arms and wrists).</p> <p>The facility Skin Event Investigations provided had these incidents stapled together. Only one IDT review was attached, addressing the bruises to her arms. The number, size, and appearance of the bruising was not described on either form. The date of the IDT review was 9/15/13, 22 days after the bruising to the right upper thigh was noted and 19 days after the bruising to the arms was noted. The Administrator did not sign the Follow-up investigation until 9/24/13, a full month after the initial bruising was noted.</p>	F 226		

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F 226	Continued From page 6 The areas of the 8/24/13 form for "Investigation Interview" contained statements from 2 facility RNs noting the presence of bruising to the upper right thigh, as well as a statement from a corporate resource person. The statements from both RNs identified the bruising consistent with the placement of the resident's adult briefs. The statement from the resource person documented, "Observed transfer resident [with] mechanical lift. Sling rubs against res[ident], res[ident] resistant [due to] dementia. Recommend new sling." None of the statements were dated or signed. The investigation did not include statements from staff in the hours leading up to the discovery of the bruises, but only statements from staff involved after the fact. There was no documentation these bruises were investigated as separate incidents, even though they appeared 3 days before the bruises to the resident's arms. The areas of the 8/27/13 form for "Investigation Interview" contained a statement from a facility LPN and a statement from the corporate resource person. The statement from the LPN documented bruises to both arms noted during a skin check, and geri-sleeves placed. The statement from the corporate resource person documented, "I observed transfer and believe bruising occurring during transfers [with] mechanical lift, sling, and res resistance." Neither statement was signed or dated. The investigation did not include statements from staff in the days or hours leading up to the discovery of the bruising. There was no documentation as to how changing the resident's	F 226			

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F 226	<p>Continued From page 7</p> <p>sling would prevent bruising to her arms. There were no documented care plan approaches addressing the addition of geri sleeves. Please see F 280 as it pertains to care plan revisions.</p> <p>*A facility PN, dated 9/15/13 at 12:57 PM, was attached to the above Skin Event Investigation forms. The PN documented, "IDT review of bruising noted to resident bilateral arms...After an observation by myself and clinical resource it appears when staff transfer resident she becomes rigid and pushes against the sling and tightens her arms by grabbing her bilateral arms with the hand of the opposite extremity in a arm crossed fashion. We were able to rule out abuse. We will have OT observe transfers and provide input into a different form of transfer to decrease resident anxiety during transfers. Will use geri gloves to provide some protection to her upper extremities..."</p> <p>It was not clear how abuse had been ruled out, given the lack of statements from staff leading up to the discovery of the bruises, and the lack of documentation regarding the specific number, appearance, and location of the bruising.</p> <p>*10/15/13 at 3:00 PM, multiple bruises on left upper arm. A hand-drawn diagram on the front of the form documented an area on the resident's hand, and several areas on the resident's upper arm, with bruising. The "Investigation Interview" area of the form documented, "During routine skin assessment multiple bruises noted to [left] upper arm. Hoyer sling lines up with bruising." [NOTE: This was the fifth incident where the lift sling was identified as a factor.] The statement contained no name, date, or signature. A second statement in that area of the form documented,</p>	F 226			

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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
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F 226	<p>Continued From page 8</p> <p>"Marking to her upper arm early this morning. Skin was dry placed lotion on it before shower." This statement contained a CNA's name, but was not signed or dated. On 10/16/14 at 11:26 AM, a facility PN documented, "IDT review of bruising...observed resident grabbing and pushing away with BUE (bilateral upper extremities) when cares are being completed by staff. Resident will also grab sling during transfers with Hoyer. Will encourage to leave geri-sleeves on..."</p> <p>The investigation did not include documentation of input from staff in the days or hours leading up to the discovery of the bruising. There was no documentation of the specific number or appearance of the bruising. There was no indication how the staff were to manage the resident's tendency to grab and push during cares.</p> <p>*1/7/14 at 11:00 AM, bruising noted to bilateral arms. The "Investigation Interview" area of the form contained unsigned, undated statements from 2 CNAs. The first statement documented, "States res pushes against staff, hands go behind res to push, res pinches staff all while transfers or turning and positioning." The second documented, "Res reaches out and grabs night stand. Report more in PM." The "IDT Recommendations" area of the form documented new interventions of moving the resident's night stand.</p> <p>Again, there was no documentation regarding the number, specific locations, size, or appearance of bruising.</p> <p>A facility PN dated 1/9/14 at 3:57 PM attached to</p>	F 226			

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F 226	<p>Continued From page 9</p> <p>the investigation documented, "IDT of bruise...After interview of staff it appears resident has increase in resistance to cares with grabbing at night stand when attempting to assist with bed positioning."</p> <p>There was no documented evidence of changes to the resident's care plan. There was no documentation the root cause of the resident's grabbing and resistive behavior was determined, or care plan updates made or monitored.</p> <p>Please see F 309 as it pertained to individualized care for persons with dementia.</p> <p>On 1/14/14 at 10:00 AM, the DNS was interviewed about the process of investigating injuries of unknown origin, including the bruising and other skin issues for Resident #1. The DNS stated she usually interviewed direct care staff regarding events, but did not usually document the results of the interviews. The DNS stated she would then use the information obtained to identify the cause and establish a plan to prevent further occurrence, relying on her memory of the interviews conducted to help establish the root cause. The DNS stated she was aware some of the follow-through on the investigations was not completed as thoroughly as it could be, so she had started a new program during the first part of August 2013. The DNS stated the facility now had a weekly Standards of Care meeting, where resident incidents were discussed, and assignments made to nurse managers to ensure all of the components of the investigations were followed up. The DNS was unable to explain why investigations for Resident #1 conducted after the implementation of the new system lacked complete information to establish the root cause</p>	F 226			

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F 226	Continued From page 10 of the incident. On 1/16/14 at 12:40 PM, the Administrator, DNS, and QI Consultant were informed of these findings. The facility offered no further information to resolve the concerns.	F 226		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on Resident Group interview, staff interview, observation and record review, it was determined the facility did not provide an ongoing program of activities designed to meet the physical, mental and psycho-social well-being of each resident. This was true for 5 of 9 residents in the Resident Group, and 1 of 7 residents (#1) sampled for activities. The deficient practice had the potential to cause more than minimal harm if residents experienced boredom or mood changes related to a lack of meaningful stimulation. Findings included: The facility activity calendar for November 2013 documented: **"Evening Activities" on Sundays, Mondays, and Thursdays each week, at 6:30 PM. **"Game Night" on Tuesdays, each week, at 6:30 PM. **"Pretty Nails" on Wednesdays, each week, at	F 248 F 248 1.A: Resident #1: care plan modified to reflect current physician orders and to include current activity preferences. B: Residents attending the group interview have all been interviewed by Activities Director and Social Services Director to provide preferences for evening and weekend activities. 2. All other residents have been interviewed by Activities Director and Social Services Director for preferences for evening or weekend activities. 3. Resident #1 and other residents with advanced dementia will have a care plan review to ensure preferences are honored in their individualized program. Based on resident input, the activity calendar has been modified to include resident preferred activities. Staff will be assigned to specific evening and weekend activities to ensure activities occur.		

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Continued From page 11
6:00 PM.
**" Evening Bingo" on Fridays, each week, at 6:30 PM.
*A variety of Sunday afternoon activities each week, including travel, crafts, and religious services.

The facility activity calendar for December 2013 documented:
**"Sunday Movie" every week at 6:30 PM.
**"Evening Activities" every Monday at 6:30 PM.
**"Game Night" Mondays at 6:30 PM, except for 12/10/13, which offered, "Gospel Music" at that time.
**"Pretty Nails", every Wednesday at 6:00 PM.
*Thursday evening scheduled "Cub Scouts," Evening Activities," and "Pretty Nails," throughout the month.
**"Evening Bingo," every Friday at 6:30 PM.
**"Evening Snacks," every Saturday at 6:30 PM.
*Sunday afternoon activities including "Crafts," "Gospel Sing-a-long," and "Mennonite Choir."

The facility activity calendar for January 2014 documented:
*No activities scheduled for Sunday, Monday, Wednesday, Thursday, or Friday evenings.
**"Lawrence Welk," a regularly broadcast television show, at 7:00 PM on Saturday evenings.
**"Gospel Music" scheduled for one Tuesday evening (1/14/13).
*Sunday afternoon activity listed as, "Leisure Activity of Choice" for 1/5/14 and 1/12/14.
Religious services offered on the afternoons of 1/19/14 and 1/26/14.

1. On 1/13/14 at 2:00 PM, 5 of 9 residents in the Resident Group meeting stated the facility did not

F 248

4. Beginning 2/3/14 weekly audits of activity occurrence and resident participation will be conducted by the Administrator or department manager designee (excluding Activities Director) X 2 months then monthly X 2 months. Results of the audits will be reported to the QA committee monthly. In addition, activity satisfaction will be discussed and documented monthly during resident council meetings.
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F 248	<p>Continued From page 12</p> <p>have enough activities on the weekends or in the evening. The residents stated they used to have enough to do, but one of the activities staff had found another job, so they were down to just one person. The residents stated after the staff person left, they expressed concerns to the facility, but were told they now had "free time" they could use to spend with their families. One resident stated, "That's OK for people who have families who visit or take them out. But not all of us have families." Another stated, "We know [the AD] is doing everything she can, so we stopped telling her. After all, she can't be here all the time. She needs to spend some time with her own family." Yet another stated, "We don't need something every night, and not incredibly late. 2 or 3 nights a week until 7:30 [PM] or so would be fine."</p> <p>On 1/13/14 at 4:30 PM, the AD was asked about the resident's concerns. The AD stated, "Basically, it's just me. I have a volunteer to call Bingo on Wednesday afternoons, but otherwise it's just me." The AD stated she had an assistant for approximately two months, but that person had found another job. The AD stated, "I try to do everything I can. I ask the residents and they say I'm doing just fine. I get as many volunteers as I can, like the gospel group on the second Tuesday of each month. You know how it is with activities. It never seems like you have enough." The AD stated after the assistant quit, she adjusted her own hours so she could be at work for activities on Saturdays, and left instructions with the nursing staff to put in movies for the residents in the evenings. She stated she did have to cut back on the structured activities on Sundays, evenings, and Wednesday mornings to compensate for the loss of her staff member. The AD stated, "We are</p>	F 248		

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F 248	<p>Continued From page 13 in the process of starting to brainstorm for a solution, but we haven't found one yet."</p> <p>On 1/13/14 at 6:00 PM, the Administrator was asked about the activities program. The Administrator stated, "The DNS is planning to add another RNA (Restorative Nurse Aide) on the weekends. RNA activities can count as group activities." The Administrator was asked if the residents had been consulted as to whether or not the addition of a group RNA activity on the weekends would satisfy their need for more activities. The Administrator stated he had not talked to the residents about this idea.</p> <p>2. Resident #1 was originally admitted to the facility on 7/7/09 with multiple diagnoses which included Alzheimer's disease, dementia with behavioral disturbances, muscle weakness, glaucoma, and anxiety.</p> <p>Resident #1's Quarterly MDS, dated 10/4/13, coded: *Unable to complete the BIMS. *Severely impaired decision making skills, per staff assessment. *Physical behaviors directed towards others 1 to 3 days out of the past 7 days. *Mood Severity score of 9 per staff assessment, indicating mild depression.</p> <p>Resident #1's most recent Significant Change of Condition MDS, dated 4/8/13, coded "Very Important" for Resident #1 to read books, listen to music, participate in groups, and attend activities.</p> <p>Resident #1's care plan documented a focus area of, "Dependent on staff for activities, cognitive stimulation, social interaction r/t [related to]</p>	F 248		

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F 248	Continued From page 14 physical limitations. Cognitive deficits." Date initiated 7/30/13. Goals of, "Will attend/participate in activities of choice by next review date," with a target date of 1/15/14; and, "Will maintain involvement in cognitive stimulation, social activities as desired through the review date," with a target date of 1/15/14. Approaches were documented as: -"Engage in simple, structured activities such as music." -"Preferred activities are: listening to music, watching TV, small groups." -"All staff to converse with resident while providing care." -"Assure that the activities attending are: Compatible with physical and mental capabilities; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation). Compatible with individual needs and abilities; and Age appropriate." -"During 1:1 visits use flash cards for [Resident #1] to read." -"Needs 1 to 1 visits and activities if unable to attend out of room events." -"Needs assistance/escort activity functions." Resident #1's Active Orders (Recapitulation orders) for January 2014 documented, "Continue with orders to reposition in bed every 1-2 hours, keep alternating pressure cushion for w/c [wheelchair] and mattress for bed, and may be up in w/c for meals only" with an order date of 12/22/13. On 1/12/14 at 2:35 PM, Resident #1 was observed in her room. She was lying in bed, positioned on her back, asleep. The room was dark and quiet; the lights were off and the blinds were drawn, there was no music or TV. The	F 248			

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F 248	<p>Continued From page 15</p> <p>resident was observed again in this same situation at 3:00 PM, 3:20 PM, and 3:40 PM. NOTE: The facility activity calendar listed, "Leisure Activity of Choice" during this time.</p> <p>On 1/13/14 at 9:35 AM, Resident #1 was again observed in her room. She was lying in bed on her back, asleep. The room was dark and quiet, with not only the blinds but her roommate's privacy curtain drawn. Resident #1 was again observed in this position at 9:40 AM, 9:45 AM, and 10:10 AM. NOTE: The facility activity calendar listed "Movin and Groovin", an exercise program, to be in progress during this time.</p> <p>On 1/13/14 at 4:25 PM, the AD was interviewed about Resident #1. The AD stated Resident #1 had been declining, and as a result her activity participation had slowed. The AD stated historically, Resident #1 enjoyed participating in music and food socials, but her participation had become limited due to, "she lays down a lot", and, "she's on thickened liquids." The AD stated she had not been made aware of the MD order from 12/22/13 for Resident #1 to be up only for meals. The AD stated, "She likes to listen to music. We put music on in her room for her." The AD was informed of the surveyor's observation of Resident #1 being in her room, with the lights off and no music playing. The AD stated, "Oh."</p> <p>On 1/16/14 at 12:40 PM, the Administrator, DNS, and QI Consultant were informed of the surveyor's findings. The facility offered no further information.</p>	F 248	<p>F253</p> <ol style="list-style-type: none"> 1. No specific residents were identified. 2. All residents who are weighed in the clean utility room on the 200 hall are at risk. 	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253	<p>Continued From page 16</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to ensure a sanitary and comfortable environment was provided in the Clean Utility Room where residents were weighed. This was true for 1 of 2 Clean Utility Rooms. Findings included:</p> <p>On 1/12/14 at 2:35 p.m., during an initial tour of the facility, the following was noted in the Clean Utility Room on Side 2: * A wheelchair scale was in the room. Twelve floor tiles, each approximately 12" x 12" (12 inch by 12 inch), were covered with black marks which looked like spray paint. These floor tiles were near the scale and in direct view of anyone who would be on the scale. Seven other floor tiles were covered with blackish gray scuff marks and had a black substance of varies sizes, approximately 12" long by 1/8" to 1/2" wide, in between where 6 of the tiles touched one another. In addition, the inside of the door frame was unsightly with blotches of missing paint all along the right side and the top right half of the frame.</p> <p>At 2:40 p.m., when asked where resident's were weighted, the DNS took the surveyor to the Side 2 Clean Utility Room. The DNS confirmed that resident were weighted in the room. Once inside the room, the DNS was asked about the floor. She stated, "It needs to be replaced in my opinion."</p>	F 253	<p>3. A. Dumpsters have been replaced. B. Covers for laundry bins were replaced. C. Door frame of clean utility on 200 hall has been painted. D. Floor of clean utility room on 200 hall has been cleaned. E. Floor behind washers in laundry has been cleaned.</p> <p>4. Beginning 2/3/14 bi-monthly physical inspection of the dumpsters, laundry room, laundry covers, door frame, floor of clean utility will be conducted by Administrator or designee for 3 months, then audits will be done 1X per month. Results will be reported quarterly to the QA Committee.</p> <p>5. February 14, 2014</p>	

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F 253	Continued From page 17 On 1/16/14 at 10:20 a.m., during an tour of the facility environment with the Maintenance Supervisor (MS), the Side 2 Clean Utility Room floor was observed to have been cleaned. The MS stated that the plan is to replace the floor. The MS also acknowledged the condition of the inside of the door frame and stated, "It needs some work." On 1/16/14 at 12:30 p.m., the Administrator, DNS, Performance Improvement Consultant, and MDS nurse were informed of the issue. No other information was received from the facility regarding the issue.	F 253			
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;	F 272	F272 1. Resident #2: Smoking assessment conducted 1/27/14. 2. All other charts have been audited for those residents who smoke to ensure that assessments are present. 3. Smoking assessments will be a part of the new admitting process and documented on the new admission tool. 4. Beginning 2/2/14, Smoking assessments will be audited for completion with 24 hours for each new admission by the Medical Records Director or management designee. Audits will be done weekly for 2 months, then bimonthly for 2 months for all new admissions. Results will be reported quarterly to the QA Committee. 5. February 14, 2014		

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F 272	Continued From page 18 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, the facility failed to ensure residents were assessed to determine if they were able to safely smoke and handle lit cigarettes. This was true for 1 sample resident (#2) reviewed for smoking. Failure to assess whether or not the resident was able to safely light and hold a cigarette while smoking created the potential for more than minimal harm should the resident not be able to safely light or hold the cigarette. Findings included: During an interview with Resident #2 on 1/12/14 at 2:45 p.m., the resident stated she enjoyed going out to the patio to smoke cigarettes. On 1/13/14 at about 5:15 p.m., the resident was observed in her wheelchair on the patio smoking a cigarette with an unidentified staff member	F 272			

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F 272	<p>Continued From page 19 present.</p> <p>A smoking assessment was not found when the resident's paper and electronic medical records were reviewed.</p> <p>On 1/15/14 at 4:45 p.m., the DNS was asked to provide the resident's smoking assessment. The DNS stated, "No one smokes without supervision." She said she would look for the assessment. The facility policy regarding smoking was requested.</p> <p>A few minutes later, a smoking policy was provided. It documented, in part, "Upon admission (7-10 days), residents who desire to smoke will be assessed as well as their ability to do so safely. All new admissions will be on supervised smoking until assessment is reviewed by the interdisciplinary team. The Interdisciplinary Team will accomplish this using the Smoking Assessment form and a review of the resident's clinical record..."</p> <p>On 1/16/14 at 2:00 p.m., the Administrator stated, "We don't have a smoking assessment for [Resident #2]."</p>	F 272		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the</p>	F 280	<p>F 280</p> <ol style="list-style-type: none"> 1. Resident #1: Care plan has been updated and individualized to reflect specific preferences. 2. Other residents with severe or worsening dementia could be affected. Care plans for these residents have been reviewed and revised as necessary. 	

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F 280	<p>Continued From page 20</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 staff interview, and record review, it was determined the facility did not update resident care plans to reflect changes in resident status. This was true for 1 of 9 residents sampled for care plan revisions (#1). The deficient practice had the potential to cause more than minimal harm when the resident continued to experience skin injuries, had a decrease in her ability to socialize, and was labeled as resistive, without having care plan revisions made. Findings included:</p> <p>Resident #1 was originally admitted to the facility on 7/7/09 with multiple diagnoses which included Alzheimer's disease, dementia with behavioral disturbances, muscle weakness, glaucoma, and anxiety.</p> <p>Resident #1's Quarterly MDS, dated 10/4/13, coded: *Unable to complete the BIMS. *Severely impaired decision making skills, per staff assessment.</p>	F 280	<p>3. Care plans will be reviewed and revised as necessary at each quarterly MDS assessment by the IDT. MDS coordinator or DNS will review each updated quarterly care plan to ensure it reflects changes in resident status.</p> <p>4. Starting 2/3/14 weekly audits of reviewed care plans will be conducted by the DNS or LN designee X 2 months then monthly ongoing. Results of the audit will be reported to the QA committee monthly.</p> <p>5. February 14, 2014</p> <p><i>See attached addendum pg 21A</i></p>	

F280

1. Resident #1: Care plan has been updated and individualized to reflect specific preferences: eye contact/communication/radio/television/holding stuff animal/blanket or other etc...to reduce anxiety and resistance to cares reducing resident risk for bruising.
2. Other residents with severe or worsening dementia could be affected. Care plans for these residents have been reviewed and revised as necessary. Individual residents with potential will be identified by social services utilizing resident BIM score. Resident with potential for skin issues or restiveness will have individualized care plans in place with appropriate interventions.
3. Care plans will be reviewed and Revised as necessary at each Quarterly MDS assessment or at change of condition by the IDT. MDS coordinator or DNS will review each updated quarterly care plan to ensure it reflects changes in resident status.
4. Starting 2/3/2014 weekly audits Of reviewed care plans will be Conducted by the DNS or LN Designee X2 months then monthly ongoing. Results of the audit will be reported to the QA committee monthly.
5. February 14, 2014

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F 280	<p>Continued From page 21</p> <p>*Physical behaviors directed towards others 1 to 3 days out of the past 7 days.</p> <p>*Mood Severity score of 9 per staff assessment, indicating mild depression.</p> <p>*Extensive assistance of 2 persons for transfers and dressing.</p> <p>*Extensive assistance of one person for eating.</p> <p>*Did not ambulate.</p> <p>*Range of motion deficits for both lower extremities.</p> <p>Resident #1's most recent Significant Change of Condition MDS, dated 4/8/13, coded "Very Important" for Resident #1 to read books, listen to music, participate in groups, and attend activities.</p> <p>Resident #1's Active Orders (Recapitulation orders) for January 2014 documented, "Continue with orders to reposition in bed every 1-2 hours, keep alternating pressure cushion for w/c [wheelchair] and mattress for bed, and may be up in w/c for meals only" with an order date of 12/22/13.</p> <p>Resident #1's care plan documented: *Focus area of, "Has the potential/actual impairment to skin integrity r/t [related to] fragile skin and MASD (moisture-associated skin damage)." Date initiated 8/3/13. Goals of, "Will be free from injury through review date," and, "Will have no complications r/t MASD through the review date." Interventions included, "Full body sling for Hoyer transfers to eliminate rubbing on wound." There was no date documented on the care plan indicating when this intervention was initiated. There were no further approaches regarding protecting the resident's skin when using the mechanical lift. There was no approach documented to use geri-sleeves.</p>	F 280			

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F 280	<p>Continued From page 22</p> <p>*Focus area of, "Dependent on staff for activities, cognitive stimulation, social interaction..." Date initiated 7/30/13. Goals of, "Will attend/participate in activities of choice by next review date," with a target date of 1/15/14; and, "Will maintain involvement in cognitive stimulation, social activities as desired through the review date," with a target date of 1/15/14. Approaches were documented as:</p> <ul style="list-style-type: none"> - "Engage in simple, structured activities such as music." - "Preferred activities are: listening to music, watching TV, small groups." - "All staff to converse with resident while providing care." - "Assure that the activities attending are: Compatible with physical and mental capabilities; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation). Compatible with individual needs and abilities; and Age appropriate." - "During 1:1 visits use flash cards for [Resident #1] to read." - "Needs 1 to 1 visits and activities if unable to attend out of room events." - "Needs assistance/escort activity functions." <p>Resident #1's Skin Event Investigation forms documented skin injuries related to the use of the mechanical lift on 7/2/13, 7/8/13, 8/3/13, 8/24/13, 8/27/13, 10/15/13, and 1/7/14. NOTE: Please see F 226 as it pertains to incident investigations.</p> <p>On 1/13/14 at 2:30 PM, CNA #1 was asked about caring for Resident #1. CNA #1 stated the resident was transferred using 2 people and a mechanical lift, and it was important to use a full body sling because of, "some skin issues." When</p>	F 280		

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F 280	<p>Continued From page 23</p> <p>asked if the resident ever became resistant, CNA #1 stated, "I know some people have a problem with that." When asked if there were specific things staff had been instructed to do to, specific to Resident #1, to minimize resistance, CNA #1 stated, "Not that I'm aware of. I can only follow what's on the care plan."</p> <p>On 1/13/14 at 4:25 PM, the AD was interviewed about Resident #1. The AD stated she had not been aware of the 12/22/13 MD order for Resident #1 to remain in bed except for meals, and had not updated her care plan. NOTE: See F 248 as it pertained to activities.</p> <p>On 1/14/14 at 10:00 AM, the DNS was interviewed about Resident #1's skin issues and resistiveness, and the surveyor's observation of the CNAs transferring Resident #1. [NOTE: Please see F 226 as it pertained to incident investigations for full details of this interview.] The DNS identified several specific approaches to be used with Resident #1 during transfers. Those approaches, however, were not listed in the resident's care plan.</p> <p>On 1/13/14 at 6:00 PM, the Administrator and QI person were informed of the surveyor's findings. The facility offered no further information.</p>	F 280		
F 309 SS=D	<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>	F 309	<p>F 309</p> <p>1.</p> <ul style="list-style-type: none"> Resident #1: Care plan has been modified to reflect current physician's orders, activity preferences and transfer techniques. Nursing staff have been in serviced on following the updated care plan. 	

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F 309	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility did not ensure residents received individualized care for dementia; did not maintain consistent communication with a hospice agency providing care and services to a resident in the facility; or ensure resident care plans were followed related to positioning of the feet. This was true for 3 of 10 (#s 1, 4, and 6) residents sampled for quality of care. The deficient practice had the potential to cause more than minimal harm when residents did not receive care tailored to their individualized needs. Findings included:</p> <p>1. Appendix PP - Guidance to Surveyors for Long Term Care Facilities, under F 309, Care and Services for a Resident with Dementia: "...Person-Appropriate Cares is care that is individualized by being tailored to all relevant considerations for that individual, including physical, functional, and psychosocial aspects...Caregivers...are expected to understand or explain the rationale for interventions/approaches, to monitor the effectiveness of those interventions/approaches, and to provide ongoing assessment as to whether they are improving or stabilizing the resident's status or causing adverse consequences. Describing the details and possible consequences of resident behaviors helps to distinguish expressions such as restlessness or continual verbalization from potentially harmful actions such as kicking, biting, or striking out at others...Identifying, to the extent possible, factors</p>	F 309	<ul style="list-style-type: none"> • Resident #4: hospice notes have been printed out and made available to all staff. Hospice care plan has been updated to reflect resident's current status. Care plan has been updated to reflect use of heel protection when in bed. • Resident #6: care plan updated in regards to heel protection and resident comfort. All nursing staff has been in serviced. <p>2. All residents with care plan interventions for skin integrity and residents on hospice could be affected. Staff has been in serviced on ensuring care plan interventions are in place as ordered. Hospice agency has been notified of the need to update care plans quarterly or upon change of condition.</p> <p>3. Staff has been educated on electronic alerts and Kardex. Hospice username and password posted at each nurse's station to enable all nursing staff access to hospice notes, care plans, and updates.</p>	

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F 309	<p>Continued From page 25</p> <p>that may underlie the resident's expressions of distress...understanding that the resident with dementia may be responding predictably given the situation or surroundings...matching activities for a resident with dementia to his/her individual cognitive and other abilities and the specific behaviors in that individual based on the assessment..."</p> <p>Resident #1 was originally admitted to the facility on 7/7/09 with multiple diagnoses which included Alzheimer's disease, dementia with behavioral disturbances, muscle weakness, glaucoma, and anxiety.</p> <p>Resident #1's Quarterly MDS, dated 10/4/13, coded:</p> <ul style="list-style-type: none"> *Unable to complete the BIMS. *Severely impaired decision making skills, per staff assessment. *Physical behaviors directed towards others 1 to 3 days out of the past 7 days. *Mood Severity score of 9 per staff assessment, indicating mild depression. *Extensive assistance of 2 persons for transfers and dressing. *Extensive assistance of one person for eating. *Did not ambulate. *Range of motion deficits for both lower extremities. <p>Resident #1's most recent Significant Change of Condition MDS, dated 4/8/13, coded "Very Important" for Resident #1 to read books, listen to music, participate in groups, and attend activities.</p> <p>Resident #1's Active Orders (Recapitulation orders) for January 2014 documented, "Continue with orders to reposition in bed every 1-2 hours,</p>	F 309	<p>4. A: Staff provision of cares and interventions per care plan will be monitored 3X/week X 2 months then weekly X 2 months starting 2/3/14. Audits will be performed by MDS coordinator or DNS.</p> <p>B: starting 2/3/14 the DNS or LN designee will audit availability of hospice notes and staff's knowledge on accessing electronic hospice records 3X/week X 2 months then weekly X2 months. Results of the audit will be reported to the QA committee monthly.</p> <p>5. February 14, 2014</p>	

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F 309	<p>Continued From page 26</p> <p>keep alternating pressure cushion for w/c [wheelchair] and mattress for bed, and may be up in w/c for meals only", with an order date of 12/22/13.</p> <p>Resident #1's care plan documented: *Focus of, "At risk for impaired cognitive function/dementia or impaired thought processes r/t [related to] Alzheimer's Disease..Date initiated 7/11/13. Goals of, "Will be able to answer yes or no to basic questions through the review date", with a target date of 1/15/14; and, "Will remain oriented to person through the review date", with a target date of 1/15/14. Approaches were documented as: Administer medications as ordered; Ask yes/no questions PRN; Call by preferred name [Resident #1's first name]; Encourage to attend diversional activities; Give time to respond; Medicate for pain per MD order; Observe for changes in affect, appetite, participation and report; Provide a program of activities that accommodate abilities; Provide re-assurance PRN; Repeat/reword communications; Speak clearly, making eye contact and use name frequently when speaking to resident; Use simple/direct language; Use task segmentation to support memory deficits.</p> <p>The care plan approaches did not include the date each approach was implemented. The focus area, goals, and approaches did not include any information regarding physical aggression or resistiveness.</p> <p>*Focus of, "Dependent on staff for activities..." Date initiated 7/30/13. Goals of, "Will attend/participate in activities of choice by next review date", with a target date of 1/15/14; and, "Will maintain involvement in cognitive</p>	F 309			

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F 309	<p>Continued From page 27</p> <p>stimulation, social activities as desired through the review date", with a target date of 1/15/14. Approaches were documented as: Engage in simple, structured activities such as music; Preferred activities are: listening to music, watching TV, small groups; All staff to converse with resident while providing care; Assure that the activities attending are: Compatible with physical and mental capabilities; Adapted as needed...; During 1:1 visits use flash cards for [Resident #1] to read; Needs 1 to 1 visits and activities if unable to attend out of room events; Needs assistance/escort activity functions."</p> <p>*Focus of, "At risk for depression r/t Dementia....and loss of physical ability r/t hip [fracture]", with an onset date of 7/11/13. Interventions were documented as: Administer anti-depressant medication as ordered. Monitor/document for side effects and effectiveness; Assist in developing/providing with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity.</p> <p>Neither the care plan for activities nor the care plan for depression addressed the physician's order from 12/22/13 stating the resident could only be up for meals. There was no specific information provided about what kind of music, books, or TV the resident may enjoy.</p> <p>Facility Skin Investigation forms for Resident #1 documented: *8/24/13 at 2:45 PM, bruise to upper right thigh. The Investigation Interview documented, "...res[ident] resistant d/t [due to] dementia..." *8/27/13 at 9:50 PM, multiple bruises to both the left and right arms. The Investigation Interview</p>	F 309			

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F 309	<p>Continued From page 28</p> <p>documented, "I observed transfer and believe bruising occurring during transfers [with] mechanical lift, sling, and res resistance." *10/15/13 at 3:00 PM, multiple bruises on the left upper arm. IDT review of the incident on 10/16/13 documented, "...Observed resident grabbing and pushing away with BUE [bilateral upper extremities] when cares are being completed by staff. Resident will also grab at sling during transfers with Hoyer..." *1/7/14 at 11:00 AM. Bruising to bilateral arms. IDT review of incident on 1/9/14 documented, "...resident has increase resistance to cares with grabbing at night stand when attempting to assist with bed positioning..."</p> <p>On 1/12/14 at 2:35 PM, Resident #1 was observed in her room. She was lying in bed, positioned on her back, asleep. The room dark and quiet, the lights were off and the blinds were drawn, there was no music or TV. The resident was observed again in this same situation at 3:00 PM, 3:20 PM, and 3:40 PM.</p> <p>On 1/13/14 at 8:30 AM, Resident #1 was observed in the dining room for the breakfast meal. The resident sat at a table facing a wall, with a large TV playing "Classic Country" music. The resident was viewing the TV with rapt attention, reading the titles and artists as they appeared on the screen and attempting to hum/sing along. Her affect was relaxed and pleasant. Resident #1 was receptive to assistance with her entire meal.</p> <p>On 1/13/14 at 9:35 AM, Resident #1 was again observed in her room. She was lying in bed on her back, asleep. The room was dark and quiet, with not only the blinds but her roommate's</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>privacy curtain drawn. Resident #1 was again observed in this position at 9:40 AM, 9:45 AM, and 10:10 AM.</p> <p>On 1/13/14 at 12:30 PM, the surveyor observed CNA #2 and CNA #3 transfer Resident #1 out of bed and into her wheelchair for lunch, using a mechanical lift. Resident #1 was lying on her back in bed, on an air mattress, with a disposable absorption pad under her. Her wheelchair was toward the foot of the bed, approximately 2 feet beyond the right corner. The mechanical lift was to the left of the wheelchair. The CNAs were speaking to one another, but not to the resident. CNA #2 stood on the right side of the head of the bed, with CNA #3 on the left. The surveyor was standing on the right side of the resident's bed, approximately 3 feet from the head of her bed. Each CNA grabbed an edge of the pad, and with one swift motion moved the resident to the right side of the bed and rolled her to her right side. The resident was then far to the right side of the mattress, on her right side, facing the room. Her face and torso were positioned at the very edge of the mattress. Her knees were bent, with her kneecaps protruding just past the edge of the bed. The resident reacted with sounds indicating mild distress, and reached out her arms to brace herself against CNA #2's body. The resident looked directly at the surveyor. Her expression was fearful, with widened eyes and a startled look on her face.</p> <p>Both CNAs then began telling the resident, "It's OK", and "You're safe" repeatedly, as they were tucking the sling for the mechanical lift under body. Quickly, they rolled her onto her left side so as to complete the placement of the sling. Again, no instruction or warning was given to the</p>	F 309			

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F 309	<p>Continued From page 30</p> <p>resident. As she was rolled from her right side to her left, the resident's arms began to flail. CNA #2 tried to take the resident's hands into her own, while continuing to tell the resident she was safe. The resident pulled her hands back from the CNA. Within seconds, the sling was placed under the resident, and the mechanical lift was brought to the bedside.</p> <p>As the CNAs attached the sling to the lift, the resident adopted a more calm demeanor. Then, without warning or instruction to the resident, the CNAs engaged the lift to put the resident into her wheelchair. As the resident was lifted from the bed, she startled again. She reached out with her right had to tightly grasp a strap to the sling. CNA #3 moved from the left side of the bed, around the foot of the bed, to retrieve the resident's wheelchair. CNA #2 continued to operate the lift, swinging the resident away from the bed on the right side. The resident swung, suspended in the sling, for approximately 3 feet, across the room, to where CNA #3 had brought the wheelchair. As she was swinging, the resident reached out her left hand to tightly grab another strap on the sling, so now both hands were grasping sling straps. Resident #1 was lowered into her wheelchair, her hair was combed, and she was brought to the dining room at 12:37 PM.</p> <p>On 1/13/14 at 12:48 PM, Resident #1 was observed to receive her noon meal in the dining room. She was placed at the table as in the previous meal observation with "Classic Country" music playing. The resident once again was watching the TV screen with rapt attention, humming/singing along. The DNS sat with the resident, to assist her to consume the meal. The DNS stated, "You should see it when her daughter is here. I think they used to dance</p>	F 309			

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F 309	<p>Continued From page 31</p> <p>together. She [the resident] just loves music." The resident consumed 100% of her meal.</p> <p>On 1/13/14 at 3:00 PM, the resident was observed in bed, on her back, in a dark, quiet room. She was again observed in that situation at 5:10 PM.</p> <p>On 1/13/14 at 2:30 PM, CNA #1 was asked about caring for Resident #1. CNA #1 stated the resident was transferred using 2 people and a mechanical lift, and it was important to use a full body sling because of, "some skin issues." When asked if the resident ever became resistant, CNA #1 stated, "I know some people have a problem with that." When asked if there were specific things staff had been instructed to do to, specific to Resident #1, to minimize resistance, CNA #1 stated, "Not that I'm aware of. I can only follow what's on the care plan."</p> <p>On 1/14/14 at 10:00 AM, the DNS was interviewed about Resident #1's skin issues and resistiveness, and the surveyor's observation of the CNAs transferring Resident #1. The DNS stated, "With [Resident #1], you have to take time with her to tell her what you're doing. If staff moves quick, she reacts quick. When the staff are rolling her even, she grabs at them." The DNS was asked how the staff should approach Resident #1 for transfers. The DNS stated, "I recommend handing her something soft, like a stuffed animal, one person making direct eye contact, soothing her." The DNS stated the resident was easily distractible, and when distracted was more likely to become resistive.</p> <p>The DNS was asked if there was a way staff could tell whether or not the resident had become</p>	F 309			

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F 309	<p>Continued From page 32</p> <p>distracted. The DNS stated, "Eye contact is key. If you have eye contact, you have her. If you lose eye contact, you have to stop and talk with her to get her back. If there are 2 people in the room to take care of her, only one should be talking." When asked how the facility ensured the direct care staff were aware of these approaches, and were using them, the DNS stated, "I have observed, [the QI consultant] has observed, therapy has observed. We in-service." The DNS was asked if the approaches should be on the resident's care plan. The DNS reviewed Resident #1's care plan in the computer and stated, "It's there. Eye contact is there." The DNS was unable to state why the other identified approaches were not on the care plan, including the approach of stopping to re-establish eye contact if the resident became resistive. The DNS was asked if the facility had considered incorporating some of their knowledge about the resident's preferences, such as music, into the care interaction. The DNS stated they had not done that, although staff could do that if they wanted to.</p> <p>Please see F 248 as it pertained to the facility activities program.</p> <p>On 1/16/14 at 12:40 PM, the Administrator, DNS, and QI Consultant were informed of the surveyor's findings. The facility offered no further information.</p> <p>2. Resident #4 was admitted to the facility with multiple diagnoses which included cervical and spinal stenosis, congestive heart failure, and peripheral neuropathy. Hospice care for debility started 3/21/12.</p>	F 309			

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F 309	<p>Continued From page 33</p> <p>The resident's most recent quarterly MDS assessment, dated 12/25/13, coded, in part:</p> <ul style="list-style-type: none"> * Impaired cognition, with a BIMS score of 8; * Extensive 2 plus person assistance for bed mobility, transfers, and dressing; * At risk for pressure ulcers (PU); * No PU, other ulcers, wounds, or skin problems; and, * Hospice care. <p>The resident's care plan included the following focus areas:</p> <ul style="list-style-type: none"> * Potential for skin integrity impairment related to immobility, incontinence, and history of PU/self inflicted scratches/lower extremity edema, dated 7/8/13. Interventions included "Prevalon boots to feet bilaterally at all times." * Anticipate overall decline in physical and mental status, health/medical condition r/t [related to]...debility...chronic health problems, and is on hospice." Interventions included, "Hospice program for comfort care thru [sic] [name of hospice provider][.] Facility staff will co work [and] closely communicate w [with]/hospice staff in order to provide comfort care for the resident[.] Observe/report increase pain rate and re-eval[uate] as needed thru [sic] hospice." <p>The resident's "Active Orders from 1/1/14 to 1/31/14" included, "Sage prevalon boots LE bilat [lower extremities bilaterally], at all times, continue offload heels" ordered 6/25/10, started 6/1/11; and, "Hospice eval[uation]., admit if appropriate," ordered and started 3/22/12.</p> <p>a) F 309 Interpretive Guidelines regarding hospice services states, "...the hospice and the nursing home must communicate... The SNF/NF and the hospice are responsible for performing</p>	F 309			

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F 309	<p>Continued From page 34 each of their respective functions...."</p> <p>On 1/14/14, LN #9 was asked where the resident's hospice documentation was kept. The LN directed the surveyor to a binder next to the resident's chart in the chart rack.</p> <p>Review of the resident's hospice binder revealed a document, dated 3/1/12. It documented that the hospice would provide the following, in part: * Hospice Aide services 1-2 times per week; * Skilled Nursing visits 1 times per week and 24 hour on-call service; and * Social Work services minimum of 1 per month.</p> <p>The most recent hospice visit notes in the resident's hospice binder included: * Hospice Aide (HA) - 12/18/13; * Skilled Nurse (SN) - 3/7/13; and, * Social Worker (SW) - 3/18/13.</p> <p>On 1/15/14 at about 4:20 p.m., the DNS was asked where the resident's hospice visit notes were kept. The DNS said they were in the resident's hospice binder. When informed of the most recent visit notes found in the resident's hospice binder, the DNS asked the MDS nurse for assistance. The DNS stated the visit notes were supposed to be printed out and placed in the resident's hospice binder by the hospice provider. The MDS nurse stated, "I can print them out, because I have the code." When asked if all nursing staff had the code to access the hospice documentation, the MDS nurse and DNS indicated no.</p> <p>There was no documented evidence the hospice provider communicated with facility staff when they made visits to the resident in the facility.</p>	F 309		

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F 309	<p>Continued From page 35</p> <p>b) On 1/13/14 at about 9:00 a.m., CNA #8 was observed as she prepared the resident for cares and called for another CNA to assist her. CNA #8 uncovered the resident's legs and feet. A thick, blue padded heel protector was noted on the resident's right foot, however, the left foot was bare with a small, blue tubular pillow under the ankle. CNA #2 arrived a few minutes later and together they provided incontinence care and repositioned the resident in bed. At that point, CNA #8 questioned where the left heel protector could be after she did not find it in the resident's room, closet, or drawers. CNA #2 suggested that it could be in the laundry. The CNAs then placed the small, blue tubular pillow and a second small tubular pillow under the resident's left lower leg and ankle and covered the resident.</p> <p>On 1/15/13 at 9:45 a.m., the resident was observed in bed with a thick blue padded heel protector on each foot as the DNS and LN #8 examined the resident's skin. Immediately afterward, when asked if the heel protectors were supposed to be in place at all times, the DNS stated, "Yes." The DNS was informed that the left heel protector was not in place during the observation on 1/13/14.</p> <p>The facility did not provide any other information regarding the issues.</p> <p>3. Resident #6 was admitted to the facility with diabetic foot ulcers on both feet.</p> <p>The resident's "Active Orders from 1/11/2014 to 1/31/2014" included, "Bed cradle to be used when resident is lying down to prevent blankets from apping [sic] pressure." It was ordered and started</p>	F 309			

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F 309	Continued From page 36 3/14/13. The resident was observed lying in or on the bed without a bed cradle in place on 1/12/14 at 2:48 p.m., 1/13/14 at 9:10 a.m., 9:20 a.m., and 1/15/14 at 10:30 a.m. On 1/15/14 at 10:30 a.m., the resident was observed lying on his bed as the DNS and LN #8 examined his feet. An approximately 0.2 centimeter diameter intact red spot was noted on the medial interphalangeal (MIP) joint on the left great toe. An intact tiny white spot was noted on the MIP on the right great toe. And, an intact faint reddened area was noted on the MIP on the 3rd right toe. When asked if a bed cradle was supposed to be in use, the DNS stated, "Yes." The DNS instructed LN #8 to obtain a bed cradle and place it on the resident's bed. The facility did not provide any other information regarding the issue. F 323 SS=G 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, review of Fall Scene	F 309	F323 1. Resident #1: Staff educated on transfer techniques specific to the residents updated care plan. Changed Hoyer sling to the full body type for safety. Resident #2: Routinely monitoring pain and treating per physician order. Resident has progressed to light weight bearing on injured leg. PT and OT to evaluate and treat as indicated. Resident #6: LN on duty on side 1 auditing alarm placement and function hourly from 10 pm – 6 am. Resident had surgical intervention for urinary issues on 2/3/14. Resident #8: CNA responsible for leaving resident unattended on toilet was terminated. Staff in serviced on resident need for supervision.	

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F 323	<p>Continued From page 37</p> <p>Investigation Reports, and policy/procedure review, the facility failed to ensure:</p> <ul style="list-style-type: none"> - a seatbelt was secured during resident transport in the facility's minivan; - alarms were turned on and properly placed; - a care plan to not leave a resident alone while on a toilet was followed; and, - mechanical lift slings were properly placed. <p>This was true for 4 of 4 residents (#s 1, 2, 6, and 8) reviewed for falls. Resident #2 was harmed when she sustained a fractured tibia and experienced pain, decreased mobility, and emotional distress related to a fall during transportation in the facility's van and was not assessed by a medical professional before the transport resumed. Resident #6, who was admitted with a history of falls experienced minor injuries related to 17 falls over 6 months when a bed and/or chair alarm was not turned on or was not properly placed. Resident #8 sustained lacerations to his head and nose from a fall when he was left unattended on a toilet. Resident #1 received abrasions and multiple bruises to her upper extremities related to the use of a mechanical lift sling. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 11/15/13 with multiple diagnoses which included chronic peripheral vascular disease, venous stasis ulcers, and debility.</p> <p>The resident's admission MDS assessment, dated 11/22/13, coded, in part:</p> <ul style="list-style-type: none"> * Able to make self understood and able to understand others; * Mild cognitive impairment, with a BIMS score of 12; * Extensive 1 person assistance for bed mobility, locomotion on and off the unit, dressing, toilet 	F 323	<p>2. All resident at high risk for falls or having experienced falls have the potential to be affected. All residents requiring the use of a mechanical lift for transfers also have the potential to be affected.</p> <p>3. A. All nursing staff in serviced on safe resident transfers using mechanical lifts. Observations of staff's performance using mechanical lifts conducted weekly by MDS nurse.</p> <p>B. All authorized van drivers have been re-educated on the updated policies and procedures for safe transportation.</p> <p>C. During walking rounds at shift change the LN will verify placement and correct operation of all alarms. The LN will verify again Q shift correct operation & placement of alarms. The IDT will evaluate appropriate use of alarms during weekly meeting.</p> <p>D. Staff in serviced on residents care plan level of supervision. Starting on 2/3/14 LN on each unit will verify through questions CNA knowledge of level of supervisions for each resident in their shift assignment. Answers will be documented and training provided on the spot if necessary.</p>	

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F 323	<p>Continued From page 38</p> <p>use, personal hygiene, and bathing; * Extensive 2 person assistance for transfers; * Impairment in both upper extremities; * Resident and direct care staff believe resident capable of increased independence in at least some ADLs; * Scheduled pain medication regimen and non-medication intervention for pain; * Occasional pain, rated at 5 on a numeric scale from 1-10; * No falls in the 6 months prior to admission; * No falls since admission; * Received 1 day of occupational therapy (OT); and, * Received 2 days of physical therapy (PT).</p> <p>The resident's CAA Worksheets, all dated 11/27/13, included the following: * Cognitive Loss/Dementia - "Reports pain but has routine pain management and has not requested PRN [as needed] pain medications... Client requires limited to extensive assist with ADL's but anticipate improvement with working with therapy..." * ADL Functional/Rehabilitation Potential - "Self care deficit secondary to limited to extensive assist with ADL's...uses a W/C [wheelchair] for mobility but is able to ambulate a few feet..." * Falls - "Sitting balance good but standing and transfer balance fair..."</p> <p>The resident's Pain Assessment Form, dated 11/17/13, documented no persistent or frequent pain during the past 2 weeks, no medication or treatment for pain received during the past 2 weeks, no observed nonverbal signs of pain, and, "Mild, occasional, and well-controlled pain..."</p> <p>The resident's Fall Scene Investigation Reports</p>	F 323	<p>4. A: Starting on 2/3/14 the DNS or RN designee will audit mechanical lift observation documentation weekly X 2 months then monthly X 2 months. B: Starting 2/3/14 PPM (Physical Plant Manager) or management designee will perform observations of the driver process of safely securing resident before transport weekly X 8 weeks then ongoing. C: Administrator or management designee to review alarm monitoring daily X 2 months then weekly ongoing. Starting 2/5/14. D: Starting 2/3/14 DNS or Medical Records Director will audit CNA competency checks weekly X 8 weeks then bi-monthly X 2 months. 5. February 14, 2014</p> <p>See addendum Pg 39A & 39B attached LK</p>		

F323

Resident #1: Staff educated
On transfer techniques
Specific to the residents

Updated care plan. Changed
Hoyer sling to full body
Type for safety. Resident

#2: Routinely monitoring
Pain and treating per
Physician order. Resident

Has progressed to light
Weight bearing on injured
Leg. PT and OT to evaluate
And treat as indicated.

Resident #6: LN on duty
Side 1 auditing alarm
Placement and function

Hourly from 10 pm-6am.
Resident had surgical
Intervention for urinary
Issues on 2/3/2014.

Resident #8: CNA
Responsible for leaving
Resident unattended on
Toilet was terminated. Staff
In serviced on resident need
For supervision.

2. All resident at high risk for
falls or having experienced
Falls have the potential to
Be affected. All residents
Requiring the use of
Mechanical lift for transfers
Also have the potential to be
Affected. Residents at risk will
Be determined by utilizing the
Fall risk assessment. All tab
Alarms will be monitored
Every shift and at shift
change. All van drivers
Will be re-educated on policy
And procedures.

3. A. All nursing staff in
Serviced on safe resident
Transfers using mechanical
Lifts. Observations of staff

LK

7639A

Performance using
Mechanical lifts conducted
Weekly by MDS nurse.
B. All authorized van
Drivers have been re-
Educated on the updated
Policies and procedures for safe
Transportation.
C. During walking rounds at shift
Change the LN will verify placement
And correct operation of all alarms.
The LN will verify again Q shift
Correct operation & placement of
Alarms. The IDT will evaluate
Appropriate use of alarms during
Weekly meeting.
D. Staff in serviced on residents care
Plan level of supervision. Starting on
2/3/2014
E. Administrator or management
Designee to review alarm monitoring
3X a week X2 month then weekly
ongoing.
5. February 14, 2014

LS

39B

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2014
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
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F 323	<p>Continued From page 39</p> <p>(FSIR) documented, in part:</p> <ul style="list-style-type: none"> * Witnessed "slide out/fall from wheelchair" while off premises "in van" on 12/19/13 at 1:15 p.m., resident was alert and oriented and in her usual mental and psychological state, and a seat belt was in use at time of fall; * "At doctors [sic] office since 9 am when done loaded resident in van making sure locks and brakes on seat belt in place and secured. Started to drive home. While on [name of road] coming up to stop light...putting on brakes car cut in front. Resident slid out of w/c on to foot pedals with feet pushed up against wall behind drivers and passengar [sic] seat legs bent. After pulling over I asked resident if she was ok and was she hurting anywhere. She stated No. With her assistance helped back in chair. Asked again if hurting she said No again. Secured her in w/c and proceeded back to facility. Had nurse check resident immediately upon arrival at facility." * "Root Cause of This Fall: Assistive/protective device"; * "What appears to be the root cause of the fall? Seat belt (van) transport"; * "Describe initial interventions to prevent future falls: educate van driver [and] inspection by maintenance of seat belt in van"; * "Care Plan updated [and] Nurse Aide Assignment updated; * "Conclusion: Fracture to (R) [right] tibia Brace to RLE [right lower extremity]." <p>The following documents were attached to the 12/19/13 FSIR:</p> <ul style="list-style-type: none"> * IDT PN, 12/20/13, "...Upon interview of resident and staff it appears while enroute back to facility from appointment the van driver slowed the vehicle...applied the brake the resident slid from w/c... The van driver immediately inspected the 	F 323			

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F 323	Continued From page 40 seatbelt for defects...right knee cap fracture..." * Nursing Progress Note, dated 12/23/13, "Upon further information...patella [knee cap] is non-injury. There is a fracture to...right tibia." * A handwritten statement, resident's last name and 12/19/13 at top of the page documented, "I thought the seat belt broke when the car cut us off [and] the driver slowed I slid from my chair. I didn't hurt until later." It was signed by the DNS, not the resident. * A handwritten statement, CNA #4's name and 12/19/13 at top of the page documented, "...coming to Hwy [highway]...putting on brake to slow down car then went to cut me off [resident's name] hollered, I looked in rearview mirror and she was sliding from the wheelchair. When the light turned green I pulled over to side of road. Her feet were against the wall [and] she was sitting on her foot rest. The seatbelt was around her but disconnected for [sic] the wall. I looked at the connection and it did not appear broke or anything. I checked the seatbelt for proper fit [and] to ensure secure prior to leaving doctors office. She denied pain [at] time of event." The statement was signed by the DNS, not the CNA. * "Follow Up Investigation" IDT Recommendations included: physician notified, x-ray completed, follow up with orthopedist, Forteo (antiosteoporotic) initiated, physician assessed, and van driver re-education. Signed by the DNS 12/23/13; however, the Administrator did not sign it until 1/10/14, 23 days after the incident. Right Tibia-Fibula Radiographs, dated 12/19/13, documented, in part, "Conclusion:...No evidence of fracture although an acute nondisplaced fracture can be occult in the setting of severe diffuse osteopenia."	F 323			

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F 323	<p>Continued From page 41</p> <p>CT (computed tomography) scan, dated 12/20/13, documented, in part, "Conclusion: ...Essentially nondisplaced acute fracture in the proximal right tibial metaphysis..."</p> <p>On 12/19/13, after the incident in the facility van, the physician ordered Norco (pain medication) 10/325 1 tablet by mouth 4 times/day prn. (Note: The resident was admitted with orders for gabapentin for diabetic neuropathic pain and Mobic, a nonsteroidal anti-inflammatory, for pain related to arthritis. And, on 11/18/13 a nurse documented, "...c/o HA [complains of headache]...No prn pain meds are ordered for res[ident]. Res states that Tylenol is what she has used at home..." The physician ordered Tylenol 500 milligrams (mg) 2 tablets 4 times/day PRN.</p> <p>A 12/26/13, Nurses Note/Reason for Office Visit, documented, in part, "Res having [increased] confusion and [decreased] ability to participate in ADLs since Norco was added for pain..." The physician discontinued Norco, ordered Tylenol #3 1 by mouth 4 times/day prn for] leg fracture.</p> <p>During an interview on 1/12/14 at 2:45 p.m., the resident stated, "I used the bathroom at first, now they use this (pointed to a mechanical lift) to get me up and I have to use that chair (pointed to a bedside commode by the bed) now since my legs won't support me now. I could walk before but now I can't. I just hate it! I just hate it (pointed to the bedside commode again)!" During the interview, the resident had 3 episodes of what she called "cramps" in both legs. She stated, "Oh yes, I have pain since the accident! And, I get these spasms a lot. It's both legs sometimes. And they have to do more for me now. I don't like it! I really don't like it, but I'm not a complainer</p>	F 323		

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F 323	<p>Continued From page 42</p> <p>honey." The resident then pressed the call light to summon staff.</p> <p>On 1/12/14 at 3:00 p.m., the MDS nurse responded to the call light. The resident told the MDS nurse she was having leg pain and spasms. Moments later, LN #5 arrived and asked the resident if she was in pain. The resident said yes. The LN asked the resident to rate the pain on a scale between 0-10. The resident stated, "8." A few minutes later, the LN administered a "pain pill" to the resident.</p> <p>On 1/13/14 at 4:45 p.m., CNA #1 and LN # were observed as they used a Hoyer type mechanical lift to transfer the resident from her bed to her w/c.</p> <p>Alternate Flow Sheet Records (AFSR) for November and December 2013 and January 2014 included, "Assess Resident Q [every] shift for pain." The resident's pain was documented every shift ("nite" "day" and "pm") as follows: * November - 0 (no pain) all shifts 11/15 - 11/30; * December - 0 all shifts 12/1 - 12/19, except 12/4 days = 4; then on 12/19 pm (after the incident in the minivan) it was 8. After that, the resident's pain was documented as 5 once, 6 - 10 times, 8 - 3 times, and 10 once; * January - 1/1 day - "+" [plus sign]," then the pain was documented as 5 - 3 times, 6 - 7 times, and 8 once. There was no documentation on 1/12 nite or 1/13 nite and day.</p> <p>The resident had virtually no pain before the incident on 12/19/13. After the incident, however, the resident's pain level increased to severe or moderately severe nearly every day. In addition, as noted in the interview on 1/12/14 at 3:00 p.m.,</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>the resident rated her pain at an 8; however, pain was documented as 0 on the day shift that day on the AFSR.</p> <p>The MARs for November and December 2013 and January 2014 documented prn pain medication were administered as follows: * November - none; * December - Tylenol: 12/4 once, 12/19 twice, 12/20 once, and 12/30 once; Norco: 12/20 once, 12/21 twice, three times on 12/22 and 12/23, and 12/24 once; Tylenol #3: 12/27 twice, and once each day 12/28, 12/30, and 12/31; * January - Tylenol: once on 1/1 and 1/2, 1/8 three times, and 1/11 once; Tylenol #3: 1/1 twice, 1/3 once, 1/5 twice, once on 1/8 and 1/9, twice on 1/11 and 1/12.</p> <p>The resident received stronger pain medication and more often after the 12/19/13 incident in the facility van.</p> <p>The resident's Physical Therapy (PT) records documented, in part: * Evaluation, with 11/20/13 start of care date - "Patient demonstrates good rehab potential as evidenced by recent onset, motivation to return to PLOF [previous level of function], active participation...and motivated to participate... Functional Assessment...Transfers = Mod[erate] (A) [assist] Gait Level Surfaces = Min[imal] (A); Distance Level Surfaces = 50 feet; Assistive Device = Front wheeled walker..." * 12/17/13 Therapy Daily Treatment Note (TDTN) - "...Patient is making steady improvement with ambulation quality and quantity..." * 12/23/13 TDTN - "...has a fractured tibia and is in a knee immobilizer with NWB R LE [non weight bearing right lower extremity]."</p>	F 323			

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F 323	Continued From page 44 * 12/26/13 TDTN - "...Patient is reporting significant R knee pain...a bit confused today..." * 12/27/13 TDTN - "Patient is cooperative with treatment focused on transfers...fairly confused and complains of significant knee pain with activity." * 12/31/12 TDTN - "...significant pain in R LE..." * 1/3/14 TDTN - "...confusion...diminising [sic]...pain medication change... Cont[inue] focus on transfer...NWB status..." * 1/7/14 TDTN - "...required frequent cueing secondary to increased confusion about various subjects..." * 1/9/14 TDTN - "...staff training with transfer...pre visit to hospital for MRI post MRI patient returned...vomiting no further treatment given..." * 1/10/14 TDTN - "...patient required multiple sessions today due to pain and nausea..." * 1/13/14 TDTN - "...general discomfort and malaise...states she still cant [sic] hold down food. 3 short sessions today due to poor there[apeutic] ex[ercise] tolerance tremors/shaking t/o [through out] each session..." * Recertification & Updated Plan of Treatment Certification Period 12/20/13 - 1/18/14: LTG (long term goal) and STG (short term goal) regarding gait: baseline (11/20/13) 50 feet, previous (12/12/13) 75 feet, current (12/20/13) 75 feet. "Gait on hold secondary to patient fracturing R tibia and is currently NWB." LTG and STG regarding transfers: baseline (11/20/13) moderate assist, previous (12/12/13) minimal assist, current (12/20/13) minimal assist. "Currently Mod/Max[imum] A secondary to NWB and R LE in a knee immobilizer." Assessment Summary Since Eval, "...Patient was making good progress with functional abilities, but had a major set back with R tibial fracture..."	F 323			

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F 323	<p>Continued From page 45</p> <p>On 1/15/14 at 1:45 p.m., CNA #4 was interviewed. The CNA said she was the minivan (van) driver on 12/19/13 and that she fastened the seatbelt around the resident's w/c and checked to be sure it was secured before she started the drive back to the facility. She stated that within moments after the resident slid out of the w/c, she pulled the van over. The CNA stated the resident denied pain several times when asked and the resident said to just help her up. When asked if the resident was assessed by a medical professional before she was moved back into the w/c, the CNA shook her head no. When asked who would assess a resident after a fall, she stated, "Nurses do an assessment before we move a resident in the facility. But she kept denying everything until about 15 minutes later." When asked if a nurse was in the van at the time of the incident, the CNA stated, "No nurse, just me. I'm a CNA. Hindsight, I wish I would have called 911. I called the facility when I got closer [she indicated the parking area in front of the facility]." When asked about the seatbelt, the CNA stated, "It came loose."</p> <p>On 1/15/14 at about 2:00 p.m., the Administrator and CNA #4 accompanied the surveyor to the facility van. The CNA demonstrated how the seatbelt was attached around the resident's w/c and to a receiver on the right side of the floor. The CNA stated that a second seatbelt was on the floor next to seatbelt receiver on the right. The CNA stated that when she hit the brakes the metal end on the second seatbelt may have caused the spring loaded latching mechanism to come undone and caused the resident's seatbelt come loose. The CNA said the resident denied pain repeatedly and kept saying to get her up. The CNA stated, "And I did [get the resident up]."</p>	F 323		

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F 323	<p>Continued From page 46</p> <p>The CNA said she then removed the second seatbelt and attached the resident's seatbelt to the receiver on the floor. She added that about 15 minutes after she resumed the trip, the resident c/o pain. The CNA stated, "We were already on the way by then so I just continued to the facility. I called the facility after that." The Administrator indicated it was a freak accident and said van drivers were inserviced after the incident. When asked about the inservice, the Administrator referred the surveyor to the Maintenance Supervisor (MS).</p> <p>On 1/15/14 at about 2:30 p.m., the MS was asked about the aforementioned inservice.</p> <p>On 1/15/14 at 2:45 p.m., the MS provided an undated Transportation Services P&P with an "All drivers read and sign" sheet, dated 12/13, attached. Five staff names/signatures were on the read/sign sheet. The MS stated he in-serviced staff after the 12/19/13 event and went over the highlighted areas (#s 1, 6, 7, and 12), which included, "Procedure: 1. In the event of a medical emergency, dial 911 for ambulance services. Do not use facility transport vehicles... 6. ...We do not transport emergent patients/residents in facility vehicles. There is no medical and/or nursing attention that can be provided while a patient/resident is being transported. 7. The transport driver will carry the facility cellular phone to communicate with the facility and for use in the event of an emergency. In the event of an emergency, dial 911...12. In the event of a resident fall during transportation van driver are instructed to call DON or Administrator immediately."</p> <p>On 1/15/14 at 4:30 p.m., the MDS nurse was</p>	F 323		

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F 323	<p>Continued From page 47</p> <p>asked about the resident's status. The MDS nurse stated a significant change MDS assessment was in progress, "Because she's had a decline."</p> <p>Resident #2 was harmed when she experienced a fracture with significant pain which necessitated the frequent use of strong pain medication, was NWB on the R LE because of a fracture to the R tibia, required mechanical lift transfers with a major set back in her ability to ambulate and transfer, and suffered emotional distress from having to use a bedside commode instead of a regular toilet, related to the fall in the facility van on 12/19/13.</p> <p>On 1/16/14 at 12:30 p.m., the Administrator, DNS, Quality Improvement Resource person and MDS nurse were informed of harm related to fracture, pain, ADL decline, and emotional distress caused by the resident's fall in the van on 12/19/13.</p> <p>No other information was received from the facility which resolved the issue.</p> <p>2. Resident #6 was admitted to the facility on 3/13/13 with multiple diagnoses which included recurrent falls and possible syncope with head injury.</p> <p>The resident's admission MDS, dated 3/20/13, coded, in part:</p> <ul style="list-style-type: none"> * Able to make self understood; * Usually able to understand others; * Severe cognitive impairment, with a BIMS score of 7; * No sign/symptoms of delirium and no behavior issues; * Extensive 2 plus person assistance for bed 	F 323			

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F 323	<p>Continued From page 48</p> <p>mobility, transfers, dressing, and toileting;</p> <ul style="list-style-type: none"> * Extensive 1 person assistance for ambulation on and off the unit; * Wheelchair (w/c) use; * Frequent urinary incontinence with decreased wetness after a trial of a toileting program (TP); * Current TP or trial; * Had falls in the last month and 2-6 months before admission; and, * Falls since admission, without injury. <p>The resident's most recent quarterly MDS, dated 12/16/13, differed from the 3/20/13 MDS above, in part, as follows:</p> <ul style="list-style-type: none"> * Usually able to make self understood - difficulty communicating some words/finishing thoughts but able if prompted or given time; * Severe cognitive impairment, with a BIMS score of 5; * Signs/symptoms of delirium with fluctuating inattention, fluctuating disorganized thinking, and continual psychomotor retardation; * Wandering occurred 1 - 3 days in the look back period; * Occasional urinary incontinence with a current TP or trail; * Two falls, no injury; and, * Two falls, with injury (not major injury). <p>Review FSIRs revealed the resident had 19 falls between 3/14 - 12/23/13. The FSIRs included the following:</p> <ul style="list-style-type: none"> * 3/14 at 12:10 a.m. - Found on knees and laying across bed, bed pressure alarm added; * Around 4/1, specific date and time not documented - Found on floor in room with pants and shirt off, tag alarm on w/c which was in restroom; The status of the bed pressure alarm, whether it was on or not, sounded or not) was not 	F 323			

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F 323	Continued From page 49 documented. * 4/17 at 2:10 p.m. - Intercepted fall as resident attempted self transfer bed to w/c, alarm sounded, assisted to floor, auto lock brake added to w/c; *6/11 at 12:10 a.m. - Found on floor in front of recliner in room, toileting during night and increased observation during night shift implemented; *6/27 at 9:50 p.m. - Found on floor in front of toilet in his restroom, tag alarm not turned on, LN on duty educated staff involved regarding proper use of alarms and to toilet/offer to toilet resident more often, redness to both knees noted; *7/4 at 5:25 a.m. - Found on floor in front of toilet in his restroom "trying to go to the bathroom," last toileted at 4:15 a.m. IDT recommendations on 7/5/13 included, "B/B [bowel and bladder] pattern [times] 7 days." *7/7 at 6 p.m. - Found on floor next to recliner, toileted 5-10 minutes earlier, resident said he, "Was trying to go to the bathroom" and that he hit his head, neuro checks initiated, complained of left hip pain with range of motion, physician/family notified. IDT review on 7/15/13 included, "...has been toileted frequently. Staff initiated post void residuals...less than 100 cc [cubic centimeters] post void...Resident prefers to rest in his recliner, however recliner has been located in his room and alarm in use. Staff have been placing his recliner in DR [dining room]/activity room with increase line of vision and larger screen television. When the recliner is in the DR resident rests quietly vs [versus] when in his room. Will continue to place resident in recliner in DR/activity room and monitor..." *7/19 at 9:30 p.m. - Found on floor in front of w/c in dining room, tag alarm in place but not sounding, LN on duty and IDT review on 7/22 did	F 323			

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F 323	<p>Continued From page 50</p> <p>not address the alarm issue;</p> <p>*9/29 at 1:00 a.m. - Found on floor with back against bed, "yelling out for his wife," tag alarm was still attached to resident and did not sound. IDT review on 10/2 noted resident "may respond better to male caregivers during HS...provide male caregiver at HS as much as possible."</p> <p>*10/17 at 2:30 a.m. - Found on floor by bed, alarm in use but came off bed with resident and did not sound, staff educated on toileting resident through night and alarm placement;</p> <p>*10/18 at 2:30 a.m. - found on floor in prayer position between bed and wall, "said he needed to use the bathroom," dry when last toileted between 10 and 10:30 p.m. (4 - 4 1/2 hours), skin impairment with abrasion to left knee 2 by 1.8 centimeters (cm) noted, denied pain. IDT review on 10/22/13 included: "Pressure alarm to be initiated to bed and referral to...urology consult. Resident to be toileted between 1:30 a.m. and 2:00 a.m. every noc shift." (Note: A bed pressure alarm was documented as added on 3/14/13.)</p> <p>*11/8 at 1:10 a.m. - Found on floor by bed, "Going pee," dry when last toileted at 10:20 p.m. (2 1/2 hours earlier).</p> <p>*11/8 at 3:20 a.m. - Found on floor by bed, stated he was "sleeping on the floor," dry when last toileted at 1:15 a.m. IDT review on 11/14 noted, "Event is outside his toileting pattern."</p> <p>*11/10 at 3:15 a.m. - Found on floor with back against bed, checked on 15 minutes earlier and dry when last toileted at 1:45 a.m. IDT review on 11/14 included, "POC [plan of care] updated for toileting at [10 p.m., midnight, 2 a.m., and 4 a.m.]"</p> <p>*11/17 at 5:15 a.m. - Found on floor by bed, said "Go to bathroom," dry when last toileted at 3:00 a.m. IDT review on 11/18/13 included, "...to be toileted every 2 hours during HS and monitored</p>	F 323		

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F 323	<p>Continued From page 51</p> <p>through fall committee. Resident has refused referral to urologist, however recently has agreed and appointment...made..."</p> <p>*12/12 at 7:45 p.m. - Found on floor next to w/c in his room, said, "I was trying to go down the hall," last toileted (voided) at 7:30 p.m., LN noted "voiding urgency" and encouraged resident to use call light;</p> <p>*12/20 at 8:15 p.m. - Found sitting on floor between wall and toilet, resident stated, "Get on the toilet," the resident's mental status prior to the fall was, "Grouchy, bad tempered, argumentative, uncooperative," dry when last toileted at 8:05 p.m., CNA #1 documented, "...toileted 4 times between [6:30 - 8:00 p.m.]. Was yelling at staff and other residents after dinner at 5:30 p.m." IDT review on 1/2/12 included, "cont[inue] scheduled toileting, F/U [follow up] [with] cardiologist/urologist."</p> <p>*12/23 at 9:30 p.m. - Found on floor next to bed, resident stated he was "trying to get up to use the toilet," last toileted "around 8." IDT review on 1/4/14 included, "Surgery scheduled for 12/27/13 for foreskin r/t [related to] voiding issues."</p> <p>During the survey, the resident was observed as follows:</p> <p>* 1/12/14 at 2:48 p.m. - Asleep in a low bed that was against the wall;</p> <p>* 1/13/14 at 8:42 a.m. - CNA #3 talked to resident through the door while the resident was in the restroom;</p> <p>* 1/13/14 at 9:10 a.m. - Awake, lying on bed;</p> <p>* 1/13/14 at 10:45 a.m. - In Cherry Blossom DR in his w/c with tag alarm in place;</p> <p>* 1/13/14 at 12:15 - 12:45 p.m. - In or near Cherry Blossom DR in his w/c, tag alarm in place;</p> <p>* 1/13/14 at 1:45 p.m. - Self propelling in w/c along handrail in hallway between Side 1 and</p>	F 323		

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F 323	<p>Continued From page 52</p> <p>Side 2;</p> <ul style="list-style-type: none"> * 1/13/14 at 3:45 p.m. - In Cherry Blossom DR in w/c with tag alarm in place; * 1/13/14 at 4:25 p.m. - In w/c by Side 2 Nurses' Station; * 1/13/14 at 5:20 p.m. - At table in Cherry Blossom DR; and, * 1/15/14 at 10:30 a.m. - Lying in low bed against wall. <p>On 1/15/14 at about 2:15 p.m., the DNS and Performance Improvement (PI) Consultant were asked about the resident's falls. The DNS and MDS nurse from another facility were also present. The DNS and PI Consultant acknowledged there had been problems with the resident's alarms and that voiding pattern monitors were not completed. When asked if increased supervision, such as every 15 minute checks or 1:1 supervision were considered, the DNS stated, "We didn't do 1:1 because it was all based around toileting." The other DNS said that on 10/20/13 every 15 minute checks were done. The documentation was requested. It was not provided.</p> <p>On 1/16/13 at about 10:00 a.m., the Medical Records Supervisor (MRS) was asked to provide all fall assessments for the resident.</p> <p>At 12:25 p.m., the MRS provided 2 Fall Risk Evaluations, dated 3/14/13 and 12/23/13, and stated, "I looked though the paper files too and I couldn't find anymore."</p> <p>The 3/14/13 Fall Risk Evaluation documented, in part: Mental status - disoriented times 2, 1-2 falls in past 3 months, regularly incontinent, balance problem while standing/walking, decreased</p>	F 323	

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F 323	<p>Continued From page 53</p> <p>muscular coordination, requires use of assistive devices, takes 1-2 of the following types of medications: anesthetics, antihistamines, antihypertensive, antiseizure, benzodiazepines, cathartics, diuretics, hypoglycemic, narcotic, psychoactive, sedative/hypnotic, and has a predisposing condition.</p> <p>The 12/23/13 Fall Risk Evaluation differed from the earlier one as follows: 3 or more falls in past 3 months and a drop of less than 20 points between lying and standing blood pressure readings.</p> <p>On 1/16/13 at 12:30 p.m., the Administrator was also informed of the issue regarding falls. However, no other information or documentation was received from the facility which resolved the issue.</p> <p>3. Resident #8 was readmitted to the facility on 12/26/16 with multiple diagnoses which included abnormality of gait, generalized muscle weakness, other specific hemiplegia affecting nondominant side.</p> <p>The resident's FSIRs were reviewed on 1/15/14 and revealed the resident had 5 falls during the past 6 months. The FSIRs included: * 8/28/13 at 4:35 p.m. - Found on the floor in his restroom, "reaching for the pull cord." The initial intervention was, "...to remain [with] patient during toileting." An IDT review on 9/9/13 included, "...Continue POC [plan of care]. Resident not to be left alone while toileting now." * 9/13/13 at 4:45 p.m. - Found on the floor in his room. "Factors observed at time of fall:...commode arm came undone when shook [and] What type of assistance was resident</p>	F 323		

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F 323	<p>Continued From page 54</p> <p>receiving at time of fall? Alone and unattended." A re-creation of the last 3 hours before the fall documented, "Res[ident] alert and oriented prior to toileting. Res toileted [at 4:00 p.m.]. Placed on commode and left unattended at [4:45 p.m.]. Called into room by CNA. Laying on (L) [left] side. Commode arm off (let down). No alarm on." "What was different this time? Res left unattended on commode. No alarm. CNA was sent home..." IDT review on 9/16/13 included, "Interview with resident he stated he had attempted to self position on commode and his hand hit the release mechanism of the commode handle and lost balance and fell forward onto floor. Staff educated and commode removed from building. Resident sent to ER [emergency room] at [name of local hospital] for evaluation. No sutures needed for lacerations to head and nose. Negative heat CT [computed tomography scan]. C [cervical]-collar for comfort..."</p> <p>On 1/15/14 at 5:00 p.m., the DNS and Performance Improvement (PI) Consultant were interviewed about the resident's falls. They acknowledged the care was not followed on 9/13/14 when the resident was left alone on the commode.</p> <p>The facility failed to follow care planned interventions not to leave the resident alone while toileting.</p> <p>No other information or documentation was received from the facility which resolved the issue.</p> <p>4. Resident #1 was originally admitted to the facility on 7/7/09 with multiple diagnoses which included Alzheimer's disease, dementia with</p>	F 323			

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F 323	<p>Continued From page 55</p> <p>behavioral disturbances, muscle weakness, glaucoma, and anxiety.</p> <p>Resident #1's Quarterly MDS, dated 10/4/13, coded:</p> <ul style="list-style-type: none"> *Unable to complete the BIMS. *Severely impaired decision making skills, per staff assessment. *Extensive assistance of 2 persons for transfers and dressing. *Extensive assistance of one person for eating. *Did not ambulate. *Range of motion deficits for both lower extremities. <p>Resident #1's care plan for ADL's, with a focus date initiation of 7/11/13, documented an approach of, "...dependent assistance with total mechanical lift for transfers and 2 staff..." NOTE: There was no implementation date documented for the approach.</p> <p>Facility "Skin Event Investigation" forms for Resident #1 documented:</p> <p>*7/8/13 at 5:30 PM, "2 cm [centimeter] diameter abrasion on below [sic] [right] gluteal fold." The "Immediate Action Taken" area of the form documented, "...Educated staff on placement of the Hoyer sling and to remove sling from between legs when in [wheelchair]. (There was excessive amount of anti-fungal cream in place over open area.)" The back of the form documented, "Noticed yellow cream covering open area, notified nurse to ensure skin area wasn't accounted for prior to me finding it." The statement was signed by a CNA #1, dated 7/8/13 at 9:35 PM. The "IDT Recommendations" area of the form documented, "MD notified," "Monitor</p>	F 323		

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F 323	<p>Continued From page 56</p> <p>until resolved," "staff education," and "update POC." A facility PN, dated 7/15/13 at 5:36 PM (7 days after the event) documented, "IDT review...After interview of staff it appears resident was found sitting up in her [wheelchair] with straps to mechanical lift sling still located between resident upper legs. It appears the straps of the sling may have contributed to the abrasion...staff education provided."</p> <p>*8/3/13 at 11:40 AM, open area in the right gluteal fold over an irregular size mass. The back of the form had several spaces for "Investigation Interviews". One space documented, "Assisted [LN name] with skin check with [Resident #1] bottom with measuring," and was signed by a CNA. The rest of the spaces were blank. A 8/5/13 PN attached to the form documented, "IDT review...Upon investigation and assessment of area resident is noted to have approximately a 3 cm X 2 cm mass located just above the abraded area. The skin above and around the mass is red and blanchable with a slightly protruding core. It appears the mass is pulling on the skin which could be causing friction from the sling strap during transfers..."</p> <p>There was no documentation as to whether the sling strap placement was investigated, in terms of the education done following the 7/8/13 incident. There were no further updates to Resident #1's care plan regarding mechanical lift sling placement or transfer technique.</p> <p>NOTE: Please see F 280 as it pertains to care plan revisions.</p> <p>* 8/24/13 at 2:45 PM bruising to the right upper thigh, and 8/27/13 at 9:50 AM multiple bruises to</p>	F 323			

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F 323	<p>Continued From page 57</p> <p>bilateral upper extremities (arms and wrists).</p> <p>The facility Skin Event Investigations provided had these incidents stapled together. Only one IDT review was attached, addressing the bruises to her arms. The number, size, and appearance of the bruising was not described on either form.</p> <p>The areas of the 8/24/13 form for "Investigation Interview" contained statements from 2 facility RNs noting the presence of bruising to the upper right thigh, as well as a statement from a corporate resource person. The statements from both RNs identified the bruising consistent with the placement of the resident's adult briefs. The statement from the resource person documented, "Observed transfer resident [with] mechanical lift. Sling rubs against res[ident], res[ident] resistant [due to] dementia. Recommend new sling." None of the statements were dated or signed.</p> <p>The areas of the 8/27/13 form for "Investigation Interview" contained a statement from a facility LPN and a statement from the corporate resource person. The statement from the LPN documented bruises to both arms noted during a skin check, and geri-sleeves placed. The statement from the corporate resource person documented, "I observed transfer and believe bruising occurring during transfers [with] mechanical lift, sling, and res resistance." Neither statement was signed or dated.</p> <p>There was no documentation indicating what type of sling was in place when the bruising occurred, or what type of sling the facility planned to use to prevent further incidents. There were no documented care plan approaches addressing the addition of geri sleeves. Please see F 280 as</p>	F 323		

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F 323	<p>Continued From page 58 it pertains to care plan revisions.</p> <p>*A facility PN, dated 9/15/13 at 12:57 PM, was attached to the above Skin Event Investigation forms. The PN documented, "IDT review of bruising noted to resident bilateral arms...After an observation by myself and clinical resource it appears when staff transfer resident she becomes rigid and pushes against the sling and tightens her arms by grabbing her bilateral arms with the hand of the opposite extremity in an arm crossed fashion. We were able to rule out abuse. We will have OT observe transfers and provide input into a different form of transfer to decrease resident anxiety during transfers. Will use geri gloves to provide some protection to her upper extremities..."</p> <p>*10/15/13 at 3:00 PM, multiple bruises on left upper arm. A hand-drawn diagram on the front of the form documented an area on the resident's hand, and several areas on the resident's upper arm, with bruising. The "Investigation Interview" area of the form documented, "During routine skin assessment multiple bruises noted to [left] upper arm. Hoyer sling lines up with bruising." [NOTE: This was the fifth incident where the lift sling was identified as a factor.] The statement contained no name, date, or signature. A second statement in that area of the form documented, "Marking to her upper arm early this morning. Skin was dry placed lotion on it before shower." On 10/16/14 at 11:26 AM, a facility PN documented, "IDT review of bruising...observed resident grabbing and pushing away with BUE (bilateral upper extremities) when cares are being completed by staff. Resident will also grab sling during transfers with Hoyer. Will encourage to leave geri-sleeves on..."</p>	F 323		

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F 323	<p>Continued From page 59</p> <p>There was no indication how the staff were to manage the resident's tendency to grab and push during cares. Resident #1's care plan contained no documentation of grabbing or pulling during cares. There were no interventions on Resident #1's care plan addressing resistance, grabbing, or pulling.</p> <p>On 1/13/14 at 12:30 PM, the surveyor observed CNA #2 and CNA #3 transfer Resident #1 out of bed and into her wheelchair for lunch, using a mechanical lift. At times during the transfer, the resident reacted with sounds indicating distress, expressions of fear and held tightly to the straps of the sling on the mechanical lift. Refer to F309 for additional information related to the transfer.</p> <p>On 1/13/14 at 2:30 PM, CNA #1 was asked about caring for Resident #1. CNA #1 stated the resident was transferred using 2 people and a mechanical lift, and it was important to use a full body sling because of, "some skin issues." When asked if the resident ever became resistant, CNA #1 stated, "I know some people have a problem with that." When asked if there were specific things staff had been instructed to do to, specific to Resident #1, in terms of protecting her from skin injuries during transfers, CNA #1 stated, "Not that I'm aware of. I can only follow what's on the care plan."</p> <p>On 1/14/14 at 10:00 AM, the DNS was interviewed about the Resident #1's continued incidents related to the use of the mechanical lift sling. The DNS stated she had observed transfers with this resident, as had the OT and the QI Resource Person (referred to in the incident investigations as "clinical resource", due</p>	F 323		

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F 323	Continued From page 60 to a change in title). The DNS stated they felt the issue was Resident #1's resistance during mechanical lift transfers, and the facility had educated the staff on how to properly transfer Resident #1. The DNS stated she would have to look for documentation to show this education had been done. On 1/15/14 at 4:35 PM, the DNS produced a, "Certified Nursing Assistant Skills Performance Satisfactory Completion" form, with a CNA's name on it, dated 8/24/13. The form contained a line item for, "Mechanical Lift." The DNS stated she was providing the form as an example of how the facility documented competency for each staff member individually. The DNS stated the facility did not have evidence of any education provided to the staff specific to Resident #1, but OT was responsible to observe staff during the annual skills test, and if the OT had signed off on the form, the CNA was considered competent. The DNS was not able to explain how the generalized training done by the facility addressed the issues of Resident #1's resistance with transfers, or included individualized approaches to protect her skin. On 1/16/14 at 12:40 PM, the Administrator, DNS, and QI Person were informed of the surveyor's concerns with Resident #1. The facility offered no further information.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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	F 329	F 329 1. <ul style="list-style-type: none"> Resident #6: Seroquel order has been discontinued according to parameters for infrequent use. Resident #7: A dose reduction, clarification of diagnosis and physician note of justification have been completed. 		

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F 329	<p>Continued From page 61</p> <p>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 did not ensure adequate indication and monitoring for the use of antipsychotic medications. This was true for 2 of 4 residents (#s 6 and 7) reviewed for antipsychotic medication use. The deficient practice had the potential to cause more than minimal harm if residents suffered side effects from medications with no clear reason why the medication was used. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 3/13/13 with multiple diagnoses which included recurrent falls, possible syncope with head injury, and deconditioning.</p>	F 329	<p>2. All other residents on anti-psychotic medication have been reviewed for appropriate diagnosis, target behaviors, justification for use, GDR and risk benefits.</p> <p>3. Psychotropic drug committee meeting will review monthly residents on anti-psychotic drugs for upcoming GDR, risk benefits, justification, behavior monitoring, and diagnosis. Licensed Social Worker will be responsible for establishing non-pharmaceutical intervention, and behavior documentation for residents with dementia diagnoses.</p> <p>4. DNS or RN designee will monitor LSW reviews weekly X4 weeks then bi-monthly X2 months. Results of the monitors will be communicated to the QA committee monthly. Audits to begin 2/3/14.</p> <p>5. February 14, 2014</p>	

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F 329	<p>Continued From page 62</p> <p>The resident's admission MDS, dated 3/20/13, coded, in part:</p> <ul style="list-style-type: none"> * Able to make self understood; * Usually able to understand others; * Severe cognitive impairment, with a BIMS score of 7; * No sign/symptoms of delirium; * No behavior issues; * No antipsychotic/antianxiety/antidepressant medications administered in last 7 days. <p>The resident's most recent quarterly MDS, dated 12/16/13, differed from the 3/20/13 MDS, in part, as follows:</p> <ul style="list-style-type: none"> * Usually able to make self understood - difficulty communicating some words/finishing thoughts but able if prompted or given time; * Signs/symptoms of delirium with fluctuating inattention, fluctuating disorganized thinking, and continual psychomotor retardation; * Wandering occurred 1 - 3 days in the look back period; * Antipsychotic medication administered 2 of the last 7 days; and, * Antidepressant medication administered 7 of the last 7 days. <p>The resident's care plan included the focus area, "Potential for a behavior problem r/t [related to] confusion and psychosis secondary to dx [diagnosis] of Dementia. Can be resistant to care with verbal and physical aggression...Date initiated: 9/25/13. Interventions included, "Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet needs, especially need to toilet frequently. Approach in a calm manner. If [resident's name] is calling out</p>	F 329		

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F 329	<p>Continued From page 63</p> <p>for...deceased wife gently visit with him. Most of the time you can remind him that she has passed and he will often redirect while looking at her picture. If he is really upset and fixated that she is somewhere-offer to assist him up out of bed, get him some coffee and a snack. Explain all procedures to before starting and allow to adjust to changes. Observe for side effects and adverse reactions of psychoactive medication... Stop and talk with resident when passing by."</p> <p>The resident's physician's orders included: * 5/6/13 - Seroquel 25 milligrams (mg) by mouth (PO) at HS everyday, 9:00 p.m. for "Parkinson's dementia." * 6/30/13 - Seroquel decreased to 12.5 mg PO every a.m. for "Parkinson's dementia." * 11/11/13 - Seroquel 12.5 mg PO changed to, "Take 1 tablet at bedtime if needed [PRN] to help sleep. D/C [discontinue] if used less than 5 times in one month [for] psychosis secondary to dementia."</p> <p>A Care Plan Conference Summary, dated 11/26/13, documented, "Seroquel was [changed] to PRN [and] is being used almost daily at HS [hour of sleep/bedtime]..."</p> <p>The resident's November and December 2013 and January 2014 MARs documented: * November: Scheduled Seroquel 12.5 mg was administered at 9:00 p.m. daily 11/1-11/10, and administered 13 times 11/11-11/30 after it was changed to PRN. * December: PRN Seroquel 12.5 mg at HS administered 5 times 12/1-12/31; and * January: PRN Seroquel 12.5 mg at HS administered 3 times 1/1-1/11.</p>	F 329		
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F 329	<p>Continued From page 64</p> <p>Per the aforementioned MARs, the reason for the PRN Seroquel and the effectiveness of the antipsychotic medication was not consistently documented as follows:</p> <ul style="list-style-type: none"> * November: for sleep on 11/23 and 11/27 with positive effect 11/27, no other documentation; * December: for "psychosis" on 12/11 and 12/14 with positive effect 12/14, no other documentation; * January: for "insomnia" with positive effect all 3 times. <p>The resident's Nursing Progress Notes for 11/7/13 - 1/14/14 did not include evidence the PRN Seroquel was monitored for effectiveness.</p> <p>On 1/14/14 at 4:45 a.m., the Social Worker (SW) was asked to provide the indication for Seroquel, PRN use of Seroquel, target behaviors identified, and behavior monitors.</p> <p>On 1/15/14 at 8:55 a.m., the SW provided the resident's behavior monitors for November and December 2013 and January 2014. The behaviors identified and monitored were:</p> <ul style="list-style-type: none"> * November: paranoia - none, depressed withdrawn - 0; * December: delusions - none, anxiety - none; and * January (1/1 through 1/15 day shift): delusions - none, agitated - none, wandering - 0. <p>The SW said the target behaviors were not specific and they "varied month to month" depending on nursing reports of the resident's behaviors. She said she would look for documentation regarding indications for Seroquel.</p> <p>On 1/15/14 at 11:45 a.m., the SW provided</p>	F 329		

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F 329	<p>Continued From page 65</p> <p>additional behavior monitors for June and August through October 2013. These monitors also documented inconsistency in the behaviors monitored. The behaviors identified and monitored were:</p> <ul style="list-style-type: none"> * June: delusions - 1 episode, anxiety - none; * August: anxious - none, hitting - none; * September: agitated/angry - 12 episodes combined, resisting cares - 7 episodes; and, * October: angry - none, hitting - none, depressed/withdrawn - none. <p>When asked to describe what paranoia and delusions looked like for the resident, the SW stated, "Nurses' notes documented lots of verbally angry, combative, but no psychosis." When asked if the resident had been evaluated by a neurologist regarding Parkinson's dementia, the SW stated, "No." Regarding the diagnosis for PRN Seroquel, the SW stated, "I can't find anything by the doctor." She said she thought the nurses may have referenced a 3/28/13 office visit note in which the physician said he would consider Seroquel for sleep/dementia. The SW said a sleep study was started 5/10/13, "But it's not a good one. It's not complete." The SW said the resident's sleep had not been monitored otherwise. When asked how nurses would know when PRN Seroquel was indicated, the SW did not offer a reply. She stated, "I can see I can do better."</p> <p>On 1/16/14 at about 12:40 PM, the Administrator, DNS, and QI Consultant were informed of the issue. No other information was received from the facility which resolved the issue.</p> <p>2. Resident #7 was admitted to the facility on 5/22/08, and re-admitted on 6/8/11, with multiple</p>	F 329			

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F 329	<p>Continued From page 66</p> <p>diagnoses which included dementia with behavioral disturbances, anxiety, depression, unspecified infantile cerebral palsy, and expressive language disorder.</p> <p>Resident #7's most recent Annual MDS, dated 12/5/13, coded:</p> <ul style="list-style-type: none"> * Unable to participate in BIMS. *Long term and short term memory impairment with severely impaired cognitive skills. *Minimal depression. *No hallucinations or delusions. *Verbal behaviors directed towards others 4-6 days of the past 7 days. *Behaviors not directed towards others 1-3 days out of the last 7 days. *Behaviors did not place the resident or others at risk of injury. *Behaviors did not significantly impact socialization or living environment. *Behaviors did not disrupt the provision of care. <p>Resident #7's Active Orders (Recapitulation Orders) for January 2014 documented:</p> <p>*"RisperDAL (Risperidone) 0.125 mg By mouth - TID [three times daily]...psychosis r/t [related to] dementia."</p> <p>Resident #7's "Note To Attending Physician/Prescriber" (Pharmacy recommendation) forms regarding Risperdal documented:</p> <p>*6/25/13. The pharmacist wrote, "It has been 6 months since this resident's Risperdal was increased to 0.125 mg TID, and should be reviewed for a possible dose reduction..." The physician had placed an "X" next to the option of, "Patient has had a good response to treatment and requires this dose for condition stability. Dose</p>	F 329		

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F 329	<p>Continued From page 67</p> <p>reduction is contraindicated because benefits outweigh risks for this patient and a dose reduction is likely to impair the resident's function and/or cause psychiatric instability (Please elaborate if there is any other patient specific information). The physician wrote, "This is a very low dose considering the max is 6 to 16 mg/day."</p> <p>The physician did not offer a specific psychiatric condition for which this medication was used, or how that condition might destabilize if the medication was reduced or stopped. The physician did not identify specific target behavioral symptoms for which the medication was being used, nor how those behaviors presented a danger to the resident or others. The physician did not indicate how the medication had been determined to be an effective intervention for Resident #7. The physician did not document how the potential benefit of the medication outweighed the potential risk of side effects for this resident.</p> <p>*11/15/13. The pharmacist wrote, "It has been 6 months since the Risperdal 0.125 mg tid was last reviewed, and it should be reviewed again at this time for a possible dose reduction..." The physician placed an "X" next to the same option as in the previous recommendation, but did not add any additional information.</p> <p>On 1/15/14 at 9:15 AM, the Social Worker (SW) was interviewed about the antipsychotic use for Resident #7, and a specific target behavior for its use. The SW stated the behavior tracked for Resident #7 changed each month, depending on nursing reports of current behaviors. The SW stated while behaviors were being tracked monthly, there was no behavior being tracked</p>	F 329			

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F 329	Continued From page 68 specifically related to the Risperdal use. The SW stated the MD had declined dosage reductions recommended by the pharmacist, but she did not ask the physician why the reduction had been declined. The SW stated, "You know, she was on it when I started here. I'll have to investigate it for you." On 1/15/14 at 2:30 PM, the SW returned, and reported the resident had a history of biting and scratching herself, and had been started on the Risperdal because of that behavior. The SW stated, "I know we can do better." On 1/16/14 at 12:40 PM, the Administrator, DNS, and QI Person were informed of the surveyor's findings. The facility offered no further information.	F 329			
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 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. 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. In accordance with State and Federal laws, the	F 431			

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F 431	<p>Continued From page 69</p> <p>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 controlled medications were properly stored and medication pharmacy labels matched the physician order. This was true for the emergency kit (E-kit) in the medication room and 1 of 8 residents (#13) during medication pass observations. The failures created the potential for diversion of controlled medications not stored in separately locked, permanently affixed compartments and could result in inadequate pain, nausea, or anxiety control for any resident if one or more of the controlled medications were not available when needed; and, unrelieved shortness of breath if Resident #13 did not receive DuoNeb breathing treatments as ordered. Findings included:</p> <p>1. On 1/16/14 at 11:00 a.m., during the inspection of the medication room with LN #10 in</p>	F 431	<p>F 431</p> <ol style="list-style-type: none"> A. Resident #1: Medication labels have been replaced by pharmacy and are accurate according to physician orders as of 1/31/14. Upon investigation it was determined a pharmacy technician was responsible for the error and reportedly has been termination. B. The Ekit has been moved to a locked cabinet permanently affixed to the wall in the locked medication room. Other residents receiving medication in the building have the potential to be affected. All other medication labels audited for accuracy as of 1/31/12. Nursing staff in-serviced on checking medication labels for accuracy per physician orders. A. The DNS or RN designee will conduct weekly audits of respiratory medication labels. Audits will be conducted weekly X2, then monthly X2 months starting 2/14/14. B. DNS or LN designee will conduct weekly audits of Ekit to ensure double lock conditions are in place. Audits will begin 2/3/14. Audits will be conducted weekly X2 months and then monthly X2 months. Audits results will be reported quarterly to the QA Committee. February 14, 2014 	

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F 431	<p>Continued From page 70</p> <p>attendance, a tackle box, approximately 18 inches tall by 12 inches wide by 18 inches long, labeled E-Kit #23, was noted on the counter. A paper labeled "Emergency Kit Alphabetical List" taped to the front of the tackle box listed the medications, which included numerous controlled medications, in the E-Kit. About then, LN #8 entered the medication room as LN #10 opened the E-kit. There were no barriers on the E-kit. LN #8 stated, "It has zip ties on the the outside when they [pharmacy] bring it and the first time someone gets into it we cut them off and they stay off." LN #8 added, "But each box has zip ties on them. And, the pharmacy changes it every Tuesday."</p> <p>The controlled medications in the E-kit included:</p> <ul style="list-style-type: none"> * alprazolam (brand Xanax, for anxiety) 0.25 milligrams (mg); * clonazepam (brand Klonopin, benzodiazepine anticonvulsant) 0.5 mg; * diazepam (brand Valium, for anxiety) 5 mg; * diazepam 10 mg/2 ml (milligrams/milliliter) syringe; * diphenoxylate/atropine (brand Lomotil, opioid antidiarrheal) 2.5/0.025 mg) * fentanyl (brand Duragesic, long acting opioid analgesic) patch 12 microgram/hour (mcg/hr); * fentanyl patch 25 mcg/hr; * fentanyl patch 50 mcg/hr; * fentanyl patch 100 mcg/hr; * hydrocodone/APAP (brand Norco-10, for pain) 10/325; * hydrocodone/APAP (Norco-5) 5/325; * hydrocodone/APAP (Norco-7.5) 7.5/325; * lorazepam (brand Ativan, for anxiety) 0.5 mg; * methadone (brand Dolophine, opioid analgesic, for pain) 5 mg; * morphine sulfate (brand MS, opioid analgesic, 	F 431			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2014
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
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F 431	<p>Continued From page 71</p> <p>for pain) 10 mg multidose vial for injection; * morphine sulfate (brand Roxanol) 20 mg/ml 30 ml bottle; * morphine sulfate ER (extended release) 15 mg; * oxycodone (brand Oxycontin, for pain) 10 mg ER tablet; * oxycodone immediate (brand Oxycodone IR) 5 mg IR tablet; * same as Vicodin (brand Lortab-5) 5 mg/500 mg; and, * zolpidem (brand Ambien, hypnotic) 5 mg.</p> <p>When asked if it was possible someone could simply pick up the E-Kit and walk off with it or open the E-kit and remove one of the boxes with controlled medications, both LNs stated, "Yes."</p> <p>On 1/16/14 at 12:30 p.m., the Administrator, DNS, QI Consultant, and MDS nurse were informed of the controlled medication storage issue. No other information was received from the facility regarding the issue.</p> <p>2. On 1/16/14 at 8:45 a.m., LN #11 was observed to set up and administer a DuoNeb nebulizer treatment for Resident #13. The LN stated the DuoNeb was a scheduled treatment. The pharmacy label on the DuoNeb medication read, "Use via nebulizer 4 times daily for 2 weeks then as needed."</p> <p>The resident's recapitulation of physician orders for January 2014 documented DuoNeb 4 times everyday for chronic obstructive pulmonary disease/shortness of breath (SOB) and DuoNeb every 2 hours as needed for SOB. The orders were dated 11/19/13.</p> <p>At about 9:00 a.m., when asked about the</p>	F 431			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 431	<p>Continued From page 72</p> <p>discrepancy between the physician's order and the pharmacy label, LN #1 provided the original 11/19/13 order which read, "DuoNeb QID & Q 2 h PRN [DuoNeb 4 times/day and every 2 hours PRN]."</p> <p>The LN indicated the pharmacy would be notified about the discrepancy.</p> <p>On 1/16/14 at 12:30 p.m., the Administrator, DNS, QI Consultant, and MDS nurse were informed of the labeling issue. No other information was received from the facility regarding the issue.</p>	F 431		
F 514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure resident records were accurate and complete. This was true for 4 of 10 residents (#s 1, 3, 6, and 7) sampled for medical record accuracy. The</p>	F 514	<p>F 514</p> <p>1.</p> <ul style="list-style-type: none"> • Resident #1: The order for the 1:00 p.m. snack has been discontinued. • Resident #3: starting on 2/3/14 daily MAR/TAR audits will be conducted. • Resident #6: The order for foot soaks has been discontinued. • Resident #7: starting on 2/3/14 daily TAR audits will be conducted. 	

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F 514	<p>Continued From page 73</p> <p>deficient practice had the potential to cause more than minimal harm if medical decisions for residents were based on inaccurate information. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 10/12/12 with multiple diagnoses which included diabetic neuropathy, hypertension and diabetes.</p> <p>Resident #3's TAR for January 2014 documented: *"Apply Iantisepic to right posterior thigh...twice a day every day." The areas to document the second daily application of this were blank for 3 out of 13 days. *"Apply Iantisepic to gluteal folds and peri area [each] shift and with each episode of incontinence...every shift every day." The form was blank for 9 of 39 opportunities. *"Monitor for s/sx [signs and symptoms] of infection to left lateral ankle. Encourage to float heels while in bed...every shift every day." The form was blank for 9 of 39 opportunities. *"Monitor for s/sx of infection to right heel. [Discontinue] when resolved. Encourage to float heels while in bed. Every shift every day." The form was blank for 10 of 39 opportunities.</p> <p>On 1/14/14 at 11:00 AM, the DNS was asked about the blank spaces on resident TARs. The DNS stated, "Obviously, we could do better."</p> <p>On 1/16/14 at 12:40 PM, the Administrator, DNS, and QI Person were informed of the surveyor's findings. The facility offered no further information.</p> <p>2. Resident #1 was originally admitted to the facility on 7/7/09 with multiple diagnoses including dementia with behavioral disturbances,</p>	F 514	<p>2. All other residents have the potential to be affected.</p> <p>3. Daily shift change documentation verifying completion of all MAR/TAR entries will begin 2/3/14. Staff in serviced on documentation requirements.</p> <p>4. Starting 2/3/14 the DNS or management designee will conduct documentation audits of the MAR/TAR 2X/week X2/months then weekly x 2 months. Results of the audit will be shared monthly with the QA committee.</p> <p>5. February 14, 2014</p>	
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See attached addendum pg 74A & 74B LK

F514

Resident #1: The order for
1:00 pm snack has
Been discontinued. Starting
On 2/3/2014 daily MAR/TAR
Audits will be conducted.

Resident #3: Starting on
2/3/2014 daily MAR/TAR
Audits will be conducted.

Resident #6: The order for
Foot soaks has been
Discontinued. Starting on
2/3/2014 daily MAR/TAR
Audits will be conducted.

Resident #7: starting on
2/3/2014 daily TAR audits
Will be conducted.

2. All other residents have the
Potential to be affected. Residents
Will be identified through shift to
Shift monitoring of MAR/TAR.

3. Daily shift change
Documentation verifying
Completion of all MAR/TAR
Entries will begin on 2/3/2014. Staff
In serviced on documentation
Requirements.

4. Oral counseling was initiated
For all LN's during documentation
In-service.

5. A LN designee will review
all respiratory medications upon
arrival to the facility for the accuracy
of the physician's
Recapitulation of orders.

6. Starting on 2/3/2014 the DNS or
Management designee will conduct
Documentation audits of the
MAR/TAR 2X/week X2months
Then weekly X2 months. Results of
The audit will be shared monthly

LK
74A

With the QA committee,
7. Starting on 2/3/2014 the DNS
Or Management designee will
Conduct 2X/week audits for
Recapitulation of orders X2 months
Then weekly X2 months. Results of the
Audit will be share monthly with
The QA committee.
7. February 14, 2014

LK
74B

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F 514	<p>Continued From page 74</p> <p>osteoporosis, and chronic thrombocytopenia.</p> <p>Resident #1's Skin Event Investigation forms documented 11 skin-related incidents between 4/6/13 and 1/10/14.</p> <p>Resident #1's Treatment Administration Record (TAR) for January 2014 included: **"Apply lotion to feet for dry skin. Order date 7/8/2009. At bedtime everyday." The spaces to document this treatment were blank for 4 of 12 days. **"Ace wraps or BK (below the knee) ted hose on [every] morning on both lower extremities for edema. Remove at [bedtime]. Order date 2/5/13. Twice a day everyday." The removal of Ace wraps or TED hose was not documented 5 of 12 days. **"Apply Calmoseptine to right posterior upper thigh. Order date 12/17/13. Every shift everyday." The form provided an opportunity to document this was done on day shift, evening shift, and night shift daily. The form was blank for 8 of 39 of those opportunities. **"Monitor BLE (bilateral lower extremity) edema [every] shift. Order date 4/1/13. Every shift everyday." The form was blank for 8 of 39 opportunities.</p> <p>Resident #1's MAR for January 2014 documented, "Offer daily sweet snack. Order date 5/10/10. Everyday at 1:00 PM. Everyday." The spaces for 1/5/14 and 1/11/14 were blank.</p> <p>3. Resident #7 was admitted to the facility on 5/22/08, and re-admitted on 6/8/11, with multiple diagnoses which included dementia with behavioral disturbances, anxiety, depression, unspecified infantile cerebral palsy, and expressive language disorder.</p>	F 514			

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F 514	<p>Continued From page 75</p> <p>Resident #7's TAR for January 2014 documented, "Ace wraps or BK ted hose to LE. On in AM, off at HS for edema." The TAR was blank for 5 of 12 opportunities to document the removal of the resident's Ace wraps or TED hose.</p> <p>4. Resident #6 was admitted to the facility on 3/13/13 with multiple diagnoses which included recurrent falls and possible syncope with head injury.</p> <p>The resident's All Active Orders for January 2014 included, "Soak resident feet daily in lukewarm water...DAYS Everyday, [6:00 a.m. - 2:00 p.m.]." It was ordered 7/3/13.</p> <p>Neither the resident's MAR or TAR contained documentation that the resident's feet were soaked daily.</p> <p>On 1/15/14 at 3:40 p.m., the DNS was asked for documentation that the resident's feet were soaked daily. The DNS stated, "That was discontinued 8/28/13. It just wasn't taken off the orders."</p> <p>No other information was received from the facility regarding the issue.</p>	F 514			

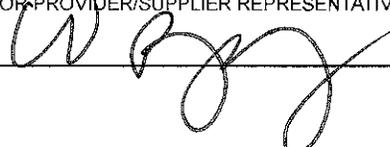
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2014
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NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CEI	STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617
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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 State licensure and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN Nina Sanderson, LSW</p>	C 000	<p style="text-align: center;">RECEIVED FEB 10 2014 FACILITY STANDARDS</p> <p style="text-align: center;"><i>SEE POC FOR F329</i></p> <p style="text-align: center;"><i>SEE POC FOR F226</i></p>		
C 147	<p>02.100,05,g Prohibited Uses of Chemical Restraints</p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician.</p> <p>This Rule is not met as evidenced by: Please see F 329 as it pertains to psychotropic medications.</p>	C 147			
C 175	<p>02.100,12,f Immediate Investigation of Incident/Injury</p> <p>f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted.</p>	C 175			

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

ADMINISTRATOR

(X6) DATE

2/8/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2014
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

RIVER'S EDGE REHABILITATION & LIVING CE **714 NORTH BUTTE AVENUE**
EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 175	Continued From page 1 This Rule is not met as evidenced by: Please see F 226 as it pertains to incident investigations.	C 175		
C 231	02.106,03 SMOKING 03. Smoking. Because smoking has been acknowledged to be a potential fire hazard, a continuous effort shall be made to reduce such a hazard in the facility. Written regulations governing smoking shall be adopted and available to all facility personnel, patients/residents and the public. These regulations shall include at least the following: This Rule is not met as evidenced by: Refer to F 272 as it related to smoking assessments.	C 231	SEE POC FOR F 272	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F 253 as it related to the Side 2 Clean Utility room floor and door frame.	C 361	SEE POC FOR F 253	
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There	C 674	SEE POC FOR F 248	

Bureau of Facility Standards

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C 674	Continued From page 2 shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Please see F 248 as it pertains to the activities program.	C 674		
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 see F 280 as it pertains to care plan revisions.	C 782	SEE POL FOR F 280	
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 see F 309 as it pertains to dementia care,	C 784	SEE POL FOR F 309	

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C 784	Continued From page 3 and following physician orders and care plans.	C 784		
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F 323 as it related to resident safety.	C 790	SEE POC FOR F 323	
C 832	02.201,02,f Labeling of Medications/Containers 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 F 431 as it related to pharmacy labels.	C 832	SEE POC FOR F 431	
C 851	02.201,03,e Storage of Schedule II Drugs e. Schedule II drugs shall be stored in a separate, locked section of the medication storage area or cabinet. (Alternate allowed under Unit Dose Pharmacy and emergency drug kit provisions.) This Rule is not met as evidenced by: Refer to F 431 as it related to controlled medication storage.	C 851	SEE POC FOR F 431	

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C 881	Continued From page 4	C 881		
C 881	<p>02.203,02 INDIVIDUAL MEDICAL RECORD</p> <p>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 see F 514 as it pertains to accuracy of medical records.</p>	C 881	SEE PDC FOR F514	



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

January 29, 2014

Warren "Douglas" Bodily, Administrator
River's Edge Rehabilitation & Living Center
714 North Butte Avenue
Emmett, ID 83617-2725

Provider #: 135020

Dear Mr. Bodily:

On **January 16, 2014**, a Complaint Investigation survey was conducted at River's Edge Rehabilitation & Living Center. Linda Kelly, R.N. and Nina Sanderson, L.S.W. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006097

ALLEGATION #1:

The complainant stated an identified resident was afraid to report concerns to the facility.

FINDINGS:

The facility's grievance file and resident council minutes were reviewed.

Several individual residents were interviewed, including the identified resident. A Resident Group interview was conducted. The facility's Administrator, Director of Nursing and social worker were interviewed

The identified resident stated they did not have any unresolved concerns with the facility and felt very comfortable bringing concerns to the social worker for resolution. Other individual

Warren "Douglas" Bodily, Administrator
January 29, 2014
Page 2 of 3

residents and the residents at the Resident Group interview stated they would report any concerns to the social worker without hesitation.

Some of the residents in the Resident Group interview stated they have filed grievances with the facility in the past and their grievances have been resolved timely.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident required continuous oxygen, but the portable oxygen tank would run out at least once a week, leaving the resident without oxygen for a few minutes. The complainant said the resident had to remind staff to fill her portable oxygen tank. The complainant stated this practice left the resident lethargic, weak and afraid. The complainant stated this had been going on for years.

FINDINGS:

The resident's record was reviewed, as well as the records of four other residents requiring oxygen. Records reviewed included physician's orders, medication and treatment records and care plans. Facility's incident reports were also reviewed.

The identified resident and one other resident requiring oxygen were interviewed. Direct care staff was also interviewed.

The identified resident was observed throughout a five-day period. The identified resident was observed on each of the five days of observation, to be up and walking and using a portable oxygen tank. The oxygen tank was set at the appropriate liter flow. There was also a concentrator in the resident's room set at the appropriate liter flow.

The identified was alert and oriented.

The resident stated she did not have difficulty with oxygen management and that the portable oxygen tank would last three to four hours. She stated that she would try to give staff a reminder after about three hours of use, so it could be filled before it ran out. The resident said she had only run out of oxygen on one occasion when she became weak and lost her balance. The resident stated staff came around to check the oxygen tank "once in a while," and that she was placed on an oxygen concentrator whenever the portable tank required filling, so she was never without the oxygen. These findings were consistent with the report from the other resident

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interviewed about oxygen use.

There was a facility's incident report detailing a resident's fall months prior, where it was discovered that the resident had disconnected themselves from the room's concentrator. That was the only documented instance of a resident being without oxygen. As a result of this incident, the facility began to document oxygen placement every two hours. That tracking has been in place for at least two months and is documented in the resident's treatment records.

A facility's registered nurse (RN) stated the resident had managed her oxygen in the community before admittance to the facility and was fairly proficient at it. However, the nurse reported that the resident would occasionally forget to turn the portable tank on or would come out of the room with the portable tank but not wearing the nasal cannula. The nurse stated that staff checks placement and liter flow at least every two hours, but it is often even more frequently to ensure the resident has not forgotten anything. The nurse stated whenever the portable tank is being filled, the resident is switched to the room's concentrator, as the resident's oxygen saturations drops if left without oxygen for even a few minutes. The nurse stated that staff usually fills the oxygen companion with the two-hour checks, because the resident is usually fairly active, although it would probably last four - six hours, if needed. The nurse stated that occasionally the resident inquires if the portable tank needs to be filled, but it is ultimately the responsibility of the charge nurse to ensure the oxygen is managed appropriately.

The resident's care plan specifies that the facility's charge nurse is to be responsible for oxygen management.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

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

LKK/dmj