



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 1888

February 12, 2014

Darrin Radeke, Administrator
Mini-Cassia Care Center
1729 Miller Avenue, PO Box 1224
Burley, ID 83318-0830

Provider #: 135081

Dear Mr. Radeke:

On **January 31, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Mini-Cassia Care 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 25, 2014**. Failure to submit an acceptable PoC by **February 25, 2014**, may result in the imposition of civil monetary penalties by **March 17, 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 have 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.

- The administrator must sign and date the first page of both the federal survey report, Form

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CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **March 7, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 7, 2014**. A change in the seriousness of the deficiencies on **March 7, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 7, 2014** includes the following:

Denial of payment for new admissions effective **May 1, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 31, 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, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS

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Regional Office or the State Medicaid Agency beginning on **January 31, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **February 25, 2014**. If your request for informal dispute resolution is received after **February 25, 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,



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

LT/dmj
Enclosures

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

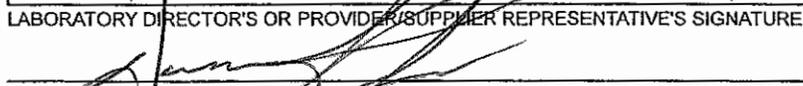
PRINTED: 02/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2014
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NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318
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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:</p> <p>Sherri Case, LSW/QIPD, Team Coordinator Arnold Rosling, RN Lauren Hoard, RN</p> <p>The survey team entered the facility on Monday, January 27, 2014, and exited the facility on Friday, January 31, 2014.</p> <p>Survey Definitions: ADL = Activities of daily living BIMS = Brief Interview for Mental Status CNA = Certified Nursing Assistant DNS/DON = Director Nursing Services/Director of Nursing EMR = Electronic Medical Record LN = Licensed Nurse RSM/RSD = Resident Services Manager/Resident Services Director MDS = Minimum Data Set assessment MAR = Medication Administration Record TAR = Treatment Administration Record W/C = Wheelchair NN = Nurses Notes Res = Resident</p>	F 000	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p style="text-align: center;">RECEIVED MAR 07 2014 FACILITY STANDARDS</p>	
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have</p>	F 225	<p>F225</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in process.</p>	3/7/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	3/6/14

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

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F 225	<p>Continued From page 1</p> <p>had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, record review, incident reports and staff interview, the facility failed to investigate injuries of unknown origin to rule out abuse or neglect. This was found to be true for 2</p>	F 225	<p>1. Resident #2 has had no adverse effect from lack of written interviews. Resident has not had other injury. No individual corrective action is needed.</p> <p>2. Resident #11 has had no adverse affect from lack of written interviews. Resident had timely x-ray with no noted fracture. Hand edema had gone, along with sensitivity by 12/25/13. No individual corrective action is needed.</p> <p>A new incident investigation witness form (completed by all witnesses) and a new incident and accident IDT review form (completed by IDT) were implemented which includes witness statements of primary resident and primary caregiver at the time of the incident, and all staff associated with the incident. If the issue was of unknown origin, there is a section on the forms that is marked when the resident, all staff working 24 hours prior, all visitors and the resident's roommates, this would ensure that all investigations will be thorough and include proper documentation of the investigations. All investigations starting January 30, 2014 will be audited and documented by the Administrator weekly x4, then every 2 weeks x4 and monthly x3, then</p>		

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F 225	<p>Continued From page 2 of 12 (#2 & 11) sampled residents. - Resident #2 had a suspicious fracture injury to her right fore arm which the facility failed to investigate to determine if staff were responsible. - Resident #11 had an injury to his left hand that was not investigated. The residents' were harmed with broken bones and there was further potential for abuse when there was lacking investigations as to how the injuries occurred. Findings include:</p> <p>The facility "Abuse Policy and Procedure" with a revision date of 6/7/13 was reviewed. The "Policy Guidelines" documented that employees were responsible to promptly report to facility management any incident of injuries of unknown origin. The policy's "Procedural Components" documented at "E. Investigation" the process staff were to use to investigate an abuse allegation or an injury of unknown origin. This process was documented as:</p> <p>"9. The individual conducting the investigation, at a minimum:</p> <ol style="list-style-type: none"> a. Review the completed resident abuse report; b. Reviews the resident's record to determine events leading up to the incident; c. Interviews the persons reporting the incident; d. Interviews any witness to the incident; e. Interviews the resident (if appropriate); f. Interviews the staff person accused (if applicable)....; g. All visible injuries must be measured and described in detail; h. In cases of injury of unknown source, all staff having possible contact with the resident over the 24 hours prior to injury discovery must be interviewed; 	F 225	<p>quarterly x3 to ensure that all applicable staff, visitors and residents have been interviewed. The results of the audit will be brought to the Quality Assurance Committee monthly x3 month and every quarter x3 quarters. The 24 hour report book was updated to include the abuse policy and procedure for easy access. On 2/10/14 the new process was presented in the all staff meeting and again in the nurse's meeting on 2/13/14-2/14/14.</p>	

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F 225	<p>Continued From page 3</p> <p>i. 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 that time;....</p> <p>m. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;</p> <p>n. Reviews all events leading up to the alleged incident;..."</p> <p>1. Resident #2 was admitted to the facility on 11/2/07. The resident had diagnoses of unspecified closed fracture proximal end ulna, alzheimers disease, depressive disorder and anxiety state.</p> <p>The most recent quarterly MDS assessment dated 10/15/13, documented the resident: - was severely cognitively impaired (BIMS = 00), - required extensive to total assistance with bed mobility, transfers, dressing, eating, personal hygiene and bathing, - had a catheter, - at I 4000 the resident had an "other fracture".</p> <p>On 7/28/13 at 9:46 a.m., the nurses notes documented Resident #2, "was noted at hs to have purple discolorations to bilat(eral) posterior hands. On the left posterior hand noted a 2 cm x 2 cm purple discoloration, three purple discoloration to the left posterior had [sic - hand] that measures 1 cm x 1 cm. On the right posterior hand resident was noted 5 in x 5 in purple discoloration...."</p> <p>On 7/28/13 at 11:20 a.m. the regional medical center did X-rays of the right wrist and determined there were no fractures seen.</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>The 7/28/13, 12:39 p.m. nurses notes documented the resident was, "Moaning and gaurding [sic] right hand which is swollen."</p> <p>The resident complained of pain and on 7/30/13 at 1:40 p.m. and was taken to the regional medical center for further X-rays of the right elbow. The X-rays identified a "common fracture of the proximal ulna with displacement."</p> <p>The facility investigation of the fractured elbow had three interviews. Only one interview was from an aide who worked with the resident on one shift. The facility did not interview staff on all shifts nor did they go back 24 hours to obtain interviews of staff. There was no through investigation of the bruising on the left hand.</p> <p>The Administrator and DON were interviewed on 1/29/14 at 11:40 a.m. They indicated the assumption at the time of the investigation was the chair the resident was in somehow caused the injuries, so they replaced the chair. They felt they had investigated the injuries but had failed with documentation. No further information was provided.</p> <p>2. Resident #2 was admitted to the facility on 9/14/07 with diagnoses which included schizophrenia, edema, osteoarthritis and paralysis.</p> <p>The resident's most recent quarterly MDS assessment, dated 12/10/13 coded, in part: * Severely impaired cognition * Extensive assistance for bed mobility</p> <p>A First Responder Investigation (FRI) dated</p>	F 225		

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F 225	Continued From page 5 12/21/13, documented CNA #6 and CNA #8 had transferred the resident prior to dinner. The communication Form attached to the FRI documented CNA #6 had assisted the resident to get ready for bed when he yelled "watch my pinky". She observed the resident's left hand was "swollen and very bruised." A Progress Note (PN), dated 12/21/13 and signed by LN #7, documented at 7:00 p.m. a staff member had reported the resident "had a dark-discoloration to the left posterior 3rd, 4th, & 5th digits of the left hand." LN #7 documented the resident complained of pain when the nurse assessed the hand. Note: The FRI contained only the statement by CNA #6, there were no attached statements by CNA #8 or LN #7 or staff which had worked with the resident in the 24 hours preceding the noted discoloration. The DON stated on 1/30/14 at 11:20 a.m., the incident had been investigated but the facility could not provide documentation of the investigation.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the	F 241	F241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Resident #2 is currently unaffected from the staff standing during meal service. There was no noted reduction in intake related to standing while feeding. No further individual corrective action is needed. Resident #15 is currently unaffected from the staff standing during meal service. There was no noted reduction in intake related to standing while feeding. No further individual corrective action is needed.	3/7/14

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F 241	Continued From page 6 facility failed to ensure assistance at meals was provided in such a way to maintain or enhance each resident's dignity when staff stood while assisting residents to eat. This was true for 1 of 6 sampled residents (#2) and 2 random residents (#15 and 16) during meal observations. This deficient practice had the potential to cause a decrease in the residents' sense of self-worth. Findings included: On 1/28/14 at 5:47 p.m., during the dinner meal observation in the Sicily dining room, 4 residents were sitting at the same table including Resident #2, Resident #15 and Resident #16. LN #1 was standing behind the horseshoe table reaching over the plates of food while assisting three of the residents to dine. The LN continued to stand for 13 minutes, despite the stool available behind her. On 1/30/14 at 11:34 a.m., during a lunch meal observation in the Sicily dining room, 4 residents were sitting at the same table including Resident #2, Resident #15 and Resident #16. CNA #2 was standing across the table while assisting three of the residents to dine. After the CNA assisted Resident #2 and Resident #16 with a bite, she sat down. The CNA proceeded to stand up again to assist Resident #2 with another bite of food and stayed standing for 3 minutes while assisting the three residents to dine. On 1/30/14 at 3:45 p.m., the Administrator and DON were informed of the meal observations. However, no further information was provided which resolved the issue.	F 241	Resident #16 is currently unaffected from the staff standing during meal service. There was no noted reduction in intake related to standing while feeding. No further individual corrective action is needed. Staff was given direction on 1/30/14 and a general staff inservice was provided on 2/10/14 to retrain nursing staff to not stand while feeding residents. The recommendation by staff was that more rolling stools be acquired. The stools arrived on 2/16/14. The meals will be audited, by the Charge Nurse, on the Daily Care Audit each meal for daily x2 weeks, then 1 meal daily x2 weeks, weekly x4, then every 2 weeks x4 and monthly x3 starting 2/19/14. Residents who have the potential to be affected by being assisted with feeding while assistant is standing will be identified on the audit. The meal service audit will be tracked by the Director of Nursing to ensure that staff sits while helping with feeding and the results will be brought to the Quality Assurance Committee.		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246			

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F 246	<p>Continued From page 7</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure call lights were within reach and that the dining room accommodated enough space to meet the needs of residents. This was true for 2 of 6 sampled residents (#1 & 2) and one random resident (#17). This deficient practice had the potential to cause more than minimal harm should resident's needs not be met. Findings included:</p> <p>a. Resident #1 was admitted to the facility on 7/25/12 and readmitted on 7/17/13 with multiple diagnoses which included schizoaffective disorder, dementia, and oosteroarthritis.</p> <p>Resident #1's most recent significant change in status MDS assessment, dated 12/17/13, documented in part:</p> <ul style="list-style-type: none"> * Unable to complete interview for BIMS score; * Totally dependent with the assistance of 2 or more people for bed mobility, transfers, and toilet use; * Totally dependent with the assistance of 1 person for locomotion on/off the unit, dressing, eating, personal hygiene, and bathing; * Walking in room and in corridor did not occur; and, 	F 246	<p>F246</p> <p>The facility will ensure that a resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Resident #1 suffered no adverse effects of the call light not being within reach. Staff was instructed on 2/10/14 and 2/14/14, on providing call light access to specifically resident #1; though resident may not have the presence of mind to use it.</p> <p>The staff was inserviced on 2/10/14 and 2/13-2/14/14 on the need to ensure that all residents need to have their call light within reach. The call light accessibility will be added to the Daily Care Audit. Starting 2/21/14, the audit will be completed by the Floor Nurse each shift x1 month, then daily x2 weeks, weekly x4, then every 2 weeks x4, monthly x3, then monthly x2 months, then quarterly x3 quarters. The audits will be monitored and tracked by the Director of Nursing/designee and will be taken to the QAPI meeting for review.</p>	3/7/14

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F 246	<p>Continued From page 8</p> <p>* Used a wheelchair for mobility.</p> <p>The Care Plan for Resident #1, with a revision date of 1/1/14, documented in part: * Focus - "I am at Moderate risk for falls r/t [related to] poor safety awareness. Confusion, Psychoactive drug use;" and, * Interventions - "Be sure [Resident #1]'s call light is within reach and encourage her to use it for assistance as needed. I need prompt response to all requests for assistance."</p> <p>On 1/29/14 at 11:15 a.m., Resident #1 was observed sitting in her wheelchair in her room. The call light was attached to the back of the wheelchair and out of reach of the resident. CNA #3 was brought into the room and asked if he saw something Resident #1 might need. The CNA noticed where the call light was and placed it in reach of the resident. The CNA was asked if Resident #1 could reach the call light where it had been, and he stated, "No."</p> <p>On 1/31/14 at 10:00 a.m., the Administrator and DON were informed of the call light issue. However, no further information or documentation was provided.</p> <p>b. On 1/30/14 at 11:35 a.m., during a lunch meal observation, Resident #18 was assisted to the Sicily dining room. While eating the meal, Resident #17 had to be moved to allow Resident #18 access to her spot at a table. One minute later Resident #15 was assisted to the Sicily dining room. While being assisted to dine, Resident #2 had to be moved to allow Resident #15 access to his spot at the table.</p> <p>On 1/30/14 at 3:30 p.m., the DON was informed</p>	F 246	<p>Residents #2, 17 had no adverse reactions to moving to allow access to residents 15 and 18. All potentially affected residents will be secured access and egresses, by ensuring tables are not moved from designated spots. Secured markings on the floor were put in places, which indicate where the tables should be located, thus allowing space for all residents egress at will. No further individual corrective action is needed.</p> <p>The staff was inserviced on 2/10/14 and 2/13-2/14/14 on the need to report if a resident needed to be interrupted to allow access for another resident. Starting 2/21/14 the Floor Nurse will monitor the spacing in dining rooms and log it into the Daily Care Audit Form each meal daily x 1 month will be completed by the Floor Nurse each shift x1 month, then daily x2 weeks, weekly x4, then every 2 weeks x4, monthly x3, then monthly x2 months, then quarterly and as needed with dining room changes thereafter. The Director of Nursing will track the information and take the information to the QAPI meeting.</p>		

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F 246	Continued From page 9 of the aforementioned observations, and was asked if the practice was acceptable. The DON stated, "No. That's disrupting their meals." No further information or documentation was provided which resolved the issue.	F 246		
F 248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on 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 6 residents in the Resident Group (who wished to remain anonymous), and 2 of 14 residents (#5 and 10) 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:</p> <p>The facility activity calendar for January 2013 documented: No activities after 2:15 p.m.. On Saturday at 10:00 a.m. was exercise, 10:30 Bingo and Word Search at 2:15 p.m. On Sundays at 8:30 a.m. the activity was hair styles and at 9:30 a.m. was LDS services . At 2:15 p.m. the activities were Word</p>	F 248	<p>F248</p> <p>The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident.</p> <p>1. Weekend activities, including exercise, games, and movies are scheduled for 8 hours each day, Sundays also includes religious services. Each activity is for ½ to 2 hours long. All residents have opportunities to participate in activities. All cognitive residents are provided with a daily activity sheet that includes the activity schedule for the day, trivia and puzzles, non cognitive residents are able to participate in the review of the activity sheet. The calendar is also posted in each resident's room and in large print on both wings. Starting on 2/1/14, cards are scheduled at least once per week. Participation records show</p>	3/7/14

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F 248	<p>Continued From page 10</p> <p>Search the first Sunday of the month, Movie the 2nd Sunday, Bingo the third Sunday and Card Games the last Sunday of the month.</p> <p>1. On 1/28/14 at 1:30 p.m., 5 of 6 residents in the Resident Group meeting stated the "weekends are pretty dull around here" and there were no evening activities. One resident stated he/she had suggested cards within the last 3 months but nothing had been done. Another resident stated there was no exercise offered to the residents and "they" (residents) needed to exercise. Another resident stated it would be nice to go outside for about 30 minutes and a different resident stated they needed to go shopping more than 1 time per month.</p> <p>On 1/29/13 the Resident Services Manager (RSM) was asked about the facility providing exercise for the residents. The RSM stated the exercise was a ball toss. When asked if this was appropriate exercise for all of the residents the RSM stated a lot of higher functioning people would leave when "doing ball toss." The RSM stated the facility had hired a new activity person about 3 weeks ago.</p> <p>On 1/30/14 at 2:55 p.m. the recently hired Activity Director (AD) provided revisions to the activity schedule for 1/23/14 through 1/31/14. A movie was added at 4:00 p.m. on Saturday through Monday and on Thursday, a word game was added at 4:00 p.m. on Friday. Additionally table or other games were added on Wednesday through Friday from 6:00 to 8:00 p.m. Later that day the AD was asked about "individualized" activities for residents. She stated she was new to the facility but had concerns regarding the activities and was in the process of changing the activities program.</p>	F 248	<p>weekend activity attendance and participation in cards. Shopping with residents has been scheduled for 2 x monthly, and 6 other outings are planned for each month. All residents who desire to go outside are able to go outside into the courtyard as they desire. Activity Director will bring participation records to the quality assurance meeting for review.</p> <p>On 2/1/14 the higher functioning residents have warm ups, stretch, and total body work out every day. Activity Director will bring participation records to the quality assurance meeting for review.</p> <p>Resident #10 goes out to smoke at least 5 times per day and is allowed to go outside as desired.</p> <p>Resident #10 prefers to watch television. Resident's refusals to participate in other activities will be documented.</p> <p>Resident #10's activity care plan has been revised and resident had been participating in activities of interest. Resident's daughter's adoptive parents prefer that resident not have communication with the daughter due to making the young daughter feel</p>	

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F 248	<p>Continued From page 11</p> <p>2. Resident #10 was admitted to the facility on 3/17/13 with diagnoses which included impulse control disorder, dementia and depression.</p> <p>The resident's Significant Change MDS assessment, dated 6/18/13 documented the resident was cognitively intact, had mild depression, it was not important for him to do things with groups but it was very important for him to do favorite activities and it was very important for him to go outside in good weather.</p> <p>During an observation on 1/29/14 at 1:15 p.m. the resident was sitting in his recliner, with the television on and his 1 on 1 staff sitting in a chair next to him. The resident stated he had recently returned from a "smoke." On 1/30/14 at 7:10 a.m. the resident was observed sitting in his recliner with a 1 on 1 staff sitting by his side. The surveyor explained the reason for the visit and the resident immediately showed the surveyor a picture of his daughter on his bulletin board and stated his daughter was not allowed to visit. The resident was later observed at 7:18 a.m., 8:05 a.m., 8:51 a.m., 9:12 a.m., sitting in his room either dozing off or watching television. During all of the above observations the resident was not observed to have any activity other than watching television. The 1 on 1 staff interacted with him when he initiated a conversation.</p> <p>Resident #10's 3/20/13 Activity Assessment (AA) documented in the "Hobbies/Interests section: Card game Black Jack, Scrabble, use to work out, baseball, rock music of the 80's, write letters to daughter, bus rides, action movies and picnics. The "Additional comments" section documented "... wants to write letters to his daughter likes to</p>	F 248	<p>guilty about his placement. Letters to daughter will be worked on during 1:1 visits. Letters are being sent to the guardian and the guardian forwards the letters to the parents of the daughter who decides if she should receive them. Activities will be providing 1:1 visits with resident.</p> <p>All 1:1 visits for all 1:1 visit residents are planned to be at least 15 minutes in length. The length of the visits will be documented on the 1:1 visit form. 1:1 visits for all identified residents are scheduled for 3 times per week. Activity Director will bring participation records to the quality assurance meeting for review monthly x3 months, then quarterly x 3 quarters.</p> <p>Resident #5 has tracking of 1:1 visits. Activities will continue to provide 1:1 visits with resident. All 1:1 visits are planned to be at least 15 minutes in length. 1:1 visits for all residents are scheduled for 3 x weekly. Activity Director will bring participation records to the quality assurance meeting for review.</p> <p>All other affected residents who have been identified through the activity assessment process will have individualized and specific care plan</p>		

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F 248	<p>Continued From page 12 go out to smoke."</p> <p>The resident's 4/3/13 Care Plan (CP) for activities included the following interventions:</p> <ul style="list-style-type: none"> *Converse with resident while providing care. *Assist with arranging community activities. *Assure activities are compatible with abilities and age appropriate, adapted as needed. *Encourage on going family involvement. *Need "1 to 1" bedside/in room visits and activities if unable to attend out of room events and escort to activity functions. <p>Note: The AA documented 2 times writing letters to his daughter was important to him, however the CP did not include this as an activity. The resident's CP did not include any of the activities identified on the AA. The resident's CP for behaviors identified the resident required 1 on 1 staff 24 hours a day. The activities CP documented the resident required "1 to 1" in room visits and activities, however the 24 hour 1 on 1 staff was not observed to provide activities for the resident.</p> <p>A Resident Services Progress note dated 12/20/13 documented, "...He does have a daughter which has been adopted by others. While....they were very good about bringing her to visit him. He is encouraged to write letters and send cards to her."</p> <p>On 1/30/14 at 11:30 a.m. the RSM stated she mailed items to the resident's guardian to give to the resident's daughter. When asked how many letters had been sent by the resident she stated she had recently sent a Christmas and a birthday package to the guardian for the daughter. The</p>	F 248	<p>interventions for which there is documentation of participation appropriate to the needs and desires of the resident by March 1, 2014.</p> <p>Activity participation is also added to the Daily Care Audit form. The licensed nurse will encourage the resident to attend activities and document on the audit form. The form will be completed daily x2 weeks, then weekly x2 months and quarterly x2 quarters. The Activity Director will provide 1:1 book that tracks 1:1 visits and will have book showing individualized care plans. The books, audits, and information will be brought to the QAPI Committee for review monthly x3 months, then quarterly x 3 quarters.</p>	
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F 248	<p>Continued From page 13</p> <p>RSM stated the assessment information had not been used to ensure the resident's activity care plan was individualized.</p> <p>3. Resident #5 was admitted to the facility on 2/13/09 and readmitted on 3/29/13 with diagnoses which included hemiplegia (paralysis of arm, leg, and trunk on the same side of the body), and osteoporosis.</p> <p>The resident's Activity Assessment, dated 3/29/13, documented the resident enjoyed: poker, football and baseball, rock and roll music, and the outdoor activity of fishing.</p> <p>Note: In the reading/writing section was written "We write letter and thank you notes to family and friends."</p> <p>The resident's 4/8/13 CP documented the resident:</p> <ul style="list-style-type: none"> * Was able to come out to group activities and go outside for a wheel chair ride. *Needed assistance/escort for activity functions *Preferred activities were to watch television in his room and have 1 on 1 visits 3 times a week. <p>The resident's activity participation sheets for 11/13 through 1/28/14 documented the following:</p> <p>11/13 - 0, 1 on 1 visits; 12/13 - 0, 1 on 1 visits; 1/14 - 5, 1 on 1 visits (possible 9).</p> <p>Observations:</p> <p>1/27/14 at 3:30 p.m. and 4:00 p.m. - In room in sheep skin lined chair with the television on. 1/28/14 *9:40 a.m., 10:10 a.m., 10:50 a.m., 11:35 a.m., 11:50 a.m., 3:10 p.m. - In room in sheep skin lined chair with television on. *4:35 p.m. till 5:50 p.m. the resident was in the common room with the television on, he was not observed to interact with staff or other residents. *5:50 p.m. the resident was taken to his room,</p>	F 248			

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F 248	Continued From page 14 but the television was not on. *6:00 p.m. the resident was taken back to the common room and at 6:20 p.m. was holding a cloth Frisbee. At that time the DON informed the surveyor the resident had been playing Frisbee with the hall monitor (responsible to monitor all residents in the hall and common area), however this was not observed by the surveyor. * 6:30 p.m. the resident was flicking his wrist back and forth while holding the Frisbee *6:42 p.m. the resident was assisted to go to bed. When asked about 1 on 1 visits the AD stated a 1 on 1 visit needed to be at least 5 to 15 minutes. The surveyor expressed concern with the lack of 1 on 1 visits documented and with a visit of 5 minutes being documented as a 1 on 1 visit. The AD stated she was new to the position and was working to correct the concerns. The Administrator and the DON were informed of the above concerns on 1/30/14 at 3:45 p.m. The facility provided no further information.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to ensure a sanitary and comfortable environment was provided. This was true for 12 of 14 (#s 1- 12) sampled residents, and had the potential to impact any resident living in the facility. Findings included:	F 253	F253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. Resident room #21 on 1/30/14 has had kick plate trimmed and a new boarder placed over the edge to prevent resident from pulling the plate down.	3/7/14

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F 253	<p>Continued From page 15</p> <p>On 1/27/14 at 11:30 AM during the initial tour of the facility, on 1/30/14 at 10:00 AM during the environmental tour with the facility maintenance director, and continually throughout the survey, the following were noted:</p> <p>Resident Rooms:</p> <ol style="list-style-type: none"> In resident room #21 the wall by the door had a plastic kick plate, the kick plate was chipped away about 45 inches long and 1-6 inches deep which exposed portions of the sheet rock. There were numerous black marks on the wall. In resident room #25 the privacy curtain was soiled with 10 streaks which appeared to be food. The wall had 6 pieces of tape 2 to 6 inches long on the wall. The wall plate next to the call light was broken. The top drawer of the bed side table was broken with tape to hold it together. The light fixture in the bathroom was dirty with a layer of dead bugs. The blinds were broken with slats missing in resident rooms 21 and #27. In resident room #32 the mopboard underneath the closet was missing <p>North hall:</p> <ol style="list-style-type: none"> A partition between the windows in the day room was missing paint approximately 4 feet above the floor. All of the wooden handrails were streaked with missing varnish, exposing the wood. By resident room #27 dried and wet hand 	F 253	<ol style="list-style-type: none"> Resident room #25 on 1/30/14 had the privacy curtain changed. Tape was removed from the wall and the wall plate was replaced, top drawer of the bedside table was repaired, and the light fixture was cleaned. Blinds in rooms #21 and #27 on 1/30/14 have been repaired. Resident room #32 on 1/31/14 has had the mopboard replaced. Paint was touched up in the day room between the windows on 1/31/14 The wooden handrail will have been cleaned by 2/21/14 repaired and re-varnished on or by 3/7/14. Hand sanitizer on the handrail had been cleaned on 1/31/14. Drip trays will be received and installed on all dispensers by 3/7/14. Brown paint that dripped on clear corner cover was cleaned on 1/31/14. On 1/30/14 the sit to stand lift was completely cleaned of any dust or debris. Updated cleaning schedule list for wheelchair, walker, canes, and lifts was updated on 2/25/14. 	

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F 253	Continued From page 16 sanitizer was observed on the wooden hand rail. The dirty hand rail was first observed on 1/27/14 and was still dirty during the environmental tour on 1/30/14. 8. Brown paint had dripped between the wall and clear plastic corner protector by resident room #29. 9. The sit to stand lift had dust and debris on the base. South Hall: 1. The base board heaters near the entry door of the facility were dirty with dust and debris. On 1/30/14 at 10:00 AM the maintenance director was asked about the above items. The maintenance director stated he would take care of the concerns. On 1/31/14 at 10:00 AM, the Administrator was informed of these concerns. The facility offered no further information.	F 253	South Hall: 1. Base board heaters near door of facility and all other heaters were cleaned of all dust and debris. Routine cleaning schedule for baseboards was implemented on 2/25/14. A complete audit of the above issues throughout the facility was completed on 2/20/14 and the facility was found to be in compliance. The Healthcare Services Group has provided a form to review the above issues and identify other environmental concerns. This form has been implemented on 3/3/14. The log will be completed by the Housekeeping Supervisor. The logs will be kept weekly x4 weeks, then every 2 weeks x4, and monthly x3. The Housekeeping Supervisor will bring audit information to the QAPI meetings for review by the team.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	F280 The facility will ensure that a comprehensive care plan be developed within 7 days of a comprehensive assessment. 1. Resident #6 has had no adverse affects from non specified diet and supplement order. Resident's weight has steadily increased since weight	3/7/14

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F 280	<p>Continued From page 17</p> <p>physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure resident's care plans were revised and reflected the care the residents were to receive. This was true for 5 of 12 (#s 1, 4, 5, 6 and 8) sampled residents. There was potential for harm when physician ordered treatments and care were not care planned to assure the residents physical and psychosocial abilities were at the highest potential. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 8/18/13 and readmitted on 10/14/13. The resident had diagnoses of after care traumatic fracture of hip, unspecified epilepsy, unspecified infantile cerebral palsy and profound intellectual disabilities.</p> <p>The resident's care plan for Nutritional Status failed to have interventions for physician ordered NEMs (nutritional enhanced meals) dated 11/15/13 and Health Shakes two times a day dated 10/30/13.</p> <p>On 12/23/13 the physician ordered the resident to</p>	F 280	<p>issue was noted.</p> <p>Resident #6 had no concerns with edema or DVT. Ted hose were added to the resident care plan on 2/13/14 and all care plans were compared to physician orders and updated.</p> <p>Resident #6 had not adverse reaction to not discontinuing the compression wraps on the care plan.</p> <p>Resident #6 resident suffered no adverse reaction from not changing the chart care plan to reflect the improvement in resident's transfers.</p> <p>2. Resident #8 suffered no adverse effects of not having weekly weights on the care plan physician orders to weigh weekly were followed and documented.</p> <p>Resident #8 suffered no ill effects of not having a date on the intervention.</p> <p>3. Resident #5 suffered no adverse effects from having a care plan intervention to "monitor diet", though he was NPO. On 2/19/14 the care plan was updated to reflect current abilities.</p>	

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F 280	<p>Continued From page 18</p> <p>wear Ted Hose. This information was not on the care plan.</p> <p>The care plan, dated 10/23/13, for "Potential impairment to skin integrity" had multiple interventions hand written in. The compression wraps were discontinued on 12/17/13 but the intervention was not discontinued.</p> <p>The care plan, dated 10/3/13, for "ADL self care performance deficit" documented an intervention of, "Slide board for [transfers] until [weight] bearing cleared..." The resident had an intervention under "Behavior problem..." dated 12/30/13, "update to care plan for transfers [changed] to transfer walk to dine [times] 2 person assist with front wheel walker..."</p> <p>The DON was interviewed on 1/30/14 at 8:45 a.m. about the care plan issues and needed changes. No further information was provided.</p> <p>2. Resident #8 was admitted to the facility on 10/5/13 and readmitted on 11/11/13. The resident had diagnoses of after care for healing traumatic fracture of hip, unspecified epilepsy, diabetes mellitus without complication and dementia unspecified without behavioral disturbances.</p> <p>The resident's care plan for Nutritional Status failed to have interventions for physician ordered "Weigh every week on Saturdays every day shift" dated 11/11/13.</p> <p>The care plan, dated 11/19/13, for "High risk for falls..." documented an undated intervention of, "2 person assist [with] gait belt." The care plan, dated 11/19/13, for "ADL self performance deficit" documented an intervention, dated 1/22/14 of,</p>	F 280	<p>Resident #5 suffered no adverse effects of a care plan intervention of wearing "non-skid footwear when mobilizing in wheelchair", though he was not mobile in chair. On 2/3/14 the care plan was updated to reflect current abilities.</p> <p>4. Resident #4 suffered no adverse effects from having discrepancies in the care plan from the number of 1:1 hours provided. On 2/19/14 the care plan was updated to reflect current situation.</p> <p>5. Resident #1 suffered no adverse effects from having discrepancies in the care plan from the ability to ambulate and her actual non ability to ambulate. On 2/19/14 the care plan was updated to reflect resident's current condition.</p> <p>An in-service on care plan documentation and the proper method to update the care plans with dates and initials was given on 2/10/14 to all staff and to the licensed nurses on 2/13/14 and again on 2/14/14. Nurses were instructed that care plans are to be made current on admission and readmission.</p>	

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F 280	<p>Continued From page 19</p> <p>"Transfers 1 person assist [with] gait belt" and "May ambulate [with] one person assist [related to] 2 person causes [increased] behaviors."</p> <p>On 1/30/14 at 8:30 a.m. the DON was interviewed and she said the resident had 1 : 1 staff with her all the time. She said the care plan should have been changed to reflect the changes. No further information was provided.</p> <p>3. Resident #5 was admitted to the facility on 2/13/09 and readmitted on 3/29/13 with diagnoses which included hemiplegia (paralysis of arm, leg, and trunk on the same side of the body), and osteoporosis.</p> <p>The resident's most recent quarterly and Significant Change MDS assessments, dated 4/4/13 and 12/10/13 respectively, both coded, in part:</p> <p>Severely impaired cognition; Total dependence of 2 or more people for bed mobility, transfers, and toileting. Received nutrition via a feeding tube Unable to propel wheelchair. Total dependence on staff.</p> <p>The resident's 1/1/14 Medication Review Report (Physician Recapitulation orders) included an NPO (nothing by mouth) order.</p> <p>During observations on 1/27/14 and 1/28/14 the resident was observed to have the tube attached and receiving his nutrition.</p> <p>* The resident's 4/8/13 Care Plan (CP) for diabetes included in the intervention section "Monitor compliance with diet and document any problems."</p> <p>During observations on 1/28/14 and 1/29/14 the</p>	F 280	<p>All facility care plans will be reviewed and updated to meet each individual resident's needs and desires by March 07, 2014.</p> <p>MDS Coordinator will ensure, after therapy discontinues or changes to an RNA program, that the care plans are updated appropriately.</p> <p>The IDT will audit all care plan prior to 3/7/14 to ensure that they are up to date and appropriate. The list of care plan audits will be checked for accuracy by the DNS and the results will be and taken to the Quality Assurance Committee for review. All care plans will be reviewed in their entirety by the IDT upon admission and as each MDS is due. The DNS/MDS Coordinator/Designee will review these care plan updates and track issues on the care plan tracking form weekly x4 weeks, then every 2 weeks x4, and monthly x3. The DNS will bring tracking to QAPI meetings for review.</p>	

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F 280	<p>Continued From page 20</p> <p>resident was not observed to leave his room or transfer from his geri-chair without the assistance of staff, the resident was not able to reach his bedside table or any food if there were any on the table.</p> <p>* The resident's CP for falls, revised on 9/27/13, included in the intervention section "Ensure that he is wearing nonskid footwear when mobilizing in w/c (wheelchair).</p> <p>On 1/29/14 at 9:00 a.m. the DON stated both CPs needed to be revised as the resident was unable to propel his wheelchair and did not need staff to monitor his intake of food.</p> <p>4. Resident #4 was admitted to the facility on 9/10/04 and readmitted on 11/27/12 with diagnoses which included altered mental status, bipolar disorder and disorder of bone and cartilage.</p> <p>* The resident's CP for elopement revised on 7/26/12 included in the intervention section the resident was supervised 1 on 1 for 24 hours a day. However the resident's CP for behaviors revised on 10/14/13 documented in the intervention section the resident had 1 on 1 supervision for 16 hours a day.</p> <p>On 1/29/14 at 9:00 a.m. the RSM stated the resident had 1 on 1 supervision for 16 hours a day and the CP for elopement needed to be revised.</p> <p>* The resident's 1/1/14 Medication Review Report included a diet order to restrict the resident's fluids to 1500 CC in 24 hours due to hyponatremia (low sodium in the blood).</p>	F 280		

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F 280	<p>Continued From page 21</p> <p>The resident's 8/2/12 CP for Altered Hydration status included an intervention section to provide extra fluids with "medication Pass."</p> <p>The resident's CP for bowel management, revised on 1/19/13, included in the intervention section "will add extra fluids with medication pass."</p> <p>On 1/29/14 at 9:00 a.m. the DON stated the nurse passing medications was to look at the fluids the resident had received in the 24 hour period and then calculate fluids to give with the resident's medication. The surveyor stated that was not clear in the CP and the DON stated the CP would be revised.</p> <p>5. Resident #1 was admitted to the facility on 7/25/12 and readmitted on 7/16/13 with multiple diagnoses which included dementia, chronic pain and generalized osteoarthritis.</p> <p>Resident #1's most recent significant change in status MDS assessment, dated 12/17/13, documented in part:</p> <ul style="list-style-type: none"> * Unable to complete interview for BIMS score; * Totally dependent with the assistance of 2 or more people for bed mobility, transfers, and toilet use; * Totally dependent with the assistance of 1 person for locomotion on/off the unit, dressing, eating, personal hygiene, and bathing; * Walking in room and in corridor did not occur; and, * Used a wheelchair for mobility. <p>The Care Plan for Resident #1, with a revision date of 1/1/14, documented in part:</p> <ul style="list-style-type: none"> * Focus - "I have Osteoporosis;" and, 	F 280		

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F 280	Continued From page 22 * Interventions - "Encourage physical activity and daily ambulation. Use assistive device if necessary." On 1/29/14 at 1:30 p.m., the DON was asked if Resident #1 ambulated. She stated, "I have not seen her ambulate" and referred the surveyor to the MDS Coordinator. On 1/29/14 at 1:38 p.m., the MDS Coordinator was asked if Resident #1 was ambulatory at which she replied, "She used to, but doesn't anymore." The MDS Coordinator reviewed the resident's care plan and stated, "Oh yeah, that should have come off." On 1/29/14 at 2:50 p.m., the Administrator and DON were informed of the care plan issue. However, no further information or documentation was provided.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure: * A resident's legs were elevated or to have the	F 309	F309 The facility will 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 care plan.	3/7/14	

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F 309	<p>Continued From page 23</p> <p>resident sit in direct sunlight as Care Planned. This was true for 1 of 8 residents sampled (#1) for care plan implementation and placed the resident at risk for increased edema and osteoporosis.</p> <p>* Physician's orders to have a resident evaluated by the hospital emergency room for pain were followed. This was true for 1 of 8 residents (#5) and placed the resident at risk to suffer pain without treatment. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 2/13/09 and readmitted on 3/29/13 with diagnoses which included hemiplegia (paralysis of arm, leg, and trunk on the same side of the body), and osteoporosis.</p> <p>The resident's most recent quarterly and Significant Change MDS assessments, dated 4/4/13 and 12/10/13 respectively, both coded, in part:</p> <p>* Severely impaired cognition; * Total dependence of 2 or more people for bed mobility, transfers, and toileting.</p> <p>A 10/28/13 (3:50 a.m.) Incident Report (IR) documented when CNAs were providing care to the resident they noted severe pain when they changed his brief. The pain was determined to be in his right hip and pelvis. The nurse assessed the resident and documented "Deformity felt by palpation (examine by touch) at the greater trochanter."</p> <p>The IR documented the physician was notified of the resident's pain on 10/28/13 at 4:45 a.m.</p> <p>A Nurses Note (NN), dated 10/28/13 at 7:42 a.m., documented when the CNA was changing the resident, the resident grabbed "them to stop them</p>	F 309	<p>1. Resident #5 had been assessed on 10/29/13 with no noted problems with pain or range of motion. A late entry was written by assessing nurse on 2/20/14. Resident suffered no problems related to the follow up note explaining the reason for not going to the hospital. Resident was noted to have functioned at a higher level with RNA program on days immediately after stated issues with pain occurred. All notes from the previous day with the 24 hour report will be reviewed each day in the morning meeting by the IDT to ensure follow-up is done on care issues. The team will sign-off on the review of the notes and the Administrator will bring the results of the sign-off to the QAPI meetings each month x3 months and every quarterly x3 quarters.</p> <p>2.a Resident #1's chair has elevated foot and legs rests on her chair which have been noted to be elevated. As of 2/20/14 the Daily Care Audit has been updated to monitor this for resident and all affected residents.</p> <p>2.b Resident #1 was discontinued from daily direct sunlight on care plan due to the inappropriateness of excessive direct sunlight with use of blood thinners, which resident is on.</p>	

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F 309	<p>Continued From page 24</p> <p>from doing so complaining of pain." The LN documented the resident had pain and resisted all efforts to straighten the leg. The NN documented "DNS and (Physician name) contacted and resident to be taken to the ER (emergency room) for further evaluation."</p> <p>The resident's NN and medical record contained no further information regarding the documentation regarding the resident being in pain or being assessed at the ER.</p> <p>On 1/29/14 at 9:00 a.m. the DON stated she would check for documentation of an x-ray regarding the resident's hip pain. Later the DON stated there had never been an order for the resident to go to the hospital. The DON stated she and another nurse had assessed the resident and during the assessment the resident could raise and lower his leg without pain. She stated she was unsure why the nurse had documented the resident was to be sent to the ER as there had never been a physician order to do so.</p> <p>On 1/30/14 at 3:45 p.m. the Administrator and DON were informed of the lack of documentation regarding the facility following up on the nurses note stating the physician ordered the resident to be taken to the ER. The facility provided no further documentation.</p> <p>2. Resident #1 was admitted to the facility on 7/25/12 and readmitted on 7/16/13 with multiple diagnoses which included venous thrombosis and embolism, edema, and dementia.</p> <p>Resident #1's most recent significant change in status MDS assessment, dated 12/17/13, documented in part:</p>	F 309	<p>Starting 2/19/14 all resident care plans will be reviewed word of word by the care plan team quarterly and prn to ensure that all interventions are appropriate and workable for each resident. The DNS/MDS Coordinator/Designee will review these care plan updates and track issues on the care plan tracking form weekly x4 weeks, then every 2 weeks x4, and monthly x3. The DNS will bring tracking to QAPI meetings for review.</p> <p>The care plans and leg positioning for all residents will be audited on the Daily Care Audit by the Floor Nurse and will be tracked by the Director of Nursing and the results will be brought to the Quality Assurance Committee.</p>		

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F 309	<p>Continued From page 25</p> <ul style="list-style-type: none"> * Unable to complete interview for BIMS score; * Totally dependent with the assistance of 2 or more people for bed mobility, transfers, and toilet use; * Totally dependent with the assistance of 1 person for locomotion on/off the unit, dressing, eating, personal hygiene, and bathing; and, * Used a wheelchair for mobility. <p>a. The Care Plan for Resident #1, with a revision date of 1/1/14, documented in part:</p> <ul style="list-style-type: none"> * Focus - "I have edema to both lower extremities;" and, * Interventions - "Staff to encourage resident to lay down and elevate legs during the day." <p>Resident #1 was observed sitting in her wheelchair with her feet setting on bilateral footrests, without her legs elevated, on:</p> <ul style="list-style-type: none"> * 1/27/14 at 3:27 p.m., 3:53 p.m., and 4:26 p.m.; * 1/28/14 at 9:40 a.m., 10:10 a.m., 10:55 a.m., 11:45 a.m., 12:15 p.m., 2:57 p.m., 4:13 p.m., 4:36 p.m., 5:08 p.m., and 5:30 p.m.; and, * 1/29/14 at 9:46 a.m. and 11:15 a.m. <p>On 1/29/14 at 1:30 p.m., the DON was asked if staff elevated Resident #1's legs during the day. She stated, "I think they do" and added she thought the chair automatically elevated the legs. The DON was informed of the observations of the resident's legs not elevated. No further information or documentation was provided which resolved the issue.</p> <p>b. The Care Plan for Resident #1, with a revision date of 1/1/14, documented in part:</p> <ul style="list-style-type: none"> * Focus - "I have Osteoporosis;" and, * Interventions - "... Vitamin D is formed in skin from being exposed to sun (direct sunlight for 	F 309			

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F 309	Continued From page 26 10-15 minutes 2-3 x/wk [times per week]..." On 1/28/14 at 10:31 a.m., Resident #1 was observed sitting in her wheelchair in her room with the lights off and the blinds closed. Resident #1 was not observed to be outside or in direct sunlight on 1/27/14, 1/28/14, or on 1/29/13. On 1/29/14 at 1:30 p.m., the DON was informed of the care plan intervention to expose Resident #1 to direct sunlight. The DON stated, "We have lots of windows" and added it was a "Fun intervention."	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, record review and staff interview, it was determined the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services, due to the lack of care plan direction, to restore as much normal bladder function as possible. This was	F 315	F315 The facility will ensure that residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident #1's care plan was updated on 2/20/14 to provide direction to staff to provide a toileting schedule and incontinence care schedule. Toileting for resident #1 and all residents will be added to the Daily Care Audit and will be updated by the licensed nurse. All care plans will be checked and updated for incontinent pattern and resident needs by 3/7/14. The Director of Nursing will track results and the results will be brought to the Quality Assurance Committee monthly x3 months and quarterly x3 quarters.	3/7/14	

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F 315	<p>Continued From page 27</p> <p>true for 1 of 6 sampled residents (#1) reviewed for incontinence. This deficient practice had the potential for more than minimal harm should a resident develop urinary tract infections, skin breakdown or urinary decline due to insufficient incontinence care. Findings included:</p> <p>Resident #1 was admitted to the facility on 7/25/12 and readmitted on 7/16/13 with multiple diagnoses which included overflow incontinence, diabetes and dementia with behavioral disturbances.</p> <p>Resident #1's most recent significant change in status MDS assessment, dated 12/17/13, documented in part:</p> <ul style="list-style-type: none"> * Unable to complete interview for BIMS score; * Totally dependent with the assistance of 2 or more people for bed mobility, transfers, and toilet use; * Totally dependent with the assistance of 1 person for locomotion on/off the unit, dressing, eating, personal hygiene, and bathing; * Used a wheelchair for mobility; * Always incontinent of bladder and bowel; and, * Received diuretic medication daily for the past 7 days. <p>The Care Plan for Resident #1, with a revision date of 1/1/14, documented in part:</p> <ul style="list-style-type: none"> * Focus - "I have MIXED bladder incontinence r/t [related to] use of diuretics and limited mobility;" and, * Interventions - "Monitor/document for s/sx [signs and symptoms] UTI [urinary tract infection]: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp[erature], Urinary frequency, foul smelling urine, fever, chills, altered mental status, 	F 315			

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F 315	<p>Continued From page 28</p> <p>change in behavior, change in eating patterns; Monitor/document/report to MD [Medical Doctor] PRN [as needed] possible medical causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, Stroke, medication side effects."</p> <p>Note: the care plan did not provide any instruction to staff for incontinence care, nor did it provide a toileting schedule or a check and change schedule.</p> <p>On 1/28/14 at 2:57 p.m., Resident #1 was observed sitting in her room in her wheelchair. She was located at the end of her bed facing the hallway. At 4:13 p.m., the resident was observed in the same position in her wheelchair and in the same location at the end of her bed. At 4:36 p.m. and at 5:08 p.m., Resident #1 was again observed in the same aforementioned position and location.</p> <p>Note: The resident was in the same position and in the same location for 2 hours and 11 minutes.</p> <p>On 1/29/14 at 9:30 a.m., CNA #9 was asked if Resident #1 was toileted as part of her incontinence care. She stated, "No." When asked if the resident was checked and changed for incontinence care, she said yes. The CNA was asked how often the resident was to be checked and changed at which she responded, "Every 2 hours, or as needed." When the CNA was asked if that was on Resident #1's care plan, she stated, "It should."</p> <p>On 1/29/14 at 9:31 a.m., CNA #3 was asked if Resident #1 experienced incontinence. He stated, "Most of the time," and added the resident will tell staff when she needs to use the toilet. When the</p>	F 315		

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F 315	<p>Continued From page 29</p> <p>CNA was asked if he had ever helped the resident to the toilet while caring for her, he stated, "No."</p> <p>On 1/29/14 at 1:13 p.m., the DON was interviewed about Resident #1's incontinence. When asked which type of incontinence the resident had, the DON said, "I haven't really worked with her incontinence." After reviewing information on the computer, the DON said the type was overflow incontinence. When asked what type of incontinence services were provided to Resident #1, the DON responded, "At least every 2 hour check and change." After review of the resident's incontinence care plan on the computer and not finding the check and change instruction she stated, "It might be under ADLs [activities of daily living]." After review of the ADL care plan the DON said "It doesn't say check and change. I don't see it on her care plan," and added there was a policy for incontinence care. The DON was asked if Resident #1 should be toileted at which she responded, "I don't know. I've never toileted her."</p> <p>On 1/29/14 at 2:15 p.m., the DON provided the Policy and Procedure for Incontinent Care which documented in part, "Check for wetness at least every two hours."</p> <p>On 1/30/14 at 3:45 p.m., the Administrator and DON were informed of the incontinence care and care plan issue. However, no further information or documentation was provided.</p>	F 315		
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident</p>	F 323		

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F 323	<p>Continued From page 30</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, incident report review, record review, and staff interview the facility failed to ensure residents received supervision to prevent accidents. There were three residents who were harmed due the facility's failure to supervise residents which resulted in falls with major injuries and increased pain.</p> <ul style="list-style-type: none"> - Resident #6 was harmed when he had two falls then fell and fractured his right hip causing increased pain. - Resident #8 had a previous history of falling and was harmed when she fell and fractured her left hip then fell again injuring her ribs which resulted in increased pain. - Resident #5 was harmed when the staff failed to use a mechanical lift as outlined in the care plan and fractured his Humerus. <p>The failure to supervise residents was found to be true for 4 of 12 (#s 5, 6, 8, & 9) residents sampled. There was a potential for harm to Resident #9 when she had unsupervised wandering, the resident could fall and sustain injuries requiring major medical intervention. Findings include:</p> <ol style="list-style-type: none"> 1. Resident #6 was admitted to the facility on 8/18/13 and readmitted on 10/14/13. The resident had diagnoses of after care traumatic fracture of hip, unspecified epilepsy, unspecified infantile 	F 323	<p>F323</p> <p>The facility will ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <ol style="list-style-type: none"> 1. Resident #6, on 9/1/13 resident had bars put on wheelchair to prevent his chair from rolling during self transfer; On 9/21/13 resident was moved to room 28b for increased monitoring. After his fall and return from the hospital he was moved closer to the nurse's station, where he could receive greater supervision from the nurse and the 24 hour hall monitor, when he fell on 12/2/13. Resident had fallen after receiving physical therapy and had felt more confident with his abilities. A 1:1 was placed with resident at that point to ensure his continued safety. 2. Resident #8 was admitted on 10/5/13 and had a 1:1 with her initially. When it was proven that she was stable in her ambulation, her 1:1 caregiver was reduced and eventually removed. After resident's fall with fracture, resident returned to the facility and was found on the floor again during sleeping time, resident had tenderness where she had 	3/7/14	

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F 323	<p>Continued From page 31</p> <p>cerebral palsy and profound intellectual disabilities.</p> <p>The most recent significant change MDS assessment dated 10/14/13, documented the resident was:</p> <ul style="list-style-type: none"> - moderately cognitively impaired with a BIMS of 11, - required extensive assistance for bed mobility, transfers, dressing, personal hygiene and bathing. - required staff assistance to stabilize him with standing, transferring on and off toilet, and surface to surface transfers. <p>An LN documented at 7:00 p.m. on the day of admission, the resident had an "ace wrap and immobilize" on the right leg. The resident was started with 1 : 1 staff for 24 hours a day. (Note: The DON confirmed during an interview on 1/30/14 at 8:45 a.m. the resident had a previous fall and fractured the tibia and fibula.)</p> <p>The Resident Service Director (RSD) was interviewed on 1/29/14 at 11:15 a.m. and stated all residents are admitted with a 1 : 1 for 24 hours and then slowly over a week are taken off 1 : 1. She further stated the resident was off 1 : 1 on 8/25/13 and the resident was receiving therapy for the right leg and was improving with strength and transfers.</p> <p>On 9/1/13 at 5:54 a.m. an LN documented in a nurses note (NN), "Resident self-transferring from bed to W/C and did not ask for help. Rested in bed thru noc [night] with eyes closed..."</p> <p>On 9/1/13 at 12:10 p.m. an incident and accident report (I&A) documented the resident fell in his</p>	F 323	<p>previously fractured her ribs, at that point resident was given a 1:1 for supervision.</p> <p>3. Resident #5's CNAs were provided training to ensure appropriate transfers were done with resident. Transfers were added to the Daily Care Audit and will be tracked by the licensed nurse. The Director of Nursing will track results and the results will be brought to the Quality Assurance Committee monthly for 3 months and quarterly for 3 quarters.</p> <p>4. Resident #9 ambulates throughout the facility with her front wheel walker. She is redirected as needed. Resident is noted to have increased anxiety with 1:1 staffing. Enjoys her independence. Resident receives redirection as needed from 24 hour hall monitor. An inservice was given on 1/10/14 instructing staff and signs were placed by each key pad reminding staff and visitors to remain by doors until the door magnet engages, after coming and going.</p> <p>In order to ensure that all residents were safe, and that all direct care staff were competent to provide needed care assistance, on 11/26/13 the facility placed itself on a voluntary</p>	
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F 323	<p>Continued From page 32</p> <p>room attempting to transfer, he was alone and unattended. The resident told staff, "I was trying to transfer to my bed and I didn't lock the brakes." The I&A documented the resident "doesn't listen to staff." There was no change in the level of supervision for the resident. (Note: the "Interventions to prevent future falls:" area on the I&A was blank.) The facility does not use alarms, according to the DON and RSD interview on 1/30/14 at 8:30 a.m.</p> <p>On 9/4/13 at 7:47 a.m. an LN documented in a NN, "Resident found to have latent injuries r/t fall. Above right hip there is a purple/yellow discoloration measuring 5 cm x 2 cm, on right mid back there is a purple yellow discoloration measuring 5 cm x 2 cm, and on mid forehead there is a 1 cm x 1 cm red scabbing area. resident denies pain to these area...."</p> <p>On 9/21/13 at 2:43 p.m. an LN documented in a NN, "Resident found sitting on side of bed when nurse went in to answer call light. Resident was getting a brief from drawer when nurse went in...."</p> <p>On 9/21/13 at 6:00 p.m. an I&A documented the resident fell in his room attempting to transfer, he was alone and unattended. The I&A documented the resident "was attempting to go to the bathroom." The I&A investigation report documented, "Resident is self mobile in w/c. Was told numerous times prior to fall that he needs to ask for assistance [with] transfer. Immediately prior to fall resident was told by nurse to wait for assistance." The documented interventions to prevent future falls was, "Assist x 2 for transfers." There was no change in the level of supervision documented.</p>	F 323	<p>hold on admissions until all direct care staff proved competency with cares or until December 15th 2013, whichever was latest. All direct care staff proved competency prior to the December 15th date. During this period the facility increased licensed nurse staff an extra 16 hour per day.</p> <p>Starting 2/19/14 all resident care plans will be reviewed word of word by the care plan team quarterly and prn to ensure that all interventions are appropriate and workable for each resident. The DNS/MDS Coordinator/Designee will review these care plan updates and track issues on the care plan tracking form weekly x4 weeks, then every 2 weeks x4, and monthly x3. The DNS will bring tracking to QAPI meetings for review.</p> <p>Daily Care Audit, starting 2/21/14, which identifies resident care needs and transfers will be updated by the licensed nurse daily x 1 month, then weekly x3 months, then quarterly x3 quarters. The Director of Nursing will track results and the results will be brought to the QAPI meetings for review.</p>	

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F 323	<p>Continued From page 33</p> <p>On 10/3/13 at 12:40 p.m. an LN documented in a NN, "Resident self transferred to toilet in room, by walking across room...."</p> <p>On 10/8/13 at 7:05 p.m. an I&A documented the resident fell in his room. The resident was "found on the floor", "attempting self-transfer", and was "alone and unattended." The resident was, "trying to return to his w/c [after] using the rest room...Missed handrail of w/c, lost his balance and fell onto his right side. 'Heard a pop' also." The I&A further documented the resident had made it back to the wheelchair and stood up to adjust his clothing and then fell when he attempted to sit down. The resident was assessed and was transferred to the local medical center. The resident sustained a fractured right hip as a result of the fall, was admitted to the hospital and had surgery to repair the fracture.</p> <p>The resident's behavior monitoring program (BMP) for 2013 documentation for wandering, revealed for September 2013 he had 57 episodes and October 2013 he had 186 episodes.</p> <p>The resident returned to the facility on 10/14/13. Review of the resident's pain assessments documented the resident had increased pain. The 8/19/13 assessment documented the resident had "frequent" pain in the right leg tibia and fibula. The resident's pain intensity was "moderate," a pain rating of "hurts a little more" and it did not interfere with his sleeping. When the resident returned from the hospital the 10/15/13 pain assessment documented "almost constant" pain in the hip area. The resident's pain was rated 8 on a 1 to 10 ratio, a pain rating of "hurt even more" and "pain made it hard to sleep at night."</p>	F 323		

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F 323	<p>Continued From page 34</p> <p>The EMR from 8/18/13 to 10/8/13 documented the resident spent most of the time in his room. The resident's supervision was not increased as he became more ambulatory which resulted in the resident falling a fracturing his hip.</p> <p>2. Resident #8 was admitted to the facility on 10/5/13 and readmitted on 11/11/13. The resident had diagnoses of after care for healing traumatic fracture of hip, unspecified epilepsy, diabetes mellitus without complication and dementia unspecified without behavioral disturbances.</p> <p>The most recent significant change MDS assessment, dated 11/18/13, documented the resident:</p> <ul style="list-style-type: none"> - was severely cognitively impaired. - required extensive assistance for bed mobility, transfers, dressing, personal hygiene and bathing. <p>The initial admission MDS assessment, dated 10/22/13, documented the resident:</p> <ul style="list-style-type: none"> - had short and long term memory problems. - severely impaired decision making skills. - had wandering on a daily basis. - required minimal to no assistance for transfers and ambulation. - had a history of falls in the month prior to admission, had a fall in the 2 to 6 months prior to admission and had a fracture from a fall in the previous 6 months. <p>The resident's admission care plan dated 10/30/13 documented a focus of, "I am at Moderate risk for falls r/t confusion, poor communication/comprehension, wandering, seizures and past history of falls." The</p>	F 323		
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F 323	<p>Continued From page 35</p> <p>interventions were:</p> <ul style="list-style-type: none"> "-Anticipate and meet my needs. -Follow facility fall protocol. - Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. - 24 hour 1 : 1 - will reduce as needed." <p>The residents care plan failed to have any approaches for supervision of the resident with a history of falls. The 1 : 1 was reduced over a 7 day period then discontinued.</p> <p>The care plan completed after the resident fractured her hip and was readmitted, documented on 11/19/13 a focus of, "I am at Moderate risk for falls r/t confusion, poor communication/comprehension, wandering, and past history of falls with fractures." The interventions were:</p> <ul style="list-style-type: none"> "- Anticipate and meet my needs. - Follow facility fall protocol. - Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes." <p>The facility did not have interventions for more supervision until after the resident injured her ribs. Then the 1 : 1 staffing was added.</p> <p>The DON and RSD were interviewed on 1/30/14 at 8:30 a.m. They confirmed the resident had 1 : 1 for 7 days on the initial admission. The 1 : 1 was discontinued on 10/22/13.</p>	F 323		

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F 323	<p>Continued From page 36</p> <p>On 10/15/13 at 3:10 p.m. an LN documented an initial admission NN of, "Resident arrived....Resident ambulates [independently] without c/o pain or discomfort.... There is also a large bruise on her left eye r/t fall previously...Resident ambulates [independently] and has a difficult time making [sic] needs known. Currently one on one present for safety."</p> <p>On 10/20/13 at 2:52 p.m. an LN documented in a NN, "Resident does wander and did need to be redirected several times as she would attempt to trespass into other [resident] rooms. [Resident] does listen to staff when we attempt to help her sit in a chair..."</p> <p>On 10/21/13 at 6:03 a.m. an LN documented in a NN, "[Resident] up and ambulating thru the eve....Wandered the halls and attempting to go in other rooms, but would stop. Confused."</p> <p>On 10/21/13 at 3:14 p.m. an LN documented in a NN, "...She does wander aimlessly. [Resident] was redirected by staff multiple times but she will turn and go the other way. Continuously walking...."</p> <p>On 10/24/13 at 7:25 a.m. an LN documented in a NN, "...Wanders thruout [sic] hall while up this shift. Confused....Hanging around this nurse this eve...."</p> <p>On 11/5/13 a late entry was made by an LN in the NN. It documented, "Late entry: 0320 [3:20 a.m.] Resident's nurse called for assistance for resident who had fallen and had unnatural leg alignment upon standing. Nurse called EMS. I found resident back in bed, aide providing traction to Left leg. Resident had a soft bump to back of</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>head approximately 2 inches in diameter....handed over to EMS for transport."</p> <p>On 10/5/13 at 3:05 a.m. an I&A documented the resident fell in her room. The resident was "found on the floor (unwitnessed)", "ambulating, attempting self-transfer", and was "alone and unattended." The resident was, "trying to get out of bed." The I&A further documented the resident was "forgetful" and had "dementia." The resident was assessed and found to have a blood sugar of 61 the resident was transferred to the local medical center. The resident sustained a fractured right hip as a result of the fall, was admitted to the hospital and had to have surgery to repair the fracture.</p> <p>On 11/11/13 at 2:54 p.m. an LN documented in a NN, "Resident arrived...Resident transfers with assist and walker, can ambulate for short distances..."</p> <p>On 11/13/13 at 6:21 a.m. an LN documented in a NN, "...While in W/C, res tried to stand alone but was stopped by staff..."</p> <p>On 11/13/13 at 1:26 p.m. a LN documented in a NN, "...Does attempt to self transfer at times....Does not remember to use call lite...Requires two assist with transfers. Was able to ambulates two to three steps with staff..."</p> <p>On 11/17/13 at 2:25 a.m. a LN documented in a NN, "... Resident is currently in bed. Earlier in the night resident has been attempting to self transfer. Noc aides observed resident to sit up on the right lateral side of the bed. Noc aides assisted resident with incontinent cares and repositioned her in bed..."</p>	F 323		

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F 323	<p>Continued From page 38</p> <p>On 11/18/13 at 9:36 a.m. a LN documented in a NN, "[Resident] awake early this morning and was rubbing the left leg, i [sic] asked if she was having pain and she states 'oh boy am I.' res was medicated....At lunch time again res was rubbing left leg again asking her if she was having pain and she states "yes" this time was medicated....has helped as she did have a decrease in restlessness and fidgeting in her w/c..."</p> <p>On 11/21/13 at 6:15 p.m. an I&A documented the resident fell in her room. The resident was "found on the floor (unwitnessed)", and was "alone and unattended." The I&A further documented the resident was "confused" and "carefree." The resident was transferred to the local medical center for x-rays.</p> <p>The Emergency room physician report, dated 11/21/13, documented: Chief Complaint: Ground level fall. History: The resident "has pain in her left hip area as well as in her right ribs...She states that she did have pain in her left hip but is more concerned about the right side of the ribs because she did land on her right side..." Physical Exam: Musculoskeletal: "...Palpation of the right sided rib cage is moderately tender to palpation at the mid axillary line as well as the rib angle..." (Note: There was multiple discussions about the residents injury to the ribs during the survey. The x-ray reports from 5/13, 11/5/13 and 11/21/13 show fractures of the ribs on the right side. It is not clear when the fractures occurred. It was noted the resident experienced increased pain in the rib area secondary to lack of supervision resulting in a fall.)</p>	F 323		
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F 323	<p>Continued From page 39</p> <p>The residents EMR documented the resident had pain in the left hip area and was observed guarding her right side due to pain. The resident was getting Norco 5-325, two tablets every four hours as needed for pain.</p> <p>The DON and RSD were interviewed on 1/30/14 at 8:30 a.m. The resident has a 1 : 1 staff with her 24 hours a day. This started after the injury to the resident's ribs. The 1 : 1 continued throughout the survey. Review of the BMP documentation it was found the resident for October 2013 [15 days] had 484 attempts of elopement, 514 episodes of pacing and 548 episodes of wandering. The documentation for November 2013 was 119 episodes of elopement, 132 episodes of pacing and 116 episodes of wandering.</p> <p>Resident #8 was harmed when the facility failed to supervise the resident. As a result the resident, who had a history of falls prior to admission, fell and fractured her left hip. The resident returned to the facility and ten days later fell, and injured her ribs which caused increased pain and discomfort.</p> <p>3. Resident #5 was admitted to the facility on 2/13/09 and readmitted on 3/29/13 with diagnoses which included hemiplegia (paralysis of arm, leg, and trunk on the same side of the body), and osteoporosis. The resident's most recent quarterly and Significant Change MDS assessments, dated 4/4/13 and 12/10/13 respectively, both coded, in part: * Severely impaired cognition; * Total dependence of 2 or more people for bed mobility, transfers, and toileting.</p>	F 323		

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F 323	<p>Continued From page 40</p> <p>The resident's 4/8/13 Care Plan (CP) for ADL included in the intervention section for transfers "I require 2 staff participation with transfers and the use of a Hoyer lift." The intervention had an initiation date of 4/8/13.</p> <p>An Incident Report (IR) dated 11/23/13 at 4:00 p.m. documented CNA #8 reported to LN#4 the resident "winced" when his left arm was moved. LN #4 assessed the left arm and documented "swelling - resident winced when I lifted arm..."</p> <p>A Nurses Note (NN) dated 11/23/13 at 4:30 p.m. documented it was a late entry of the above incident and the resident occasionally had swelling in the arm due to immobility. The NN documented the nurse instructed the aides to elevate the left arm, had notified the next shift and had put the incident on the 24 hour report for further monitoring. The NNs had no further documentation of the injury until 11/25/13 at 6:19 p.m. which documented the resident continued to have swelling to the left elbow and ice was applied. A NN dated 11/26/13 at 5:17 p.m. documented the resident returned from the emergency room with a cast on his left arm.</p> <p>A physician report, dated 11/26/13 documented the resident was sent to the emergency room after an x-ray revealed a fracture of the left humerus.</p> <p>Note: The 11/26/13 x-ray was done 3 days after the resident's pain was reported to the nurse.</p> <p>Attached to a 11/26/13 Investigation Report was a "Records Review: Significant Information" (SI). The SI documented the following:</p>	F 323		

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F 323	<p>Continued From page 41</p> <ul style="list-style-type: none"> * The resident was to only be a 2 person mechanical lift transfer. * All staff working from 11/20/13 - 11/23/14 on the the hall the resident resided on gave statements. * Night shift reported they used the mechanical lift, however, the video recordings from the night shift did not show the mechanical lift go into the residents room. * Day shift reported they never transfer the resident. * All of staff on the evening shift reported a 2 person stand pivot was used when the resident is transferred. * The shower team stated a 2-3 person stand pivot was used to transfer the resident. <p>Communication Forms attached to the Investigation Report (statements by nursing staff) documented at least 7 staff used a stand pivot to transfer the resident. One of the Communication Forms documented a CNA had been trained to use a stand pivot transfer with 2-3 staff when transferring Resident #5 and nurses and other CNAs had witnessed the staff use a stand pivot transfer with the resident.</p> <p>The investigation of the fracture of the resident's humerus did not state the fracture was the result of staff using a stand pivot to transfer the resident. However, the investigation documented the resident was care-planned to be transferred with a mechanical lift and page 10 of the Investigation Report documented: "Repeated failure to follow a care plan Harm occurred because of failure to follow a care plan."</p> <p>A 12/9/13 "Facility Requested Fracture</p>	F 323		

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F 323	<p>Continued From page 42</p> <p>Investigation" (FREI) documented the resident had severe osteoporosis and an x-ray had revealed a fracture of the Humerus. The FREI also documented "Because there had been no witnessed injury a thorough investigation was performed, the most likely root cause identified..."</p> <p>On 1/30/14 the DON stated a hold on new admissions was initiated on 11/27/13 due to the nursing staff not following the CP to use a Hoyer lift and resident #5's fracture. Additionally all CNAs were required to attend training to demonstrate competency in CNA skills.</p> <p>The facility was informed of the above concern on 1/30/14 at 3:45 p.m. The facility provided no further information.</p> <p>4. Resident #9 was admitted to the facility on 7/13/13 with diagnoses of dementia unspecified w/ behavior disturbances, diabetes without complication and unspecified psychosis.</p> <p>The most recent quarterly MDS assessment, dated 10/15/13, documented the resident:</p> <ul style="list-style-type: none"> - had short and long term memory problems, - had severe impairment of decision making skills, - required limited assistance with bed mobility, transfers. - required extensive to total assist with dressing, personal hygiene and bathing. - the resident wandered every day. <p>The resident's care plan, dated 8/5/13, documented a focus of, "I am an elopement risk/wanderer AEB[as evidenced by] impaired safety awareness, Significantly intrudes on the privacy or activity." The interventions were:</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>"- Assess for fall risk, - Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, Resident prefers: - Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. - Monitor for fatigue and weight loss. - Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes."</p> <p>The resident had a "Behavior Management Plan" dated 7/30/13. The resident had multiple behaviors. The plan for wandering documented: "Defined as going aimlessly from place to place, with no purpose. Goal: Resident will have an average of 2 (wandering) for 3 consecutive months. Intervention: 1. Redirect to day room. 2. Escort the resident to an appropriate area for the resident to be in." The plan for trespassing documented: "Defined as going into other room uninvited, going into room mates space/belongings not honoring others personal boundaries. Goal: Resident will have an average of 4 (trespassing) for 4 consecutive months. (Interventions) 1. Explain in simple terms that it is not her room or belongings. 2. Remove from area and show her where her room and belongings are. 3. Encourage to be involved in activities. 4. Ask what she is looking for."</p> <p>The multidisciplinary EMR has frequent documentation of the resident not being supervised and being found either wandering to trespassing. Some of the documentation was:</p>	F 323		

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F 323	<p>Continued From page 44</p> <p>On 7/14/13 at 1:09 a.m. an LN documented a NN, "Resident asked to rest on bed when she arrived...Resident immediately began wandering when she arrived. Did climb into closet and was assisted out of closet. Wandering in other residents rooms....Attempted to climb on bed with another resident and no injuries or issues."</p> <p>On 7/18/13 at 3:25 p.m. an LN documented a NN, "...Res does use her FWW [front wheel walker] but she tends to pull it along behind her and then she is ready to sit down..."</p> <p>On 7/19/13 at 12:38 a.m. an LN documented in the NN, "Resident awake and alert. Wandering in lobby. Has to be closely watch or will trespass in other residents room, nurses stations. Was in lobby in the evening and removed clothing several times, removed shirt and nothing underneath. Took off pants and sat on chair in attends. Has to be closely watched."</p> <p>On 7/20/13 at 3:07 a.m. an LN documented in the NN, "Resident has been up most of night. Trespassing in rooms. does strip clothes off where ever she is at - such as lobby or dining room...."</p> <p>On 7/28/14 at 3:07 a.m. an LN documented in the NN, "Resident up and wandering during the night. Went into room (#) and urinate in trash can. Assisted back to room..."</p> <p>On 8/4/13 at 1:38 a.m. an LN documented in the NN, "...Continues to wander and requires close supervision for safety. Does trespass in others rooms at times..."</p>	F 323		

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F 323	<p>Continued From page 45</p> <p>On 8/16/13 at 1:08 p.m. an LN documented in the NN, "Res has not shown any latent injuries noted from fall..." (Note: No documentation was found during survey for this fall.)</p> <p>On 8/18/13 at 4:45 a.m. an LN documented in the NN, "Restless and awake most of night. Has to be closely monitored or trespasses in other residents rooms. Will take cloths off in lobby."</p> <p>On 9/7/13 at 5:52 p.m. an LN documented in the NN, "...Res does ambulate freely at times she does have a FWW she uses and she does sometimes forget where she leaves the FWW. Gait is low but fairly steady..."</p> <p>On 9/16/13 at 6:25 p.m. an LN documented in the NN, "Resident lost balance and fell backward hitting the floor, head hit the table leg causeing [sic] two small laceration on the back of her head. Floor was wet from coffee spill, shoes on. ROM within normal limits for resident Neuro checks [within normal limits] for resident. Resident assisted up off the floor, no other injury noted at that time. No c/o pain resident taken per facility van to [medical facility] for evaluation and treatment..." (Note: The resident required staples to close the lacerations on the head.)</p> <p>On 9/16/13 at 6:00 p.m. an I&A documented "Resident - hit her she fell back" and fell to the floor (witnessed), in the dining room, and she was alone and unattended. The resident told staff, "Resident was folding wash cloths." The interventions to prevent future falls was, "Monitor ambulation."</p> <p>The 9/18/13 Investigation report documented, "Resident was folding towels and when she got</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>up to leave the table had put her hand on another resident's wheelchair to steady herself and was moving away, when the resident in the chair told her not to touch her chair. When a staff member intervened, the staff member got between [Resident #9] and the other resident which threw the resident off balance and she fell."</p> <p>On 9/29/13 at 11:58 a.m. an LN documented in the NN, "No latent injuries from fall. But resident very anxious and agitated. Keeps ambulating around halls and confused. Attempting to enter other resident rooms."</p> <p>10/11/13 at 7:00 a.m. an LN documented in the NN, "Resident has increasing times on being non-compliant. Trying to leave, pulling her pants down, trying to force her way down the halls. Has not been violent. Just persistent..."</p> <p>11/23/13 at 6:06 a.m. an LN documented in a NN, "Resident had dinner, ambulated around during evening ambulated to south doors and was re-directed back with no complications..."</p> <p>On 12/3/13 at 9:33 a.m. an LN documented in a NN, "Res is alert and does smile and wave at staff...Res does need staff to redirect her at times. This res does wander aimlessly and does at times trespass into other rooms, again staff does redirect her..."</p> <p>On 1/20/14 at 4:01 p.m. the RSD documented a Resident Services note, "...[Resident] does ambulate independently with a front wheel walker. She does require reminders to use the walker as she will forget due to her dementia. She is being tracked (every) shift for behaviors. Her behaviors include physical assault, verbal assault,</p>	F 323		

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F 323	Continued From page 47 wandering, trespassing, noncompliance, undressing in public areas.... Her behaviors do seem to escalate in the evening hours... She does require verbal reminders for activities and often escort also. She usually wanders in and out of them...." The residents' documented history of behaviors, especially her wandering and trespassing, included: Wandering: July 2013= 227, August 2013= 17,327, September 2013 = 521, October 2013 = 453, November 2013 = 10, and December 2013 = 89. Trespassing: July 2013 = 43, August 2013 = 17,269, September 2013 = 91, October 2013 = 99, November 2013 = 0, and December 2013 = 128. The residents' behavior management plan documented a goal of 2 episodes of wandering for 3 consecutive months and 4 episodes of trespassing for 4 consecutive months. There has not been a change in the behavior plan, and the resident continues to wander and trespass. There was evidence of a lack of supervision found in the residents' NN and there was a potential the resident would be injured if she were to wander into a resident's room who was violent. The DON and RSD were interviewed 1/30/13 at 9:00 a.m. There was discussion about the large amount of behaviors. The behavior care plan was provided. No other information was provided.	F 323			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333			

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NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318		
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F 333	<p>Continued From page 48 any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review it was determined the facility failed to ensure a resident was free from any significant medication errors. This was true for 1 of 12 (#4) sampled residents. This deficient practice had the potential for more than minimal harm if the resident experienced seizure activity due to not receiving the prescribed amount of his anticonvulsant medication. Findings include:</p> <p>Resident #4 was admitted to the facility on 9/10/04 and readmitted on 11/27/12 with diagnoses which included epilepsy, bipolar disorder and disorder of bone and cartilage.</p> <p>The resident's most recent quarterly and annual MDS assessments, dated 1/7/14 and 10/8/13 respectively, both coded the resident had a seizure disorder or epilepsy.</p> <p>The resident's 12/13 Medication Review Report (Physician recapitulation orders) included an order for Phenobarbital (anticonvulsant) 30 mg every a.m. and 60 mg at bedtime for seizures, both with a start date of 11/27/12.</p> <p>The resident's Nurses Notes (NN) dated 12/26/13 at 7:40 p.m. stated "Res (resident) has had a seizure that happened last NOC (night shift) that caused res to fall out of bed."</p> <p>A Fall Scene Investigations Report (FSI) dated 12/26/13 documented the resident fell from bed at 3:00 a.m., received no injuries and the root</p>	F 333	<p>F333</p> <p>The facility will ensure that residents are free from any significant medication error.</p> <p>Resident #4 has suffered no long term effects of the medication error. The nurse who made the significant error has had their employment at the facility terminated. Medication errors are reviewed each work day by the DON and the IDT.</p> <p>The root cause of the errors was lack of nurse education. A pharmacy representative provided instruction on medication administration and documentation on 2/13/14 and 2/14/14 with licensed nurses. Starting 3/5/14, the DON/ Unit Manager/ Designee will audit a medication pass for each nurse to ensure knowledge about the proper way to pass medications, the audits will be performed for each nurse. The audits will be performed thereafter on each nurse 1x quarterly for 3 quarters. The DNS will bring tracking to QAPI meetings for review. The DNS will log errors into the medication error log and provide 1:1 training prn to nurses and the information will be taken to the</p>	3/7/14	

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F 333	<p>Continued From page 49 cause of the fall was a seizure.</p> <p>a. A Medication Error & Analysis (MEA) documented a medication error on 12/22/13. The MEA included the resident was to receive Phenobarbital 60 mg (for seizures) in the evening. A Narcotic Record (NR), dated 12/17/13 through 12/26/13, attached to the MEA documented each tablet was 15 mg. The NR documented on 12/22/13 at 7:00 p.m. the resident had only received 1 tablet or 15 mgs. The action taken documented a lab for the Phenobarbital level was drawn and the result called to the physician. The physician changed the Phenobarbital dose to 60 mg twice a day. The MEA documented a Level 3 error which resulted in need for increased monitoring but no ultimate harm to the resident</p> <p>Note: The resident should have received 4 tablets to equal 60 mg.</p> <p>b. The resident's 1/14 Medication Review Report (Physician recapitulation orders) included an order two times a day for Phenobarbital 60 mg for seizures. The section labeled Laboratory documented "Phenobarbital level one time only for Phenobarbital dosing change until 01/06/14.</p> <p>A second MEA, dated 1/3/14, documented the resident was to receive 60 mg of Phenobarbital. The tablets were 15 mg each and the resident only received 2 tablets. The MEA documented the physician was notified on 1/4/14, however the time of the notification was not included.</p> <p>Note: The Medication Review Report, MEA and Medication Administration Record (MAR) did not include the time when the resident was to receive</p>	F 333	Quality Assurance Committee for review indefinitely.	

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F 333	Continued From page 50 the Phenobarbital. Additionally the Medication Review Report and the MAR documented the dose was to be 60 mg but instructed to give "1 tablet by mouth two times a day" which would only be 30 mg. per day. A NN, dated 1/4/14 at 5:32 a.m. documented "Resident received incorrect dose of 30 mg of Phenobarbital with evening dose." The NN also documented the Physician assistant was contacted (date and time not documented) and ordered the resident receive another 30 mg "now" and then resume 60 mgs. NN through 1/6/14 did not document any seizures and on 1/7/14 at 2:15 p.m. document "... Res has had no seizures thus far and we do continue to monitor for any type of change." On 1/31/14 at 9:30 a.m. the DON stated the resident had received the wrong dose of Phenobarbital 2 times. The surveyor asked why the incident on 12/22/13 was not in the NN. The DON stated the medication error was found when the facility was investigating the reason for the resident's seizure on 12/26/13. The DON was asked how 2 different nurses had made an error on the Phenobarbital. The DON stated the nurse for the 1/3/14 medication error was a new nurse and the facility provided training for the nurse and the nurse was terminated that made the 12/22/13 medication error.	F 333			
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	F 431			

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F 431	<p>Continued From page 51</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review and staff interview, it was determined the facility failed to ensure expired medications were not available for administration to residents. This created the potential for sub-optimal efficacy for any resident who could have received the expired supplements and anti-itch cream. Findings</p>	F 431	<p>F431</p> <p>The facility will ensure drugs and biological used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>On 1/31/14 the med rooms were audited by the DON for outdated medications and all outdated medications and supplies were eliminated.</p> <p>An ongoing weekly audit will be performed by the Unit Manager or the Director of Nursing for over the counter medications (medication rooms and medication carts). They will be checked for outdated medications and cleanliness. The audit will be reviewed each month by the DON and the results will be brought to QAPI meeting.</p>	3/7/14

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F 431	<p>Continued From page 52 included:</p> <p>On 1/30/14 at 10:15 a.m., during inspection of the North side medication storage room, with LN #4 in attendance, 2 bottles of Calcium 600 mg (milligrams) were observed and both expired in December 2013. One bottle of Calcium 500 mg was observed which expired in September 2013, and one bottle of Oystershell Calcium 500 mg plus Vitamin D 400 mg/unit was observed which expired in July 2013. Additionally, one Hydrocortisone anti-itch cream was observed which expired in May 2013. The LN said she was not aware if she was supposed to check medications in the medication storage room and expressed concern over the finding of expired medications. The LN removed the expired medications from the room.</p> <p>On 1/30/14 at 10:28 a.m., during inspection of the South side medication storage room, LN #5 was asked who took care of OTC (Over The Counter) medications on the North side. She said the nurses on the floor were responsible and added the nurses were, "Not supposed to take them [OTC medications] over there [North side]." The LN was informed of the issue of expired medications on the North side and she stated, "I'll take care of them."</p> <p>On 1/30/14 at 11:54 a.m., the DON provided the Policy and Procedure for Medications Accesses and Storage, with a revision date of 7/11/11, which documented in part, "Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the</p>	F 431			

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F 431	Continued From page 53 pharmacy, if a current order exists." On 1/30/14 at 3:45 p.m., the Administrator and DON were informed of the expired medications. However, no further information or documentation was provided which resolved the issue.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. Resident #3 is free from infection and unaffected by the noted event. The CNA was given special hand washing instructions by the Director of Nursing on 2/5/14. On 1/31/14, laundry staff was inserviced to cover clean laundry during transport. The Housekeeping Supervisor will track on the Housekeeping Audit Form the transport of all clean laundry to ensure that it is covered while transporting it from the laundry room to the clean linen storage areas. The form will be completed daily x2 months and 1x weekly thereafter. The completed forms will be reviewed by the	3/7/14	

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F 441	<p>Continued From page 54</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review and staff interviews, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 12 sampled residents (#1) when hand hygiene was not performed, and linens were not covered during distribution. Failure to follow standard infection control measures placed residents at risk for infections. Findings included:</p> <p>a. On 1/28/14 at 9:40 a.m., CNA #9 and CNA #10 were observed as they provided AM cares for Resident #3. CNA # 10, wearing gloves, drained the foley catheter into a container which was set inside a plastic bag and put it aside. The CNA proceeded to assist with peri-care and then assisted CNA #9 in transferring the resident into a foam cushion chair. CNA #10 continued to assist Resident #3 by providing oral care and washing the resident's face with a wet cloth. Note: CNA #10 was not observed changing gloves or performing hand hygiene after providing peri-care. Upon exiting the resident's room, CNA #10 was asked if she changed gloves after providing peri-care for the resident, at which she said yes. The CNA was asked when she donned new gloves and she stated, "After peri-care." CNA #10 was asked if she performed hand hygiene</p>	F 441	<p>administrator each week and the results will be brought to the Quality Assurance Committee for review.</p> <p>Inservice was given on 2/10/14, to all staff, on proper hand washing technique.</p> <p>Nursing administration or designee will audit every regular scheduled nurse and nursing assistant to ensure understanding of policy and procedure for proper hand washing/hygiene. With the use of the Competency Evaluation Form for Hand Hygiene with understanding that additional soap, paper towels, and garbage bags are available at any time in designated areas by 3/7/14.</p> <p>Nurse administration or designee will perform 6 (2 on each shift) random audits each month on 6 nursing personnel on the Hygiene Competency Evaluation Form monthly x 3 months. The results will be brought to the Quality Assurance Committee for review.</p>	3/7/14

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F 441	Continued From page 55 between removing the old gloves and donning a new pair. The CNA stated, "No." On 1/30/14 at 2:49 p.m., the DON provided the Policy and Procedure for Hand Hygiene/Hand Washing, with a revision date of 7/11/11, which documented in part, "It may be necessary to clean hands between tasks on the same residents to prevent cross-contamination of different body sites... Times to perform hand hygiene... After removing gloves..." On 1/30/14 at 3:45 p.m., the Administrator and DON were informed of the lack of hand hygiene. However, no further information or documentation was provided which resolved the issue. b. On 1/28/14 at 12:10 p.m., clean laundry was being distributed to residents on the South side. The clean clothing was laid in 2 baskets, uncovered, which were on a cart. The clothing was zigzagged to separate between residents. When asked if that's how laundry was usually distributed, the laundry assistant said yes. On 1/29/14 at 11:45 a.m., the laundry assistant was distributing clean clothing to the residents on the North side. The clothing in one basket was covered, while the second basket of clothing was not covered.	F 441			
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	F 518	F518 The facility will train all employees in emergency procedures when they begin to work in the facility, and periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.	3/7/14	

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F 518	<p>Continued From page 56</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's emergency policies, it was determined the facility did not ensure staff were trained on procedures for responding to emergencies. This was true for 3 of 3 staff members (CNA s #10 &12 and LN #13) interviewed on emergency procedures. This deficient practice had the potential for harm should an emergency arise and staff not know how to respond. Findings included:</p> <p>1. On 1/30/14 at 1:20 pm CNA #12 was asked what to do if there was a power outage. The CNA responded there were red extension cords to plug in but she did not know where to "plug them in."</p> <p>2. The facility's "Fire Protection" policy documented staff were to: * Remove residents in immediate danger and close room door to contain fire. * Pull fire alarm nearest to fire. * Announce on intercom, "Attention Please - Code red and give the room number or location. * Call fire department, give your name, facility name, location of fire. The policy stated the fire alarm will notify the fire department but staff are to call to verify the notification and to give the exact location of the fire.</p> <p>CNA #10 was asked to explain the procedure if a fire was discovered. The CNA stated to clear the</p>	F 518	<p>As part of the safety training for new staff, there is training on the use of red plugs for emergency power, and what to do in the event of an intruder. On 2/10/14 there was refresher training for all staff on the use of red plugs and what to do if there is an intruder.</p> <p>During monthly generator testing staff will use the red plugs for all essential power services. Un announced intruder drills will be held each quarter.</p> <p>Training on power outages and intruder situations has been added as part of the training schedule for all staff on a regular basis. As part of the training, staff will complete a written test with intruder procedures, and emergency power integrated into it. Training on red plugs and intruders will be given monthly x3 months and quarterly x3 quarters.</p> <p>The Administrator will track the training and on the staff education agenda form and the audit will be brought to the Quality Assurance Committee monthly x3 months and quarterly x3 quarters.</p>		

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F 518	<p>Continued From page 57</p> <p>hallway by the fire, ensure residents were in an area away from the fire, check all residents rooms to make sure they were not in the room, put a glove on the door handle of the room checked to prevent other staff from rechecking the room, and wait to hear "all clear" before returning residents to the area where the fire was.</p> <p>The CNA did not state to pull the fire alarm, announce code red or contact the fire department.</p> <p>3. The facility's "Outside Intruder Policy" documented: * The first person to identify a person posing a physical threat to the facility, staff or residents will activate the fire alarm. * Using the telephone paging system dial "620" to activate the overhead page and alert personnel by announcing Code yellow. * Use the telephone to dial 9-911 and alert the authorities of the situation.</p> <p>When asked the emergency procedure for an intruder LN # 13 stated to make sure the residents were safe by keeping them away from the intruder, to distract the intruder and to call 911.</p> <p>The LN did not state to activate the fire alarm or to announce Code yellow over the paging system.</p> <p>When asked the emergency procedure for an intruder CNA #13 stated remove the residents from the area where the intruder was. The CNA could not remember the code to yell. The CNA stated specifically stated the intercom was not to be used but staff were to yell.</p>	F 518		

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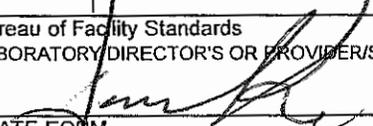
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F 518	Continued From page 58 The CNA did not state to activate the fire alarm. The Administrator and the DON were informed of the above concerns on 1/30/14 at 3:45 p.m. The facility provided no further information.	F 518		

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey and complaint investigation of your facility. The surveyors conducting the survey were: Sherri Case, LSW/QMRP, Team Coordinator; Arnold Rosling, RN/QMRP; and, Lauren Hoard, RN.	C 000	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F 241 as it relates to dignity while dining.	C 125	C 125 Please refer to F F241	3/7/14
C 175	02.100,12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F 225 as it related to investigation of injuries of unknown origin.	C 175	C 175 Please refer to F 225 RECEIVED MAR 07 2014 FACILITY STANDARDS	3/7/14
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT	C 361	C 361 Please refer to F 253	3/7/14

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 3/6/14
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/31/2014
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NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318
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C 361	Continued From page 1 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 F253 as it relates to maintenance of the facility.	C 361		
C 393	02.120,04,b Staff Calling System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F246 as it relates to call lights being available to residents.	C 393	C 393 Please refer to F 246	3/7/14
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as:	C 644	C 644 Please refer to F 441	3/7/14

Bureau of Facility Standards

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C 644	Continued From page 2 i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it relates to handwashing.	C 644		
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) meeting attendance records and staff interview, it was determined the facility did not ensure the Housekeeping Representative and Pharmacist attended/participated in quarterly ICC meetings. This failure created the potential for a negative affect for all residents, staff, and visitors in the facility when ICC members were not involved in the ICC meetings. Findings included: On 1/30/14 at 1:00 p.m., LN #11, who was the designated Infection Control Nurse, was interviewed about the Infection Control Program. The LN was asked to show attendance records for 3 consecutive months of ICC meetings. The attendance records documented the staff who attended the aforementioned ICC meetings, but the Pharmacist and Housekeeping Representative were not on the list. When asked if the Pharmacist and Housekeeping representative attended the ICC meetings at least quarterly, she stated, "No." On 1/130/14 at 3:45 p.m., the Administrator and	C 664	C 664 Pharmacist and housekeeping representative will attend infection control meetings at least quarterly. The infection control meeting will be scheduled during the time that the pharmacist will be in the building and there will be an attending housekeeping representative during the meetings. The Infection Control Nurse will invite the Pharmacist and the housekeeping representative and they will attend Infection Control Meetings for 3 months consecutively and then at least quarterly. They will sign the attendance sheet to show participation in the meeting and the results will be taken to the QAPI meeting by the infection control nurse for review.	3/7/14

Bureau of Facility Standards

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C 664	Continued From page 3 DON were informed of the ICC meeting attendance issue. However, no further information or documentation was provided.	C 664		
C 671	02.150,03,b Handling Dressings, Linens, Food b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Refer to F441 as it relates to clean linen distribution.	C 671	C 671 Please refer to F 441	3/7/14
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248 as it relates to activities.	C 674	C 674 Please refer to F 248	3/7/14
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	C 782	C782 Please refer to F280	3/7/14

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C 782	Continued From page 4 to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to care plan revisions.	C 782		
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 246 as it pertains to accommodation of resident needs.	C 784	C784 Please refer to F246	3/7/14
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F309 and F333.	C 788	C788 Please refer to F309 and F333	3/7/14
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 relates to resident injuries.	C 790	C790 Please refer to F323	3/7/14
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation	C 795	C795 Please refer to F315	3/7/14

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C 795	Continued From page 5 and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Refer to F315 as it related to incontinence.	C 795		3/7/14
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Refer to F431 as it relates to expired medication.	C 821	C821 Please refer to F431	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0009
PHONE 208-334-6626
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March 6, 2014

Darrin Radeke, Administrator
Mini-Cassia Care Center
PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **January 31, 2014**, a Complaint Investigation survey was conducted at Mini-Cassia Care Center. Lauren Hoard, R.N., Arnold Rosling, R.N., Q.M.R.P., and Sherri Case, L.S.W., Q.M.R.P., conducted the complaint investigation.

This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey. Facility incident reports and the records of eighteen residents, including those of the identified residents, were reviewed. Observations of resident care were conducted throughout the survey. Interviews were conducted with residents, their families and/or representatives and a variety of facility staff.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006288

ALLEGATION #1:

The complainant stated the following:

1. An identified resident is only to be transferred with a Hoyer lift, staff are not using the Hoyer lift to transfer the resident.
2. A second resident's hand was swollen and black. It was unknown how the injury happened and facility did not investigate the cause of the injury.

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Darrin Radeke, Administrator
March 6, 2014
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3. A third resident suffered a fracture while in the facility.

FINDINGS:

1. Based on staff interviews, review of incident reports and an investigation, the allegation was substantiated, and the facility was cited at F323.
2. Based on staff interviews, review of a incident report, and nursing notes, the allegation was substantiated, and the facility was cited at F225 for failure to investigate the cause of an unknown injury.
3. The third resident's medical record, nurses notes and Fall Investigation reports (December 5, 2013 and December 26, 2013) were reviewed. The Director of Nursing (DoN) was interviewed. The records did not document a fracture. The DoN stated the resident had not had a fracture related to the falls on December 5, 2013 or December 26, 2013.

CONCLUSION:

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

ALLEGATION #2:

The complainant stated a resident's physician had ordered that the resident be sent to the hospital for evaluation of hip pain. The physician's order was not followed.

FINDINGS:

Based on staff interviews and review of an incident report and nurse's notes, it was confirmed that physician orders were not followed regarding evaluation of pain for the identified resident. The facility was cited at F309.

CONCLUSION:

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

ALLEGATION #3:

The complainant stated residents are being put to bed immediately after the evening meal without being asked if they want to go to bed. The residents do not receive a bedtime snack or oral care due to going to bed so early.

FINDINGS:

During observations after the evening meal on January 28, 2014, two residents were observed to be assisted to bed. Both resident's indicated to the certified nurse aides (CNAs) that they wanted to go to bed. During an observation at 6:42 p.m., one resident resisted being transferred and the CNA again asked the resident if he wanted to go to bed. The resident indicated he wanted to go to bed. The CNA was observed to provide oral care for the resident.

During the group meeting with six residents, a family member and the surveyors, the residents responded as follows:

- When asked if they had to go to bed at a certain time, all six residents indicated they went to bed when they wanted.
- When asked if oral care was provided, five stated they were independent with oral care, but the facility made sure they had the necessary items to brush their teeth or clean their dentures. One of the residents stated he had never brushed his teeth since he was a boy, and he did not brush them now.
- When asked if they received bed time snacks, two of six residents stated they were not offered a bedtime snack.

Three CNAs on evening shift were asked when snacks were passed. All stated at about 3:00 p.m. and 8:00 p.m. All stated the bedtime snacks were offered to everyone. When asked why some residents stated they were not offered a snack, a CNA stated the snacks are always offered but some residents refuse because they are "too full."

Based on observations, group interview and individual residents' interviews, the concern was not substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated that nursing staff were not trained on how to document information in the electronic medical records (EMR) system.

FINDINGS:

Interviews were conducted with the MDS Coordinator, three licensed nurses, medical records

Darrin Radeke, Administrator
March 6, 2014
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staff and the DoN.

All staff reported the training was provided in June 2013, the month prior to the EMR system being implemented. The nursing staff stated the training was available to all shifts; there was a sign-up sheet for the time they could come to the training. Nursing staff stated a consultant for the facility was available to contact if there were problems when the electronic system was implemented. All nurses stated that the Medical Records staff was very good with the system and always willing to help them if they were having problems with the system.

The DoN stated a series of two-hour classes were offered every week in June 2013. The facility also offered one-to-one training for nurses.

It could not be determined that the facility failed to provide training related to the EMR.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

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

LK/lj