



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
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CERTIFIED MAIL: 7012 1010 0002 0836 1871

February 14, 2014

G. David Chinchurreta, Administrator
Sunny Ridge
2609 Sunnybrook Drive
Nampa, ID 83686-6332

FILE COPY

Provider #: 135102

Dear Mr. Chinchurreta:

On **January 31, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Sunny Ridge 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 the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 27, 2014**. Failure to submit an acceptable PoC by **February 27, 2014**, may result in the imposition of civil monetary penalties by **March 19, 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 will you 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 CMS-2567 and the state licensure survey report, State Form.

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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 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

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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 27, 2014**. If your request for informal dispute resolution is received after **February 27, 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,



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

LKK/dmj
Enclosures

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

PRINTED: 05/23/2014
FORM APPROVED
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2014
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NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686
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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	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey and complaint investigation at your facility. This report reflects changes resulting from the Informal Dispute Resolution (IDR) process. The survey was conducted from January 27-31, 2014. The survey team was: Nina Sanderson LSW BSW, Team Coordinator Susan Gollobit RN Survey Definitions: ADL = Activity of Daily Living BFS = Bureau of Facility Standards BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CMS = Centers for Medicare and Medicaid Services CNA = Certified Nurse Aide CNC = Corporate Nurse Consultant DHW = Department of Health and Welfare DNS/DON = Director of Nursing LN = Licenced Nurse MDS = Minimum Data Set assessment PRN = As needed RN = Registered Nurse SSD = Social Service Designee	F 000	"This Plan of Correction is prepared and submitted as required. By submitting this Plan of Correction, Sunny Ridge Center does not admit that the deficiencies listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		3/7/14

RECEIVED
JUN - 2 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>B. D. Churchurata, Adm.</i>	TITLE	(X6) DATE 5/27/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 248	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility did not ensure an activities program consistent with specific interests expressed by the residents. This was true for 3 of 9 residents (#s 2, 7, and 8) sampled for their activities program. The deficient practice had the potential to cause more than minimal harm should residents experience changes in their psychosocial well-being related to lack of appropriate stimulation. Findings included:</p> <p>1. Resident #8 was admitted to the facility on 3/12/13 with multiple diagnoses which included spinal stenosis, deconditioning with acute back pain secondary to acute L 3 (3rd lumbar vertebrae) endplate compression fracture, and osteopenia to her left hip as well as degenerative changes to bilateral hips, dementia, and failure to thrive.</p> <p>Resident #8's 3/19/13 admission MDS assessment coded: -BIMS of 15, indicating the resident was cognitively intact; -Very important for the resident to choose what she wore, take care of her personal belongings, have a family member involved in her care, listen to music she liked, be able to go outside, and participate in religious activities.</p> <p>Resident #8's care plan for activities documented: -Focus, "[Resident #8] was a housewife...self-initiates activities and enjoys reading...TV...Crossword puzzles...socializing</p>	F 248	<p>1. Resident # 2 was interviewed by recreational director on or before 2/26/14 for activity preferences, and to ensure that current activity programming meet his needs. Care plan and activity programming updated at time of review by recreational director to reflect current choices.</p> <p>Staff that care for resident #2 were educated on residents activity preferences including music activities, this included education on their responsibility to ensure that he was offered and assisted to attend them as indicated by the activity director on 2/21/14.</p> <p>Resident #7 was interviewed by the activity director, on or before 2/24/14, related to activity preferences. Resident #7's activity programming and plan of care were updated by the activity director on or before 2/26/14. Resident # 7 was provided with an audio recorder that plays audio books, on or before 2/1/14 by recreational director. Care plan updated to reflect preferences.</p>	

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F 248	<p>Continued From page 2</p> <p>with others...has her own cell phone...Friends and Family visit weekly...finds faith in [Denomination] Religion and enjoys pastor visits...Voting Absentee...Pet Visits...grooming herself...gardening...games...music...sing a longs...outing, parties and special events." Date initiated was 3/19/13, revised on 8/12/13.</p> <p>-Goals of, "...will continue to participate in Group Activities of Choice 2 times per week." Date initiated was 3/19/13, revised on 8/12/13. "...will attend formal activities 1 X per month." Date initiated 3/19/13.</p> <p>-Interventions were, "Assist [Resident #8] to and from Activities until she is familiar with Facility." Date initiated 3/20/13. "Introduce to residents with similar interests." Date initiated 3/19/13. "Remind [Resident #8] when group outings are being held in case they [sic] decide to participate." Date initiated 3/19/13.</p> <p>There were no new interventions developed since the time of her admission, even though the resident had demonstrated deterioration in her mood state, cognition, and activity participation. There was no instruction for the staff to assist the resident to access reading materials, assist her to use her television, or which groups offered by the facility which might be consistent with her interests. There was no updated interventions indicating whether or not she had become familiar with the facility in the almost 9 months which had passed since her admission, nor if she had been successfully introduced to residents with similar interests.</p> <p>Resident #8 resided in a room in the facility without access to an outside window. Her bed was placed in the corner of the room, such that there was a wall to both the head and left side of</p>	F 248	<p>Resident # 8 privacy curtain was pulled back to enable her to watch people in the hallways by director of nursing on 2/21/14.</p> <p>Center staff that care for resident #8 were educated by the Director of Nursing on 2/21/14 to assist her with activities of preference such as obtaining her book, assisting her with the remote, and checking to see if she would like her privacy curtain left open when she was in bed</p> <p>Resident #8 was also assisted by recreational director to obtain books of her choice on 2/21/14. Resident #8's activity programming and plan of care was updated by the activity director on 2/21/14 to include routine walks outside as weather permits or throughout the facility.</p>	

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F 248	<p>Continued From page 3</p> <p>her bed. Resident #8 was observed in bed, with the privacy curtain drawn around the foot and right side of her bed on 1/27/14 at 3:15 PM. There was a television mounted from the wall at the foot of her bed. The television was on, although the resident was lying on her side in the fetal position with her eyes closed. Resident #8 stated at that time her past hobbies included gardening and hiking in the [nearby mountains] with her children collecting rocks. Resident #8 stated she did have the opportunity to be outside tending to the facility's garden the previous summer, but did not recall being outside since that time. Other than the TV, no indication of leisure supplies was visible in the resident's area of the room, during any of the surveyor's observations.</p> <p>On 1/28/14 at 3:00 PM, Resident #8 was observed lying in her bed, again with the privacy curtain completely drawn. The television was not on. At that time, there was a music program in progress in the facility's sitting area.</p> <p>On 1/29/14 at 1:40 PM, the resident was observed lying in bed. Her room was dark, with the privacy curtain drawn tightly around the bed. The resident was lying on her back, with her eyes closed. The television was not on. The surveyor asked the resident if she had anything to keep her busy throughout the day. The resident stated, "Not really." The resident indicated she would like to watch television, but did not think she had one. The surveyor pointed out the television. The resident stated, "Oh. Well. I haven't been able to find the remote." The surveyor informed the resident the remote was laying on the overbed table. The resident needed assistance to reach the remote. The resident fumbled with the remote</p>	F 248	<p>2. A review of other resident's activity interests was completed by director of nursing or designee on or before 3/6/14 to ensure that residents were assisted to activities of choice and that their preferences were current. Care plans were updated as indicated, at time of review by members of the interdisciplinary team. Resident council was addressed by recreational director 2/13/14 for activity choices and availab of activities.</p> <p>3. Nursing staff will be educated by director of nursing or designee on or before 3/6/14 to ensure that residents are offered and assisted to activities of their choice and to inform recreational director if the resident expresses desire of an activity that they are not receiving. Recreational director educated by center administrator on or before 3/6/14 to seek assistance from</p>		

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	<p>Continued From page 4</p> <p>for a few minutes, then asked for assistance to turn the television on. The resident was unable to state which program she would prefer to watch at that time.</p> <p>On 1/29/14 at 11:45 AM, the Activity Director (AD) was interviewed regarding Resident #8's activity program. The AD stated the resident would like to come out to do more things, but could not because she was limited by pain. The AD stated the resident's leisure routine consisted of family visits, coming out for music programs, reading, and watching TV. The AD was unable to state why the resident had not been in attendance at the previous day's music program, other than she presumed someone had asked her and she said no. The AD further stated the resident enjoyed "people-watching" from her bed. However, the AD stated the furniture in the resident's room was in a new configuration, and the resident would have difficulty seeing into the hallway given her current bed placement.</p> <p>2. Resident #2 was admitted to the facility on 4/6/12 with multiple diagnoses including pancreatic abnormalities and failure to thrive.</p> <p>Resident #2's change of condition MDS assessment, dated 10/18/13, coded: -BIMS of 15, indicating the resident was cognitively intact. -Music was very important to the resident. -Choice of activities was very important to the resident.</p> <p>Resident #2's Activities care plan documented, "...initiates activities and enjoys listening to music..." as a focus area. However, there were no documented interventions as to how music</p>		<p>other staff members to ensure residents are brought to activities of their choice and to assist residents with needed materials for independent activities as indicated on activity assessment.</p> <p>4. Beginning the week of 3/3/14, Director of Nursing or designee will review 4 residents for activity preference's and programming that meets the residents needs and assistance to activities weekly for 4 weeks and then monthly for 2 months. Results will be reviewed by center performance improvement committee for 3 months. Activity Director will report directly to the Director of Nursing who will be responsible for compliance.</p>	3/7/14

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F 248	<p>Continued From page 5 was to be provided to the resident.</p> <p>On 1/28/14 at 3:10 PM, Resident #2 was observed lying in his bed in his room. There was a music activity in progress in the facility's sitting area. The music could not be heard in Resident #2's room. The resident was watching television when the surveyor entered the room, but turned it off, stating, "This thing (the television) kinda dulls the mind, I think, I'd rather talk to a person any day." The resident was asked about his interest in music. The resident stated, "I don't like the modern stuff. But big band, swing, anything like that I could listen to all day." The surveyor asked if the facility ever had music programs for him to attend. The resident stated, "No. Not that I know about." The resident was asked if he had been informed of the music activity (piano) in progress at that time. The resident stated he had not.</p> <p>On 1/29/14 at 11:25 AM, the AD was interviewed about Resident #2's activity involvement. The AD stated she posted an activities calendar in the resident's room, and the resident would have been welcome to attend the previous day's music activity. The AD stated she was not completely sure the resident had been invited, but stated, "I tell the aides. They should have invited him."</p> <p>On 1/29/14 at 4:30 PM, the Administrator and DNS were informed of the surveyor's concerns. On 2/4/14 the facility sent a fax to BFS with some additional information regarding Resident #8. However, the information did not resolve the concerns.</p> <p>3. Resident #7 was admitted to the facility on 6/14/12, and had diagnoses which included depressive disorder, congestive heart failure, and</p>	F 248		

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F 248	<p>Continued From page 6 chronic airway obstruction.</p> <p>The resident's BIMS Interview Tool, dated 11/7/13 documented a score of 15, cognition intact.</p> <p>The resident's Activity/Recreation Assessment dated 6/20/12, documented: -Admission -Preferred Activity Settings (check all settings in which activities are preferred): "Own Room." -Visual Impairment: "Wears glasses- needs new glasses." -Withdrawn from activities: "Yes, daily." -Reduced social interactions: "Yes, daily." -Interests: Cognitive: Reading, "Nora Roberts, Romance."</p> <p>The resident's IDT (Interdisciplinary Progress Note), completed by the AD dated 6/20/12, documented: -"[Resident's name] chooses to get out of bed at times. Awake some of the time." "[Resident's Name] leisure incl. (includes) activities of choice is in reading (Nora Roberts and Romance). Sister states she will bring iPod in for [resident's name] to listen to books due to her not being able to see well."</p> <p>The resident's IDT completed by the SSD (Social Services Designee), dated 11/15/13, documented: -"She uses bilateral 1/4 side rails for positioning in bed as she doesn't ever get out of bed except for showers....She spends her days lying in bed watching TV all day and into the evening hours, we just gave her a pair of cordless headphones to start using as she does keep her TV quite loud, she thanked me and said 'I'll be glad to use them'.... Vision is impaired, she wears glasses to</p>	F 248		

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F 248	<p>Continued From page 7</p> <p>watch TV but states she doesn't see well enough to read large print."</p> <p>The resident's Care Plan documented: *Focus: "[Resident's name] past occupation was a professional Babysitter. [Resident's name] self initiates activities and enjoys socializing 1:1 with others. Family visits weekly. [Resident's name] finds faith in the Christian Religion and prefers to practice on own. She enjoys Pet Therapy. [Resident's name] enjoys Reading Large Print Items. She likes to write notes. [Resident's name] enjoys watching TV (Old Reruns, Cop Shows, Mysteries and Comedies, she enjoys channel 14 after 4 pm). [Resident's name] enjoys Take Out brought into her. She enjoys grooming and having her nails done." Date Initiated: 6/21/12 Revision on: 8/7/13.</p> <p>*Interventions: -"Help [Resident's name] order her choice of Take Out. -"Provide [Resident's name] with Nail Care." [NOTE: The interventions did not address the resident's choice activity of reading.]</p> <p>On 1/27/13 at 8:00 am, while on Initial Tour of the facility, the surveyor asked the resident if she had enough activities, and she stated, "I love to read. I had books on tape before coming in but had to give the machine back." Was asked if she was offered books on tape/ CD while in the facility, the resident stated, "Well I am not totally blind so I can't get the service."</p> <p>On 1/29/14 at 3:20 pm, the resident was interviewed about enjoying reading, she stated, "[Name of author] is one author I liked. I like romantic type authors." When the resident was</p>	F 248		

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F 248	<p>Continued From page 8</p> <p>asked if books on tape/ CD had ever been offered to her while in the facility, she stated, "I am not blind enough." The resident was asked if it was OK to have the AD come in and get that set up for her, and if she would like that, and she stated, "Yes, (AD name) has tried that before."</p> <p>On 1/29/14 at 1:40 pm, the SSD was interviewed about providing audio books for the resident. She stated, "(AD name) handles that." She was then asked if she would be involved in setting them up for the resident, "I would be involved. She never told me she had books on tape before. I have talked to her many times and told her we have large print books." The surveyor then asked if the SSD had ever told the resident about books on tape, and she stated, "no."</p> <p>On 1/30/14 at 2:05 pm, the AD was interviewed about providing audio books for the resident, and she stated, "I offered her a book on tape and she said her sister was loading an iPod for her. I did tell her I had lots of books in large print, and tried a magnifying glass for a while. I offered books on tape and she did not want it." The AD was asked if she had documentation that showed she had addressed the audio books since the resident's initial admission. The AD left and returned with the initial IDT note from 6/20/12. The report documented the iPod. The AD was asked if she had offered books on tape/CD, and she stated, "I did in the last quarterly assessment, but didn't write it." When the surveyor brought attention to the iPod issue being a year and a half ago, she stated, "I have offered reading material over the year and a half. I have followed up with her sister about the iPod, but she has not brought it in." The AD was told by the surveyor the resident would like the audio books and the resident was aware</p>	F 248		
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F 248	Continued From page 9 the surveyor was going to talk to her about them. On 1/30/14 at 4:00 pm, the Administrator, DON and CNC was notified of the findings. No other information was provided.	F 248			
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility did not ensure resident rooms were decorated in a homelike manner. This was true for 2 of 7 (#s 2 and 8) sampled for homelike settings. The deficient practice had the potential to cause more than minimal psychosocial harm when residents were residing in starkly furnished rooms, or rooms furnished with items not to their liking. Findings included: 1. Resident #8 was admitted to the facility on 3/12/13 with multiple diagnoses which included spinal stenosis, deconditioning with acute back pain secondary to acute L 3 (3rd lumbar vertebrae) endplate compression fracture, and osteopenia to her left hip as well as degenerative changes to bilateral hips, dementia and failure to thrive. Resident #8's 3/19/13 admission MDS	F 252	1. On or before 2/5/14, resident # 8 was interviewed by Social Services Director for personal item preferences and room décor on or before 2/5/14. The family was contacted on or before 2/5/14 by SS Director to bring in the items requested by the resident. A stone table and pictures were brought in by family on 2/24/14. Nursing staff has been re-educated by Director of Nurses or designee on 2/17/14 to not place roommate's oxygen concentrator in her room. Resident #2 decorative fishing items were removed from room on or before 2/5/14 by SS Director and resident has been interviewed for preferred items for his room which facility or family will purchase on or before 3/6/14.	3/7/14	

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F 252	<p>Continued From page 10 assessment coded: Very important for the resident to choose what she wore, take care of her personal belongings, have a family member involved in her care, listen to music she liked, be able to go outside, and participate in religious activities.</p> <p>On 1/27/14 at 3:15 PM, Resident #8 was observed in her room. The decor in her room consisted of a bed, wheelchair, over bed table, portable wardrobe, 1 picture hanging on the wall, and her roommate's oxygen concentrator. The resident stated she would like to have some of her own possessions in the room.</p> <p>On 1/29/14 at 11:45 AM, the AD was asked about the lack of personal possessions in Resident #8's room. The AD stated she had wondered if the resident's family could bring in some of her things, but had never asked.</p> <p>2. Resident #2 was admitted to the facility on 4/6/12 with multiple diagnoses including pancreatic abnormalities and failure to thrive.</p> <p>Resident #2's change of condition MDS assessment, dated 10/18/13, coded a BIMS of 15, indicating the resident was cognitively intact.</p> <p>On 1/28/13 at 3:10 PM, Resident #2 was observed in his room. The decor consisted of a fishing pole with a wooden fish dangling from the line, a picture of some mountains with water in front of them, grandmother clock with fish pendulums, and a bulletin board with small pieces of paper and a car calendar posted. The surveyor asked the resident about his interest in fishing. The resident stated, "I couldn't care less about that. None of that stuff is mine. It was here when I</p>	F 252	<p>2. A review of other resident's rooms to ensure personal home-like items are included in their décor will be completed by SS Designee on or before 3/6/14. It was discussed with residents by recreational director in Resident Council 2/13/14 that residents have the right to a "home-like" environment which includes personal pictures and other personal items. No issues were identified at time of discussion.</p> <p>3. Center staff will be re-educated by Director of Nurses or designee on or before 3/6/14 to ensure that residents are offered the personal choice in room décor and home-like item.</p> <p>4. Beginning the week of 3/03/14 the Director of Nurses or designee will review four residents for personal home-like preferences weekly for four weeks and monthly for two. Results will be reviewed by center Performance Improvement committee for three months. Director of Nurses is responsible for compliance.</p>	3/7/14	

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F 252	Continued From page 11 got here. The only thing in this room that's mine is that calendar over there. I love cars. I have a 1974 Lincoln that I treat like a baby." On 1/29/14 at 11:25 AM, the AD was asked whether or not Resident #2 liked fishing. The AD stated, "He doesn't like fish, he likes cars. That stuff was just in the room when he moved in." On 1/30/14 at 10:45 AM, the SSD was asked about the decor in Resident #2's room. The SSD stated she was aware the resident didn't like fish, but fish were the decorations chosen by the facility. The SSD stated, "He really likes cars." The SSD stated she would contact one of the resident's friends to see if some of his car-related items could be brought in to replace the fish.	F 252		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		3/7/14

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F 280	<p>Continued From page 12</p> <p>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, interview, and record review, it was determined the facility did not update resident care plans to reflect individualized information, or consider resident input. This was true for 2 of 9 residents (#s 6 & 8) sampled for care plan revisions. The deficient practice had the potential to cause more than minimal harm if residents received care based on inaccurate information. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 1/12/11 with multiple diagnoses which included chronic airway obstruction and diabetes. The resident was re-admitted to the facility on 11/15/12 following an out-of-facility placement for depression during which she expressed suicidal ideation.</p> <p>Resident #6's most recent Annual MDS, dated 11/21/13, coded mildly impaired cognition and minimal depression.</p> <p>Resident # 6's care plan documented: *Focus of, "Potential for feelings of sadness, comments she'd be better off dead, nothing to live for...long hx of making suicidal comments." Date initiated 4/18/11. *Goals included: -"Express desire to live and control over own</p>	F 280	<p>1. For resident # 6 the care plan was reviewed by SS Director on or before 2/27/14 to assure inclusions of a plan for staff interventions should the resident verbalize any suicidal ideations and at what point the physician should be notified. Resident #6 was assessed by SS Director on 2/27/14 with no adverse effect noted.</p> <p>For resident #8 the care plan has been reviewed by the IDT for individualized interventions for mood changes and activity preferences, on or before 2/3/14.</p> <p>Resident #8 was assessed for pain by the licensed nurse on 2/19/14. The results of the pain assessment were reviewed by the IDT on 2/19/14 and care plan updated at time of review. Her primary physician will review her pain management regimen on 2/26/14.</p> <p>Resident #8's care plan was updated by the Social services Director and the activities director on 2/3/14 to reflect interventions for mood changes, and current activity preferences. Statements in the care plan of not talking about self and discussing weaknesses have been deleted.</p>	

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F 280	<p>Continued From page 13 fate." Date initiated 4/18/11. -"No comments of wanting to commit suicide thru the next review." Date initiated 8/22/13. *Multiple interventions, including: -"Convey acceptance of resident and provide repeated honest appraisals of resident strengths to resident." Date initiated 4/15/11. -"Realistically discuss residents weaknesses and determine options to improve with resident." Date initiated 4/18/11. -"Resident's physician is aware of her comments about wishing she was dead and not interested in life." Date initiated 7/18/11. -"...will agree to comply with state mandated requirement of participating in...counseling." Date initiated 11/15/12. -"In the event that symptoms occur, treat with non-pharmacological interventions and document." Date initiated 10/7/13.</p> <p>The care plan did not document whether or not the resident had ever verbalized a specific suicide plan. The care plan did not document what steps the staff should take to ensure resident safety should the resident make suicidal comments. While the care plan documented the resident's physician was aware of her history of her comments of wishing she was dead, it did not indicate, should those comments continue or intensify, at what point the physician should be notified again.</p> <p>On 1/30/14 at 10:45 AM, the SSD was asked about Resident #6's care plan. The SSD stated Resident #6 had only verbalized suicidal ideation on one occasion that she knew of while in the facility, and at that time she was sent out for more acute treatment for her depression, and that as far as she knew, the resident never vocalized a</p>	F 280	<p>2. A review of other residents care plans was conducted by Director of Nurses or designee on or before 03/06/14 to ensure that other residents with history of suicidal ideations or who trigger decline in mood state have individualized care plans addressing these issues. Resident care plans will be reviewed and updated on or before 03/06/14 to reflect individualized information and resident input.</p> <p>3. Licensed, activities and social services staff will be re-educated on or before 03/06/14 by Director of Nurses on individualized and accuracy of resident care plans.</p> <p>4. Beginning the week of 3/3/14, resident care plans will be reviewed by the Director of Nurses or designee and IDT to ensure that they are individualized and that they accurately reflect the care and services provided to the resident. This will be done weekly for four weeks, then every month for two months. Results will be reported to the Performance Improvement Committee for three months. Director of Nurses is responsible.</p>	3/7/14

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F 280	<p>Continued From page 14</p> <p>specific suicide plan. The SSD stated if Resident #6 began to engage in those comments again, she would expect the staff to place a 1:1 attendant with the resident. The SSD was asked if this information should be included in Resident #6's care plan. The SSD stated, "Oh. Yes. I see."</p> <p>2. Resident #8 was admitted to the facility on 3/12/13 with multiple diagnoses which included spinal stenosis, deconditioning with acute back pain secondary to acute L 3 (3rd lumbar vertebrae) endplate compression fracture, and osteopenia to her left hip as well as degenerative changes to bilateral hips, dementia and failure to thrive.</p> <p>Resident #8's 3/19/13 admission MDS assessment coded: -Very important for the resident to choose what she wore, take care of her personal belongings, have a family member involved in her care, listen to music she liked, be able to go outside, and participate in religious activities.</p> <p>*Quarterly MDS assessment 10/25/13: -BIMS of 7, indicating severe cognitive impairment; -Mood severity score of 15 (moderate to severe depression); -Occasional pain, which limited day-today activities, with a severity of 8; -Received routine and as needed pain medications, as well as non-medication interventions; -Received an anti-depressant medication daily for the past 7 days; -Received psychological counseling 2 days out of the past 7 days.</p>	F 280		

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F 280	<p>Continued From page 15</p> <p>Resident #8's care plan documented: *Under the focus of, "Feelings of sadness, emptiness anxiety, uneasiness, depression characterized by: ineffective coping, low self esteem, tearfulness, motor agitation, withdrawal from care/activities, loss of independence, related to: DX [diagnosis] depression, started on anti depressant." Date initiated 5/10/13. -Goals were documented as, "Carry on conversation about subject other than self," and "No side effects from anti-depressant use." Date initiated for both goals was 5/10/13. Numerous interventions were documented, including: -"Convey acceptance of resident and provide repeated honest appraisals of residents strengths to resident, " followed by, -"Realistically discuss residents weaknesses and determine options to improve with resident."</p> <p>It was not clear what an, "honest appraisal" of a resident strength was, nor what the staff should "realistically" discuss as the resident's weaknesses, nor what options would indicate improvement over the situation.</p> <p>*Focus, "[Resident #8] was a housewife...self-initiates activities and enjoys reading...TV...Crossword puzzles...socializing with others...has her own cell phone...Friends and Family visit weekly...finds faith in [Denomination] Religion and enjoys pastor visits...Voting Absentee...Pet Visits...grooming herself...gardening...games...music...sing a longs...outings, parties and special events." Date initiated was 3/19/13, revised on 8/12/13. -Goals of, "...will continue to participate in Group Activities of Choice 2 times per week." Date initiated was 3/19/13, revised on 8/12/13. "...will attend formal activities 1 X per month." Date</p>	F 280		
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F 280	<p>Continued From page 16 initiated 3/19/13. -Interventions were, "Assist [Resident #8] to and from Activities until she is familiar with Facility." Date initiated 3/20/13. "Introduce to residents with similar interests." Date initiated 3/19/13. "Remind [Resident #8] when group outings are being held in case they [sic] decide to participate." Date initiated 3/19/13.</p> <p>On 1/29/14 at 8:15 AM, the DNS and SSD were interviewed regarding Resident #8. The SSD was asked about the resident's mood state care plan, particularly the goal for the resident to not talk about herself, and to remind the resident of her weaknesses. The SSD and DNS stated the goal was likely referring to the resident's pain, and the staff were to discourage her from talking solely about her pain. As far as the intervention to remind the resident of her weaknesses, the SSD stated, "That's probably a pre-printed care plan. It may have just been what was printed due to the problem." The SSD was asked if the facility had the ability to individualize a resident's care plan, versus using a pre-printed care plan. The SSD stated, "Yes, but I don't always have time to do that." The SSD was asked if the resident had been involved in the development of the goal for her not to talk about herself, or the intervention of reminding her of her weaknesses. The SSD stated, "No."</p> <p>On 1/29/14 at 11:45 AM, the Activity Director (AD) was interviewed regarding Resident #8's activity program. The AD stated the resident would like to come out to do more things, but could not because she was limited by pain. The AD stated the resident's leisure routine consisted of family visits, coming out for music programs, reading, and watching TV. However, there was no</p>	F 280		

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F 280	Continued From page 17 documentation in Resident #8's care plan reflecting these preferences as her current routine. On 1/30/14 at 3:45 PM, the Administrator and DNS were informed of the surveyor's findings. On 2/4/14 the facility faxed additional information to BFS, but it did not resolve the surveyor's concerns.	F 280		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review, and CMS definition of Pressure Ulcer review, the facility failed to prevent reoccurring pressure ulcers to 1 of 2 residents (5) reviewed for pressure ulcers. This deficient practice caused actual harm to Resident #5, when the facility failed to ensure preventive interventions were implemented to prevent the resident from developing a reoccurring pressure ulcer to her coccyx. The resident developed a Stage 2 pressure ulcer that was identified during the survey to the area of the resident's coccyx where she had a previous Stage 3 pressure ulcer.	F 314		3/7/14

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F 314	<p>Continued From page 18</p> <p>Additionally, the facility failed to ensure preventive interventions that were in the care plan, were being implemented to protect the resident's heels. Findings include:</p> <p>*The CMS "definitions for the stages of pressure ulcers identified below are from the Long-Term Care Facility Resident Assessment Instrument User's manual, Version 3.0."</p> <p>- "Stage I" - An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters"</p> <ol style="list-style-type: none"> 1. Skin Temperature (warmth or coolness); 2. Tissue consistency (firm or boggy); 3. Sensation (pain, itching); and/or 4. A defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. <p>- "Stage II" - Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister.</p> <p>- "Stage III" - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.</p> <p>Resident #5 was originally admitted to the facility on 8/5/13, and readmitted on 9/15/2013 with diagnoses that included, pressure ulcer stage 3, pressure ulcer stage 2, pressure ulcer lower back, unspecified hereditary and idiopathic</p>	F 314	<ol style="list-style-type: none"> 1. For resident #5 her turning schedule and the application of her pressure-relieving boots were re-instated on 2/03/14. Her original wheelchair cushion was replaced with a center-pressure relieving cushion on 2/5/14. Her memory foam overlay was removed and she was placed on an air mattress on 2/14/14. Doctor's orders were reviewed on 2/17/14 concerning the amount of time resident should spend in her w/c. Direct care nursing staff re-educated to encourage change of position q 2 hrs., as noted in Dr.'s orders. Above actions were completed by Director of Nurses or designee. 2. Skin assessments were completed by Director of Nurses or designee on other residents on 2/4/14 and 2/13/14 to identify other residents that may be affected. No other residents were found with pressure areas. 		

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F 314	<p>Continued From page 19 peripheral neuropathy and other specified muscle disorders.</p> <p>The resident's Significant Change MDS (Minimum Data Set), dated 9/22/13, recorded: *BIMS score- 15 Cognition intact *Rejection of Cares- Behavior not exhibited *Bed Mobility- Extensive 2 person physical assist *Toilet Use- Extensive 1 person physical assist *Functional limitation in ROM(Range of Motion)- Lower extremity impairment on both sides *Risk of Pressure Ulcers- Yes *Unhealed Pressure Ulcer-Stage 1 or higher- Yes Stage and number of pressure ulcers -Stage 1 =2, Stage 2=0, Stage 3=1.</p> <p>The resident's Quarterly MDS, dated 12/20/13, recorded: *BIMS score- 13 Cognition intact *Rejection of Cares- Behavior not exhibited *Bed Mobility- Extensive 2 person physical assist *Toilet Use- Extensive 2 person physical assist *Functional limitation in ROM- Lower extremity impairment both sides *Risk of Pressure Ulcers- Yes *Stage and number of pressure ulcers- Zero [NOTE: Pressures sore were recorded as healed on the Quarterly assessment.]</p> <p>The resident's Braden Scale -For Predicting Pressure Sore Risk, dated, 9/15/13, 9/24, 10/1, 10/8, 12/16/13, scored the resident at an 18- mild risk for developing pressure sores.</p> <p>The resident's Doctor orders for January 2014 documented: *Braden Scale assessment. On Admission/Readmission weekly x 4, quarterly and with anticipated decline.</p>	F 314	<p>3. Nursing staff will be re-educated by Director of Nursing or designee on or before 03/06/14, on identifying and notifying licensed staff on skin integrity issues, and following care planned measures and physicians orders related to preventative skin care. Nursing staff will also be re-educated to document refusals and notify MD.</p> <p>A new system of listing residents due for their weekly skin check on the staff's daily assignment sheet was implemented by Director of Nurses on 2/3/14.</p> <p>4. Beginning the week of 3/3/14 the Director of Nurses or designee will review four residents to ensure that skin integrity and pressure ulcer prevention plans are followed per plan of care weekly for four weeks then four residents monthly for two months. Results will be reviewed by PI Committee for three months. Director of Nurses will be responsible.</p>	3/7/14
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F 314	<p>Continued From page 20</p> <ul style="list-style-type: none"> *Pressure reducing mattress to bed. *Encourage res(resident) to change positions Q 2 hr. Every shift Everyday. *Float heels with pillows when in bed. Every shift Everyday. *Pressure redistribution cushion to chair. *Standard convoluted suspension boots to reduce pressure. Every shift Everyday. *Turn Q 2 H (every 2 hours) while in bed. Night hours -Night Shift Everyday. *Weekly skin check by licensed nurse, Y=Skin Intact, N=Skin not Intact. -Day Shift Specific days of the week. Thu. <p>On 1/24/14, the Doctor's orders documented: "Okay to D/C (discontinue) "Float heels or pillows while in bed" as wears convoluted suspension boots to reduce pressure while in bed."</p> <p>The resident's TAR for January 2014 documented:</p> <ul style="list-style-type: none"> *Standard convoluted suspension boots to reduce pressure, every shift everyday. The LN initialed through 1/29 for Day and Night shift. The Evening shift LN initialed through 1/27, and recorded circles around the initial on 1/5, 1/6, 1/7, 1/8, 1/12, 1/13, 1/14, 1/15, 1/19, with no recordings for 1/28 or 1/29. *[NOTE: For 11 of 29 days the documentation provided for the 2 pm to 10 pm shift, recorded the boots were not in place. It was not clarified in the resident's chart whether the resident was up for 8 hours in her wheelchair or in bed without the boots in place.] *Encourage res to change positions Q 2 hrs. Every shift, everyday. The LN initialed every shift, every day of the month, except on Evening shift 1/28 and 1/29 the column was left blank. 	F 314		

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F 314	<p>Continued From page 21</p> <p>*Float heels with pillows when in bed. Every shift, everyday. The LN initialed every shift through 1/23, and night shift initialed on 1/24. On 1/24 the Day and Evening shift column was blank. The column recorded "D/C'd (discontinued) 1/24/14," for the remainder of January.</p> <p>*Turn Q 2 H while in bed -night hours. Night shift, everyday. The LN initialed night shift, everyday of the month through January 29th.</p> <p>*Weekly skin check by license nurse; Y=Skin Intact, N= Skin not intact. Day shift, every Thu (rsday.) The LN recorded on 1/2 "Y," 1/9 "I," 1/16 was initialed, but had not recorded if the skin was Intact or not intact, and 1/23 "I." [NOTE: On 1/2, 1/9, 1/16, and 1/23 the LN's did not identify a concern with the resident's skin, during the skin checks.]</p> <p>The resident's Care Plan recorded:</p> <p>*Focus: Potential for skin breakdown related to: long history of gluteal/coccyx breakdown over the past year. Skin very fragile.</p> <p>*Revision on: 1/6/14.</p> <p>*Interventions:</p> <ul style="list-style-type: none"> - "Apply moisture barrier cream after each incontinence episode." - "Complete Braden skin assessment on admission/readmission weekly x 4, quarterly and with unanticipated decline." - "Elevate heels off of bed with pillow(s)/other floatation devices." - "Assist to turn and reposition as every ___ (sic) hours as needed." - "Pressure reducing/relieving devices as ordered." - "Weekly skin assessment." <p>*Focus: Decreased mobility related to : inability to</p>	F 314		

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F 314	<p>Continued From page 22</p> <p>move independently, Loss of muscle strength r/t (related to) neuropatic (sic) pain in lower extremities.</p> <p>*Revision on: 10/2/13</p> <p>*Interventions: -"Mobility- Independent with electric wheelchair." Revision on: 10/30/13 -"Encourage resident to position self when in bed with use of bilateral assist bars." -"Observe resident for signs of fatigue when sitting in chair." -"Provide and encourage use of pressure redistribution devices." -"Scheduled turning and repositioning. Turn and reposition every 2 hours when in bed laying from r (right) ide(sic) to almost on back, then back to L (left) side. Pressure reducing boots on when in bed, pillows and bedding adjusted for comfort."</p> <p>*Focus: self care deficit change in mobility, loss of muscle strength, physical limitations r/t chair bound, decreased vision, neuropathy, cardiac problems.</p> <p>*Revision on: 10/30/13</p> <p>*Interventions: -"Baths and showers per schedule and PRN (as needed.) Skin check, shower, shampoo hair, nail cares, and lotion PRN." Date Initiated: 8/5/13</p> <p>*Focus: Requires anticoagulant therapy Related to: Atrial Fib *Date initiated: 8/16/13 *Interventions: -"Inspect skin with daily care and observe for bruising."</p> <p>*The resident's Skin Integrity Report for "Sacral area" for initial date 8/5/13, documented: *Anatomical Location: "Sacral Area."</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>*Type of wound: "Pressure," with a note that stated "HX (history) open area x 1 yr (with) wound vac." Not incontinence related, was checked.</p> <p>*The Weekly Data Collection documented:</p> <p>-8/5/13</p> <p>- Pressure Ulcer Stage: "2."</p> <p>- Appearance: "pink- nonblanching fragile granulation."</p> <p>-Length: "2.0" Width: "2.5" Depth "(less than) 0.1 cm."</p> <p>-9/4/13</p> <p>-Pressure Ulcer Stage: "2."</p> <p>-Appearance: In the column was a drawing of a buttocks with a circle on the right cheek.</p> <p>-Length: "2.6" Width: "3.0" Depth: "(less than) 0.1."</p> <p>- 9/15, the day the resident was readmitted to the facility, and documented on the original 8/5 report:</p> <p>-Pressure Ulcer Stage: "3."</p> <p>-Appearance: No assessment was provided.</p> <p>-Length: "1.7" Width: "2.4" Depth: "(approximately) 0.1 cm."</p> <p>*[NOTE: Prior to being discharged to the hospital on 9/8/13 the Stage 2 Pressure Ulcer to the resident's sacral area had increased in length and width, from 8/5 to 9/4.]</p> <p>*A second resident's Skin Integrity Report for "Sacral area" with initial date of 8/15/13, documented:</p> <p>*Type of Wound: "Pressure"</p> <p>*Weekly Data Collection documented:</p> <p>-8/15/13</p> <p>-Pressure Ulcer Stage: Stage "3."</p> <p>-Appearance: "50% G (granulation), 50% N (necrotic)."</p> <p>-Length: "1.7" Width: "2.4" Depth: "(approximately) 0.1 cm (centimeter)." The</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>column included a picture of a round circle with 3 smaller circles inside it.</p> <p>*[NOTE: No further documentation was found on this wound. On the top of the form was written, "see New form for Re-admit."]</p> <p>*The resident's Skin Integrity Report for "Coccyx" with initial date of 9/15/13, documented: *Anatomical Location: "Coccyx" *The Weekly Data Collection documented: - 9/23/13 -Pressure Ulcer Stage: Stage "3." -Appearance: "(greater than) 75% g." -Length: "0.6" Width: "0.4" Depth: "(approximately) 0.1 cm." - 9/30/13 -Appearance: "E (Epithelial) Surround area excoriated." -Length: "5 cm" Width: "3 cm" Depth: "0.1 cm." -11/4 -Appearance: "E/G" -Length: "0.7" Width: "0.5" Depth: "(less than)0.1." -11/11 and 11/19 -Appearance: "H." -Length: "0.0" Width: "0.0" Depth: "0.0." *[NOTE: The first assessment on this form, which was dated as initiated on 9/15, was completed on 9/23. This was 8 days after the resident had been readmitted. The assessment from 9/23 to 9/30 recorded an increase in the length, width and depth of the wound. The wound had an overall increase in length, width and depth from 9/23 to 11/4, prior to the wound being assessed as healed on 11/11.]</p> <p>*The resident's Skin Integrity Report for "Heel" with initial date of 9/15/13, documented: *Type of Wound: Pressure (right) heel.</p>	F 314		

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F 314	<p>Continued From page 25</p> <p>*The Weekly Data Collection documented: - 9/23/13 - Pressure Ulcer Stage: Stage "1." - Appearance: "(greater than) 75 l (intact)." - Length: "3.5" width: "2.3" Depth: "0." - 10/28/13 - Appearance: "I." - Length: "0" Width: "0" Depth: "0" The Report recorded, "Resolved," after the 10/28 assessment. *[NOTE: On 9/23 was the first documentation of the pressure ulcer on the right heel. This was 8 days after the resident was readmitted to the facility.]</p> <p>*The resident's Change of Condition Documentation dated 1/13/14, recorded: -"Res. had her left foot pinned underneath the big left wheel of her electric wheelchair. Res. called out help. I saw the situation & rolled her w/c slightly forward. I freed her left leg and she went about her way. 2 min later, she C/O soreness of her right shin. skin tear measures 1.5 cm x 1.5 cm. Will monitor for s/sx of infection per facility policy. Family has been notified."</p> <p>The resident's IDT (Interdisciplinary Progress Notes) documented: -10/25 "Assessed & redressed buttock area. Area now measuring 0.7 x 6 [crossed out] 0.7 x 0.2, edges pink healthy, (increase) depth is a concern, will continue to assess. -11/11 "Wound review: Coccyx wound is healed. Will cont.(continue) to moniotr x 4 weeks." -12/18 "Skin is closely monitored due to hx pressure ulcers prior to admit, et present upon admit." -12/20 "res. skin is intact. Coccyx & heels are healed. Blanch to touch. No C/O (complaint of) of</p>	F 314			

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F 314	<p>Continued From page 26</p> <p>skin pain. Will CTM (continue to monitor.) -12/29 "She is frequently incontinent of bowel and does use the toilet at her request, but does not always feel when she needs to defacate due to neuropathy." "Skin is intact, and pressure relieving devices are used to protect skin. She is on a turning and repositioning program."</p> <p>The following observations were made by the surveyor:</p> <p>*On 1/27 at 1:42 and 2:22 pm, the resident was asleep in bed, lying flat on her back with bilateral feet on the bed. Protective boots were not in place.</p> <p>*On 1/28 at 1:25 pm, the resident was awake in bed lying slightly on the right side, bilateral feet directly on the bed. Protective boots were not in place. When asked about the sores on her back, she stated, "it's a bed sore." When asked if it was getting better the resident stated, "One healed up, and the other one opened up at the hospital." She was asked about her feet being directly on the bed and does the facility use any protection for her. The resident replied, "I have these rubber boots at night." When asked about her mattress, she stated "Yeh it does all kinds of stuff." The resident was observed to have a memory foam overlay on top of the facility mattress along with a Chenille bedspread. The resident was laying on top of the Chenille bedspread. When asked about the memory foam, she stated "I brought it with me. I love it. I have had seven back surgeries."</p> <p>*On 1/28 at 3:07 pm, the resident was asleep in bed slightly on the right side, feet directly on the bed. Protective boots were not in place.</p>	F 314		
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F 314	<p>Continued From page 27</p> <p>*On 1/28 at 4:05 pm, the resident was up in her electric wheelchair propelling down the hall to her room.</p> <p>*On 1/28 at 5:08 pm, 5:15 pm, and 6:07 pm, the resident was in her electric wheelchair at her table in the dining room.</p> <p>*On 1/28 at 6:24 pm, the resident was in her electric wheelchair in her room. The resident was asked what time she liked to go to bed, she stated "I like to go to bed about 7:00 pm. I went to bed early last night. I have to stay up for 30 minutes after eating." When asked if she had problems with getting help, the resident stated "No, I think they do pretty well. They are under handed. They wake me up at 6 for a shower. I have a shower on Monday and Thursday, that girl gives the nicest shower."</p> <p>*On 1/28 at 7:02 pm, the resident was up in her electric wheelchair in her room.</p> <p>*On 1/28 at 7:33 pm, the resident was up in her electric wheelchair in her room. When she was asked if they put the boots on her feet when she was in bed, she stated "Yes they put them on at night." When asked if they ever put them on during the day, she stated "No because I am up and down so much." The resident stated the boots were in the closet and went to the closet to show them to the surveyor. The resident was not able to find the boots in the closet.</p> <p>*On 1/28 at 7:52 pm, the resident was propelling herself down the hall to the medication cart. The resident stated, "I am going to get my pills." A staff member standing nearby stated, "It will probably be at 8:00 pm, (LN name) is getting a</p>	F 314		

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F 314	<p>Continued From page 28</p> <p>bite to eat." The resident was asked by the surveyor if she was ready to go to bed, she replied "I am always ready for bed. I get up at 6." The resident propelled herself towards her room and stated, "I'll turn my light on." At 7:57 pm, the resident went into her room. CNA #1 passed by the resident's room, looked in and kept going. [NOTE: The resident had been up in her electric wheelchair for 3 hours and 52 minutes.]</p> <p>*On 1/29 at 9:40 and 10:51 am, the resident was in her bed asleep, bilateral feet were directly on the bed. Protective boots were not in place.</p> <p>*On 1/29 at 10:58 am, CNA #2 and CNA #3 were getting the resident up from bed to her electric wheel chair. A pillow was taken from under her lower extremities, the resident stated "take off them beautiful boots." CNA #2 stated, "oh no you don't need those til tonight." While moving the resident from side-to-side to place the Hoyer lift pad the resident stated, "it hurts so bad." The resident was asked what hurt, and she stated "it's a bed sore, the right one, trying to get it healed up for a year, comes back for no reason. Today it's really hurting." When CNA #2 was asked about the use of the boots and where they were, she stated "In the top of her closet. They put them on at night. Evening shift puts them on at night. I usually put a pillow under them to elevate them."</p> <p>*On 1/29 at 1:00 pm, SCLN was interviewed concerning the resident's pressure ulcers, he stated "it is resolved right now. It was on her coccyx and her feet." The SCLN stated he uses a Skin Integrity Report to document skin issues. When asked what preventive measures were currently in place he stated, "turn every 2 hours, gets up, has a pressure relieving pad in bed and</p>	F 314			

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F 314	Continued From page 29 chair. The shower aide comes to me whenever they spot anything new." When asked about prevention for the resident's feet, he stated "she does have boots, it's up to her whether she wants them on or off. We try to float her heels." When asked if the boots were to be used during the day, he replied "whenever she is in bed." When asked about her previous pressure sores, he stated "I believe she got them when she got here. I took over in September, July, not sure if she came here with them. "The MDS Coordinator was standing nearby, she stated "she came in with them from (Facility name.)" On 1/29 at 1:25 pm, the surveyor went with the SCLN to observe the resident's skin. The residents bilateral feet were directly on the bed, blue boots were not in place. While the SCLN was removing the resident's socks he asked her about the boots, she stated "sometimes they do, sometimes they don't." Upon moving the socks the right heel was clear. The left inner heel, into the back of the heel, was observed to have an area the skin was peeling from and was surrounded by a darker area. The SCLN started to pull the raised skin and stated, "is that tape." When asked what he would call the area, he stated, "I'd call it a stage 2." The SCLN left the room to get a tape measure. The resident was asked by the surveyor if she minded having the boots on, and she stated "No." At 1:30 pm the SCLN returned to the room and measured the area. The length was 4 cm, the width was 5.3 cm and depth was 0. The SCLN then placed a pillow under the resident's lower legs. The surveyor suggested the protective boots be placed on her feet. The resident agreed to the placement of the boots and they were placed on the resident's feet. The surveyor asked to observe the coccyx area.	F 314			

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F 314	<p>Continued From page 30</p> <p>The SCLN rolled the resident up onto her left side, toward himself, and pulled down her brief. The resident was incontinent of stool. The SCLN got CNA #2 in to assist in cares. When the resident was cleaned the coccyx area was assessed to have a red, round, open area to the scar tissue of the coccyx. CNA #2 stated, "It use to be worse, it is getting smaller. When she goes on the commode and we spread the area, it comes open. When we use the bedpan it gets better." CNA #2 was asked when she had noticed the area now presently open and she stated, "Yesterday morning. They know the bathroom situation with her. Throughout the whole 2 weeks I have told the DON, SCLN and (named several other staff)." When asked if she had told anyone about the current open area to the coccyx, she stated, "That one, no." The SCLN was asked if he was going to measure the open area, and he stated "I can't even see it from this side." With the assistance of CNA #2, the SCLN assessed the wound, and stated, "tiny, tiny red spot, .3 x .3 is what I am getting, over old scar tissue." The SCLN was asked whether the mattress the resident had on her bed was pressure reducing or pressure relieving, and he stated "pressure reducing mattress." When asked about the top overlay on the bed, he stated "that's just memory foam."</p> <p>[NOTE: -This is the first the SCLN was aware of the Stage 2 Pressure Ulcer to the coccyx, and the undetermined area to the left heel. -The previous night, 1/28, the resident was observed sitting up in her electric wheelchair for 3 hours and 52 minutes. -The CNA #2 had observed the open area to the coccyx on 1/28, and had not reported the concern to staff.]</p>	F 314		

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F 314	Continued From page 31 The Skin Integrity Report with an initial date of 1/28/14, documented: *IHA: In House Acquired. *Anatomical Location: The figure recorded a circle to the coccyx area. *Type of Wound: "Skin Tear." *The Weekly Data Collection documented: -1/29/14 -Pressure Ulcer Stage: "0." -Appearance: Column was left blank. -Length: "0.3 cm" Width: "0.3 cm" Depth: Column was left blank. -Drainage: "NA." -Surrounding Tissue: "H." -Wound Edges: "H." -Odor: "no." [NOTE: The Skin Champion LN #4 (SCLN), identified by the facility as the skin nurse, did not identify the round, open area to the scarred tissue of the resident's coccyx as a Stage 2 pressure ulcer. Refer to the CMS description of a Stage 2 Pressure Ulcer.] A second Skin Integrity Report for the resident with an initial date of 1/28/14, documented: *IHA (In House Acquired) *Anatomical Location: The figure recorded a circle to the area of the back of the left heel. *Type of wound: "Other: Bruise." *The Weekly Data documented: -1/29/14: -Pressure Ulcer Stage: "SDTI (Suspected Deep Tissue Injury)." -Appearance: "IP/ 25% (Intact deep purple), I/ 75%" -Length: "4 cm" Width: "5.3 cm" depth: "0." -Drainage: "NA." -Surrounding Tissue: "H." -Wound Edges: "H."	F 314		

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F 314	<p>Continued From page 32</p> <p>-Odor: "no."</p> <p>[NOTE: -The resident had an incident on 1/13 with the left heel pinned under her electric wheelchair wheel. This was documentd on the resident's "Change of Condition" report dated, 1/13/14.</p> <p>-This was the first documentation of a bruise to the resident's left heel. When the area was identified on 1/29, with the surveyor in attendance, the SCLN described it as a "Stage 2".]</p> <p>On 1/29 at 2:20 pm the DON and CNC was interviewed about the concerns of the resident's skin. When asked about the memory foam on the bed and it's pressure relieving properties, the DON stated "she had it on admission, it was her choice." The DON asked if the resident had been observed on her side very much, and stated "because that was our agreement." The CNC stated the Resident had been to the Emergency Room on 1//24 and had a skin assessment on Monday 1/27 and her "skin was fine." The CNC was asked about documentation for the pressure relieving properties of the memory foam overlay, she stated she did not have any to provide but would work on getting it.</p> <p>On 1/29 at 4:00 pm, while discussing the skin concerns with the DON, CNC and LN #5, LN #5 stated "a week ago there was a faint little area that went away, to the left inner heel. My CNA's told me she didn't want to wear the boots. I told them no, she has to, and she has been wearing them on my shift."</p> <p>On 1/30 at 10:00 am, the facility's MD (Medical Director) came to talk to the surveyors about the concerns with the resident's left heel. The MD</p>	F 314		

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F 314	<p>Continued From page 33</p> <p>confirmed the resident was high risk for skin issues related to vascular and arterial problems. He stated that when he is in the building the resident is always up in her chair. He stated he would have more concerns for the resident when she was in her wheelchair than in bed. The surveyor explained to the MD the observations of the resident being in bed between meals, without the preventive boots in place, and her feet directly on the bed. The MD stated, "hum ok." The surveyor then stated the resident is also on antibiotics and not feeling well, maybe she is in bed more than usual and the preventive measures would be important, he stated "that is true."</p> <p>The resident's Physician Progress Notes dated 1/30/14, recorded: "Patient has several issues I was asked to address today. She has skin changes to a localized area on the inner post aspect of her (left) heel. She is at risk from multiple factor Neuropathy (hx spinal stenosis / foot drop, she has mild/mod chronic edema & has risk for PVD (Peripheral Vascular Disease) (80 year smoker hx). She has aprox. 4 cm area (with) surrounding resolving callous (with) some deep erythema/ ecchymosis. This looks to me to be traumatic and likely achieved when she got tangled up in her w/c."</p> <p>The resident was harmed when the facility failed to implement interventions to prevent the reoccurrence of a pressure ulcer to the resident's coccyx area.</p> <ul style="list-style-type: none"> - The resident's memory foam overlay, on top of her pressure reducing mattress, was not assessed for pressure relieving properties. -The resident was observed to be up in her 	F 314		

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F 314	<p>Continued From page 34</p> <p>electric wheelchair for longer periods of time than the MD had ordered.</p> <p>-The resident had MD orders and a care plan for protective boots to be in place while in bed. On 1/27, 1/28 and 1/29 observations were made with the resident in bed without the protective boots on.</p> <p>-On 1/29 at 1:35 pm, the surveyor requested the SCLN to perform an assessment of the resident's skin, with the surveyor in attendance. The resident had a new, previously-unidentified Stage 2 pressure ulcer to the coccyx area, where she had a previous Stage 3 pressure ulcer.</p> <p>-The resident's left heel had a new, previously-unidentified area that the SCLN identified as a Stage 2 pressure ulcer, during the observation.</p> <p>On 1/30/14 at 4:00 pm, the Administrator, DON, and CNC were informed of the findings. No additional information was provided at this time.</p> <p>On 1/31/14 at 12:00 pm, after the Exit conference, the DON was asked to provide the pressure relieving information on the electric wheelchair. She stated she would fax it to the office.</p> <p>On 2/3 at 5:00 pm, a fax was received from the DON and documented:</p> <p>"She agreed to continue to remain in bed for pressure relief after breakfast and lunch. On the morning of 1/28/14 with the surveyor in attendance, she presented with a 3 mm open area in the crease of her coccyx which we immediately requested orders for treatment." [NOTE: The CNA #2 stated the open area was observed by her the day before.</p>	F 314		

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F 314	<p>Continued From page 35</p> <p>-The time of the observation was on 1/29 at 1:35 in the afternoon.]</p> <p>"Resident #5 had come to us with a 2" foam overlay with a washable cover that she requested to keep on her bed. It was clean and in good repair. I am continuing to investigate the quality of the pad. The surveyors also had questions about the quality of her w/c cushion. The cushion is custom made for her electric chair from the (name of the store), made by (name of Company.) When the cushion cover is being washed we use one of our (name of company) cushions in her w/c."</p> <p>[NOTE: -The resident had been in the facility approximately 5 months and the facility had not verified the pressure relieving properties of the memory foam overlay.</p> <p>-The facility failed to provide the pressure relieving properties of the resident's electric wheel chair."]</p> <p>"And regretfully she presented to the survey team without her foam boots in place on the first mornings of the visit. There had been some miscommunication concerning the boots with the nursing staff responsible for her care. However, we feel the absence of her boots did not contribute to the worsening of her heel bruise."</p> <p>[NOTE: -The resident was observed in bed without the preventive boots in place on 1/27, 1/28, and 1/29 at varying times both in the morning and afternoon.</p> <p>-The "heel bruise" was not identified by the facility until the 3rd day of the survey when the boots had not been implemented and the surveyor had concerns of the condition of resident's heels. At that time the SCLN was asked to assess the resident's skin, with the surveyor present.]</p>	F 314		

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F 328 SS=D	<p>The additional information did not resolve the issues with the resident's skin.</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure residents were provided with oxygen therapy per physician's orders. This was true for 3 of 5 residents (#s 4, 5, and 6) sampled for oxygen therapy. The deficient practice had the potential to cause more than minimal harm if residents experienced respiratory distress when their oxygen companions were either empty or turned off. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 12/30/11 with multiple diagnoses including cerebrovascular accident (CVA).</p> <p>Resident #4's Active Orders (Recapitulation Orders) for January 2014 documented the</p>	F 328		3/7/14	

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F 328	<p>Continued From page 37</p> <p>resident was to receive oxygen 2 liters continuous.</p> <p>On 1/28/14 at 5:40 PM, Resident #4 was observed sitting in her wheelchair in the alcove in front of her room. She had oxygen tubing in her nose, which was attached to an portable oxygen tank at the back of her chair. When the surveyor checked, it was determined the portable tank was empty. At 5:46 PM, the DNS was alerted to the surveyor's observation. As the surveyors and DNS approached the resident, she was noted with rapid, shallow breathing. The surveyor counted the resident's respirations at 32 per minute. The resident was having difficulty holding her head up. At 5:49 PM, the DNS checked Resident #4's oxygen saturations, and reported they were at 88 percent. The resident's portable tank was filled and returned to her, after which her saturations increased to 92 percent. The resident lifted her head and began to look around.</p> <p>2. Resident #6 was admitted to the facility on 11/15/12 with multiple diagnoses including chronic airway obstruction and dependence on supplemental oxygen.</p> <p>Resident #6's Active Orders (Recapitulation Orders) for January 2014 documented the resident was to receive oxygen at a rate of 3 liters per minute continuously.</p> <p>On 1/28/14 at 6:00 PM, Resident #6 was observed leaving the main dining room. The resident reported she felt short of breath. The DNS approached, checked the resident's portable oxygen tank, and discovered it was not set to the appropriate setting. Resident #6's respirations were 32, and her oxygen saturations 90 - 91</p>	F 328	<p>1. Resident #4's oxygen tank was filled and her oxygen saturation was checked by Director of Nurses at time of finding. No adverse effects noted at time of checking saturations.</p> <p>For resident #5 licensed nurse immediately checked her saturation level for normal levels and returned her oxygen levels to the appropriate flow at time of finding. No adverse effects noted at time of checking saturations.</p> <p>For resident #6 her oxygen orders were immediately checked to determine the correct flow and her tank was adjusted to the appropriate setting by Director of Nurses at time of finding. Licensed nurse verified that her saturation level was within normal limits on at time of finding.</p> <p>2. Residents on oxygen therapy will be reviewed by the Director of Nursing or designee on 2/21/14 to ensure that oxygen flow rates are set per physician orders and that portable oxygen tanks are filled.</p>	

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F 328	<p>Continued From page 38</p> <p>percent. The DNS left to check the resident's record to determine the correct liter flow, returned at 6:03 PM, and turned the setting on the tank to 3 liters per minute.</p> <p>3. Resident #5 was readmitted to the facility on 9/15/13, with diagnoses that included, pneumonia, atrial fibrillation, and obstructive sleep apnea.</p> <p>*The resident's Significant Change MDS, dated 9/22/13, recorded: -BIMS score- 15 Cognition intact -Special Treatments, Procedures, and Programs- Oxygen therapy.</p> <p>The resident's January, 2014, Physicians Orders, documented: - "Oxygen at 2 liters via nasal cannula continuous- Every Shift Everyday" with an order date and start date 9/15/13.</p> <p>The resident's Care Plan recorded: *Focus: Altered Respiratory Status: Sleep Apnea requiring bi-pap when in bed, and has hx (history) of chronic O2 (oxygen) dependency. Date initiated: 8/9/2013. Revision on: 9/25/13. *Interventions: -"Educate resident on not increasing oxygen." -"Provide oxygen as ordered @ 2lnc (2 liters per nasal cannula.)"</p> <p>The resident's TAR (Treatment Administration Record) for January, recorded: -Oxygen at 2 liters via nasal cannula continuous. Start Date: 9/15/2013 Every shift Everyday. The LN initialed all three shifts through 1/29, except the Evening LN on 1/28 and 1/29, the column</p>	F 328	<p>3. Nursing staff will be re-educated by Director of Nurses or designee per oxygen companion refill procedure, and ensuring that physician orders for oxygen flow rates are followed on or before 2/21/14.</p> <p>4. Beginning the week of 03/03/14 the Director of Nursing or designee will review four residents for oxygen companions to assure that they are set at the appropriate liter flow and that they have oxygen in them. The concentrators will be checked to be sure they are turned on to the correct liter flow. Weekly x four then monthly x two. Results will be reported to the PI Committee for three months. Director of Nurses will be responsible.</p>	3/7/14

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F 328	Continued From page 39 was left blank. On 1/28/14 at 6:07 pm, the resident was sitting in her electric wheelchair at the table in the dining room. The resident's oxygen companion was set at 2 liters and the resident had her oxygen cannula in place. The gauge indicated the amount of oxygen in the tank was at 0. The surveyor brought it to the attention of CNA #1. CNA #1 and LN #5 verified the tank was empty. CNA #1 took the tank to fill it. The surveyor asked the resident if she was short of breath, the resident replied, "No, not any more than usual." LN #5 was asked to obtain an oxygen saturation. The oxygen saturation was 91%. At 6:12 pm, CNA #1 returned with the filled oxygen companion. CNA #1 left the room prior to turning the oxygen on. At 6:14 pm, CNA #1 and LN #5 returned to the resident and turned on the resident's oxygen. The CNA was asked what the process was for filling the tanks, and she stated, "We have an oxygen room that we take them to and fill them." CNA #1 was asked if the CNA's were responsible for filling them and she replied, "yes."	F 328			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced	F 332		3/7/14	

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F 332	<p>Continued From page 40</p> <p>by: Based on observation, record review, resident interview and staff interview it was determined the facility failed to ensure 2 random residents (#12, #13) were free from medication errors. The deficient practice had the potential to cause more than minimal harm when Resident #12 was given the wrong strength eye medication, and Resident #13 did not get an ordered medication as a result of not being told that the water she was given had medication in it. The facility's medication error rate was 7.4%. Findings included:</p> <p>1. Resident #12's Physician orders dated January 2014, documented: -Refresh (Polyvinyl Alcohol - Povidone (ophth) (almic) 1-1% Solution Ophthalmic - Three times a day. Every day. 2 drops OU (both eyes).</p> <p>On 1/29/14 at 8:27 am, LN#4 was observed administering eyes drops to the resident. The medication administered was: -Refresh Plus o/s (Optive Sensitive) (UD) (unit dose) 0.5% drops. Instill 2 drops into both eyes three times a day.</p> <p>On 1/29/14 at 11:00 am, after the surveyor had completed the medication reconciliation of the resident's chart, LN#4 was asked about the eye drops given. LN#4 verified the strength of the eye drops, and the medication error.</p> <p>2. Resident #13 had Physician orders dated January 2014, that documented: -MiraLax (Polyethylene Glycol 3350) 17 grams powder by mouth (oral) - daily. Everyday: Mix with 8 ounces liquid. Constipation.</p> <p>On 1/29/14 at 8:50 am, LN#7 was observed</p>	F 332	<p>1. For resident #12, no adverse reactions to medication error were noted by director of nursing at time of finding. MD notified at time of finding and new order requested. New order received on or before 2/25/14.</p> <p>On 2/4/14 Resident #13 was assessed by licensed nurse related to her ability to self-administer medication and was found to be safe. For resident #13, Director of Nurses requested and received order for self-administration of medication on 2/4/14. Resident's bowel record was reviewed by director of nursing or designee on or before 2/27/14 with no adverse reaction noted.</p> <p>Identified LNs were included in re-educated of nursing staff on the 5 rights of medication administration by Nurse Practice Educator on 2/7/14 and provided a return demonstration.</p> <p>2. Residents who have a physician order for eye drops were reviewed by the Director of Nursing on or before 3/7/14 to ensure that the medication on hand was the same dosage as the physician order.</p>		

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F 332	Continued From page 41 mixing the MiraLax in tap water for the resident. Upon entering the resident's room with the medication the resident was eating her breakfast. LN#7 handed the resident the pill cup with her morning medications and gave her the medicated water to drink. After swallowing the pills with a small drink of the water the resident handed the cup back to the LN#7. LN#7 asked, "You are not going to drink anymore?" The resident replied, "I will drink off of my tray." LN#7 took the remainder of the medicated water and dumped it in the sink and left the room. When LN#7 was asked if she told the resident there was medication in the water, she replied, "She knows it's her medication." NOTE: The resident had a cup of juice on her breakfast tray. On 1/29/14 at 9:04 am, the resident was asked by the surveyor if she realized the water had her MiraLax in it, she replied, "No, usually I ask her if it is loaded. I didn't today. I don't always take it." The resident was asked if she would have drank it today if she knew it was her medication, the resident gestured "yes" by shaking her head. On 1/30/14 at 4:00 pm, the Administrator, DON and CNC were informed of the findings. No additional information was provided.	F 332	A review of other residents receiving water mixed bowel care was reviewed by the director of nursing or designee on or before 3/7/14 for wishes to self-administer if deemed safe and appropriate. Orders requested as indicated at time of review. 3. Licensed staff will be re-educated on or before 03/06/14 by Director of Nurses or designee, regarding medication administration protocol. 4. Med Pass Competency will be completed on licensed staff on or before 3/6/14 by Nurse Practice Educator. Results will be reported to the PI Committee for three months. Director of Nurses will be responsible for compliance.		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		3/7/14	

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F 431	<p>Continued From page 42 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, staff interview and record review it was determined the facility failed to ensure: *Resident medication dispensing cards were accurately labeled, *Medication Administration Record (MARs) reflected discontinued (D/C'd) physician orders, and *Medication stored in the Emergency Kit (E KIT) and in the refrigerator were labeled accurately,</p>	F 431		

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F 431	<p>Continued From page 43</p> <p>This was true for 2 random residents (#11, #15), and medications that were stored in the medication refrigerator. The deficient practice had the potential to cause more than minimal harm with the possibility for Resident #11 to receive medications inaccurately and that had been D/C'd by the physician. Findings include:</p> <p>1. Resident #11 had Physician orders for January 2014, that documented: -Lactobacillus Extra Strength, 1 capsule by mouth every day, -Tramadol HCL 50 mg (milligram) tab[let] by mouth twice a day, -Mandelamine 500 mg every day.</p> <p>The resident had a Physician order dated 1/28/14, which documented: - "D/C meth- (illegible)." The order was initialed by an LN on 1/28/14.</p> <p>The resident's Medication cards were labeled: -BACID 1B - 250mg Tablet. Take 1 to 2 tablets by mouth every day. NOTE: This medication is the same as the Lactobacillus. -Tramadol HCL 50 mg tablet. Give 1 tab by mouth twice daily and give 1 tab by mouth three times daily as needed for pain.</p> <p>During the medication pass observation on 1/29/14 at 8:00 am, LN#7 was dispensing medications for Resident #11. LN#7 stated, "The Mandelamine is not here today. I will investigate that."</p> <p>On 1/29/14 at 11:10 am, LN#7 was asked what she found out about the Mandelamine, and she stated, "It was D/C'd last night and the nurse did not yellow it out on the MAR." The DON was</p>	F 431	<p>1. For resident #11, the medication order for Mandelamine was discontinued on or before 2/1/14 from the MAR by licensed nurse.</p> <p>For resident #11, her mislabeled medication card was identified by the appropriate sticker to refer to chart for correct dispensing directions by the Director of Nurses at time of finding. On 2/19/14 the refill cards have the correct instructions on them.</p> <p>There was (is) no resident #15 on the Resident ID list.</p> <p>The Emergency Kit medications have been replaced with correct labeling by the Director of Nurses on 2/17/14.</p> <p>2. Director of Nurses will review medication cards as compared to the resident's current orders to identify other residents who may be affected on or before 03/06/14.</p> <p>The emergency kit medications were reviewed by the consultant pharmacist on 2/18/14 with no concerns noted.</p>	

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F 431	<p>Continued From page 44</p> <p>standing nearby and was asked what process the facility had for putting the dispensing cards in the medication carts, the DON stated, "We get a daily delivery. The evening nurse checks them. They are usually delivered around 6:00 or 7:00 pm." The medication dispensing cards with the labeling issues were shown to the DON. She stated, "Well that's weird." The LN had marked off the inaccurate labeling of the card. The DON told LN#7, "You can not mark through labeling," and handed it back to LN#7 to get new labels.</p> <p>2. On 1/29/14 at 11:40 am, while checking medication dates in the Medication Refrigerator the following labeling inaccuracies were observed:</p> <p>*E KIT -Novolin R (regular) 100 u (unit)/ ml (milliliter). The package the medication was stored in, read: Exp. (expires) 12/17/13 or see pkg (package). The vial inside the package, read: Exp. 9/2014. -Humalog 100u/ ml. The package the medication was stored in, read: Exp. 12/27/13 or see pkg. The vial inside the package, read; Exp. 5/15. -Novolog 70/30 ml/ unit. The package the medication was stored in, read: Exp. 12/27/13 or see pkg. The vial inside the package, read: Exp. 2/14.</p> <p>*A medication for Resident #15 which was labeled: -Fluticasone propionate 120 metered Give 1 spray every day. The package the medication was in, read: Exp. 12/30/14. The medication in the package, read: Exp. 7/15.</p> <p>On 1/30/14 at 4:00 pm the Administrator, DON,</p>	F 431	<p>3. Licensed staff will be re-educated on or before 03/06/14 by Director of Nurses or designee as to the process in avoiding altering of medication card labels and using the appropriate stickers in notifying staff as to discrepancies. Re-education will also include assuring expiration dates on labels and vials are matching.</p> <p>4. Beginning the week of 3/3/14, four resident's meds will be reviewed to ensure that they are labeled accurately and the emergency kit will be checked for expired medications by the Director of nursing or designee weekly for one month then monthly for two months. Results will be reported to the PI Committee for three months. Director of Nurses will be responsible.</p>	3/7/14

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F 431	Continued From page 45 and CNC were notified of the findings. On 2/3/14 at 7:05 pm, a fax was received from the facility. The fax was a letter from the Senior Director, Pharmacy Service, of the facility's corporate office quoting the Board of Pharmacy Rules of another state. The information did not resolve the issue.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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	F 441		3/7/14

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F 441	<p>Continued From page 46</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, it was determined the facility failed to ensure: *Clean linen were not stored near soiled linen; *Staff washed their hands or changed gloves when their hands were soiled; and, *There was a system in place to maintain documentation of staff with communicable infections or open skin lesions.</p> <p>This had the potential to affect most of the residents in the facility including 9 of 9 sampled residents (#1- 9). Failing to ensure the separation of clean and soiled laundry and the washing of hands after staff came in contact with bodily fluids, placed the residents at risk for the spread of infections. Additionally, the facility was not tracking staff illnesses. Findings included:</p> <p>The facility's Infection Control Policies and Procedures, documented, in part:</p> <p>*Policy Title: Linen Handling: -Policy: "All linen will be handled, stored, transported, and processed to contain and minimize exposure to waste products." -Purpose: "To provide effective containment and</p>	F 441		
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F 441	<p>Continued From page 47</p> <p>reduce potential for cross-contamination from soiled linen."</p> <p>-Process:</p> <p>1. Maintain clean linen in a closed storage area.</p> <p>1.1 Keep clean linen covered.</p> <p>7.4 Place soiled linen directly in covered container at the location where removing linen. Water soluble bags are not necessary.</p> <p>8. Maintain appropriate, adequate system for containing soiled linen.</p> <p>8.4 Do not place any loose linen in the laundry chute. All linen must be bagged.</p> <p>*Policy Title: Hand Hygiene</p> <p>-Policy: "Adherence to hand hygiene practices is maintained by all Center personnel. This includes washing with soap and water when hands are visibly soiled and the use of alcohol based hand rubs for routine decontaminating in clinical situations.</p> <p>-Purpose: "To improve hand hygiene practices and reduce the transmission of pathogenic microorganisms.</p> <p>-Process:</p> <p>1. Wash hands with soap and water in the following situations:</p> <p>1.1 After removing gloves or other personal protective equipment (PPE);</p> <p>1.2 Before and after direct patient care;</p> <p>1.3 Immediately after contact with blood, body fluids, or other potentially infectious materials;</p> <p>1. On 1/30/14 at 10:20 am, while on the Environmental tour with the Maintenance Director, the laundry room was observed. In the washing machine room there were 2 large blue containers with lids closed. The container on the right had an opened clear bag on the top of it. There were visibly soiled red cloth napkins in the</p>	F 441	<p>1. The clean and dirty linens were separated and placed in their appropriate areas to avoid cross-contamination from soiled linens on or before 2/1/14 by laundry supervisor and laundry staff.</p> <p>Resident #5 was assessed by LN on 3/3/14 for adverse effects related to LN not changing gloves. No signs or symptoms of adverse effects were noted at time of assessment.</p> <p>LN#7 was immediately re-educated as to the appropriated procedure for hand-washing by Nurse Practice Educator at time of finding.</p> <p>The Staff Tracking System for maintaining documentation of staff with communicable infections or open skin lesions was put into place 2/27/14 by Nurse Practice Educator. A review of the last 30 days of staff call-ins was completed by the director of nursing or designee by 3/7/14 to track communicable infections or open lesions.</p>		

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F 441	<p>Continued From page 48</p> <p>bag, on top of the bag, to the side of the bag and underneath the bag. On the right, beside this container was a basket of clean wet items which included: resident gowns, sheets, and towels which had been removed from the washer, and was to the right of the basket. The basket of clean laundry was not covered. When the Laundry Employee (LE#8) was asked about the napkins, she stated, "The kitchen staff brings them in off the tables, sometimes the residents' are not all done. So they bring them down loose and put them on the top, unbagged." LE#8 gathered up the loose linen, put them in the bag, covered the wet linen and took them to the dryer area.</p> <p>On 1/30/14 at 3:10 pm, the Housekeeping Manager was interviewed about the linen. The surveyor explained the observation to her and she stated, "The clean linen shouldn't be in with the dirty. That is not appropriate."</p> <p>2. On 1/29/14 at 1:25 pm, LN #7 was observed assessing Resident #5. LN#7 rolled the resident onto her left side towards the LN and reached over the resident's side, pulled her brief and pants down her buttocks, exposing the buttocks. The resident was incontinent of stool. The LN pulled the brief and pants up with the soiled gloves, then straightened the resident's pillow and blankets. The LN#7 was asked about changing the soiled gloves, and the LN stated, "Absolutely," and took off the gloves and washed his hands.</p> <p>3. On 1/30/14 at 2:30 pm, the Infection Control designee (LN#10), was interviewed about the monitoring of employees with infectious diseases/wounds/infective skin lesions. LN#10 stated, she did not have a policy or tracking</p>	F 441	<p>2. A review of residents requiring antibiotics in the last 30 days was completed by the infection control nurse on 2/27/14. No indicators of residents receiving infections from staff cross- contamination was noted.</p> <p>3. Hand washing competencies will be accomplished for resident care-givers on or before 03/06/14 by Nurse Practice Educator. Laundry staff were re-educated on or by laundry supervisor at time of finding. The Staff Tracking System was initiated on 2/27/14 and appropriate staff will be orientated to it by Nurse Practice Educator.</p>	

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F 441	Continued From page 49 system for the staff, "(DON's name) may have that." On 1/30/14 at 3:00 pm, the DON was interviewed about monitoring and tracking employees, "If we do I don't know anything about that." The DON further stated, "The protocol is they call into the nurse, the nurse leaves me a form and I make a note of it, and send the form to (office staff name). She makes the changes in the computer." The surveyor asked if anyone in the office tracks that, she replied, "Not that I am aware." On 1/30/14 at 4:00 pm, when the issue of employee illness surveillance was discussed, the Administrator was not aware of the requirement to monitor or track staff with infectious diseases/wounds/infective skin lesions. On 1/30/14 at 4:00 pm, the Administrator, DON and CNC were informed of the findings. No additional information was provided.	F 441	4. Beginning the week of 2/1/14 laundry staff will be audited to ensure that cross contamination of linen does not occur by laundry supervisor. 3 dressing changes will be observed to ensure glove changes and hand washing per policy on 3/6/14 by Director of Nurses or designee. Weekly four times per month for one month then monthly for two months. Results will be reported to the PI Committee for three months by the laundry supervisor and Director of nursing are responsible for monitoring and follow up. Hand washing competencies will be reported to the PI Committee for three months by the Director of Nurses or designee.		
F 461 SS=D	483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET Bedrooms must have at least one window to the outside; and have a floor at or above grade level. The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident.	F 461	The Staff Tracking System will be monitored by the Nurse Practice Educator or designee weekly for one month then monthly for two months. Results will be reported to the PI Committee for three months. The Director of Nursing is responsible for monitoring and follow-up. F441	3/7/14	

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F 461	<p>Continued From page 50</p> <p>CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations--</p> <p>(i) Are in accordance with the special needs of the residents; and</p> <p>(ii) Will not adversely affect residents' health and safety.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, review of a notice from CMS and record review, it was determined that not all residents resided in rooms that provided access to a window to the outside. This was true for 3 of 22 resident rooms (#207, 213, 217) and had a negative effect on 1 of 10 sampled residents (#8) who resided in room #213. The deficient practice had the potential to cause more than minimal harm when the resident's lack of access to an outside window from her bedroom was not assessed as a factor when her mood state deteriorated. Findings include:</p> <p>The resident's admission record documented she was admitted into a room with a "C" bed (Room #213), identified by the facility as a bed without a direct view of an outside window, and included in the CMS waiver.</p> <p>On 4/2/13, a notice to the facility from CMS documented, in part, "CMS will grant a waiver</p>	F 461		

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F 461	<p>Continued From page 51</p> <p>...on a resident-by-resident basis...as long as the following conditions are met...At a minimum the application for each particular resident must provide an explanation regarding how the lack of a view to the outside would not have a negative impact on the resident's quality of life...The plan of care...must reflect how the resident's need for orientation, weather, and general awareness of space outside the facility will be met...The facility should have a procedure in place for assessing resident appropriateness, based on the condition and needs of the resident, prior to being assigned an affected room. The procedure should clearly outline how and when the resident will be reassessed, what signs staff should monitor for that would indicate adverse effects and what measures should be taken if adverse effects develop."</p> <p>Resident #8 was admitted to the facility on 3/12/13 with multiple diagnoses which included spinal stenosis, deconditioning with acute back pain secondary to acute L 3 (3rd lumbar vertebrae) endplate compression fracture, and osteopenia to her left hip as well as degenerative changes to bilateral hips, dementia and failure to thrive.</p> <p>Resident #8's MDS assessments coded: *Admission assessment 3/19/13: -BIMS of 15, indicating the resident was cognitively intact; -Mood Severity score of 4 (minimal depression); -Had not received an anti-depressant medication in the past 7 days; -Had not received psychological therapy services in the past 7 days.</p> <p>*Quarterly MDS dated 5/7/13:</p>	F 461	<ol style="list-style-type: none"> 1. Resident #8 will be moved from the waived 3-bed to a two bed room with a window as soon as one becomes available. 2. Other residents in the waived 3-bed have the potential to be affected. They will also be moved to a two bed room with a window as one becomes available. 3. The Center will no longer request the approval to use the 3rd bed in the identified rooms that fall under the CMS approved waiver. 4. The administrator will assure that the waived 3-beds have been removed. Administrator will be monitored beginning 3/6/14 weekly x four weeks then monthly for two months. Results will be reported to the PI Committee for three months. Administrator will be responsible. 	3/7/14

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F 461	<p>Continued From page 52</p> <ul style="list-style-type: none"> -BIMS of 11, indicating moderate cognitive impairment; -Mood severity score of 10 (moderate depression); -Did not receive an anti-depressant medication in the past 7 days; -Had not received psychological therapy services in the past 7 days. <p>*Quarterly MDS assessment 8/7/13:</p> <ul style="list-style-type: none"> -BIMS of 9, indicating moderate cognitive impairment; -Mood severity score of 7 (mild depression); -Received an anti-depressant medication 7 out of the past 7 days; -Received psychological counseling 2 of the past 7 days. <p>*Quarterly MDS assessment 10/25/13:</p> <ul style="list-style-type: none"> -BIMS of 7, indicating severe cognitive impairment; -Mood severity score of 15 (moderate to severe depression); -Received an anti-depressant medication daily for the past 7 days; -Received psychological counseling 2 days out of the past 7 days. <p>Resident #8's clinical record contained a copy of an undated document, addressed to DHW, requesting a temporary waiver for Resident #8 to be admitted into a room with no window to the outside. The document stated, in part, "The resident has been notified that the bed they will be occupying lacks a window to the outside. They have received explanation through our pre-admission process as to the possible adverse effects of the lack of said window to the outside. Should the resident express to the facility that</p>	F 461		

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F 461	<p>Continued From page 53</p> <p>they are being adversely affected by the lack of said window, the facility will move the resident to a bed with a window at the next possible opportunity as a bed becomes available."</p> <p>NOTE: Due to the lack of date on this document, it is unclear as to whether or not the resident was informed of this requirement prior to admission or at a later date. This document places the burden on the resident, who had a diagnosis of dementia, to inform the facility if she felt negatively impacted, rather than on the facility to initiate an assessment of this potential, as specified in the waiver granted by CMS.</p> <p>On 6/7/13, an 'Assessment for Appropriate Placement in Bed 'C' of [Resident rooms identified in the waiver]" [NOTE: This document was dated 87 days after the resident was admitted into bed C of one of the waived rooms in the facility.] The document had a series of "yes" or "no" questions. For Resident #8, all of the questions were answered, "yes.", including, "Has the perspective resident been given an explanation of possible effects of residing in a room without an outside window including loss of appetite, withdrawal from usual activities, new depressed affect/mood and/or expression of distress concerning the lack of a window?" [NOTE: Resident #8's MDS assessments completed on 3/19/13 and 5/7/13 documented a deterioration in the resident's mood state from minimal to moderate depression.] There was no staff signature on the document, making it unclear who had completed this questionnaire. The resident had signed the document. [NOTE: Resident #8 had a diagnosis of dementia. On the most recent MDS assessment completed before this questionnaire was completed, the resident</p>	F 461		

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F 461	<p>Continued From page 54</p> <p>was noted with moderately impaired cognitive skills.]</p> <p>A "Post Admission/Quarterly Re-assessment" form in Resident #8's clinical record documented:</p> <p>**1. Has the resident expressed any distress concerning the lack of a window?" This question was answered with, "no."</p> <p>**2. Has the resident exhibited any signs of adverse effects including loss of appetite, withdrawal from usual activities, new depressed affect/mood?" Answered with, "no."</p> <p>**3. Resident remains oriented to weather and generally awareness of space outside the facility?" Answered with, "yes."</p> <p>The form contained 4 spaces for a date to be added, along with the signatures of the resident and a nurse. The resident and DNS had signed the form on 6/7/13 and 9/10/13. The resident signed the form again on 11/7/13, but the space for the nurse's signature was blank.</p> <p>At the time of the first set of signatures, the resident had already demonstrated a deterioration in her mood state, per the mood severity scores on her MDS. The resident's cognition had also shown deterioration since admission, from cognitively intact at the time of admission (before she was documented to have the opportunity to partake in an assessment regarding her room placement), to severe cognitive impairment prior to the last dated signature on the page. It was unclear what criteria were used to assess the risk factors identified in the second question, or how it was assessed those indicators had not already occurred related to her room placement, given the changes in her MDS scores.</p>	F 461		

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F 461	<p>Continued From page 55</p> <p>Resident #8's care plan documented: *Under the focus area, "Potential for adverse psychological effects r/t [related to] bed placement without an outside window." Date initiated: 11/5/2013. -Goal of, "Resident will maintain current orientation to weather and general awareness of space with no adverse effects r/t placement without a window." Date initiated 11/5/13. -Interventions of, "Assess resident on admit for appropriateness of bed placement without a window and reassess quarterly, annually, or with SCOC [significant change of condition]; Monitor for any adverse effects including loss of appetite, withdrawal from activities anew [sic] expressions of depression; Orient resident to weather, etc, by activity programs, dining services, therapy programs, social services programs and other facility interactions." Date initiated for all interventions was documented as 11/5/13.</p> <p>The resident was admitted to the facility on 3/12/13. The first documented assessment for placement in a room without access to the window was 6/7/13. At the time this intervention was documented as being initiated, the resident had demonstrated a deterioration in her mood state. There was no documentation the facility had assessed placement in this bed as potential contributor to the change in her mood state.</p> <p>On 1/27/14 at 7:30 AM, the surveyors entered the facility, and began the initial tour. Each resident room was divided into three distinct sections by a "Y" shaped wall, creating two sleeping spaces with a window to the outside along the base of the Y, and an ante room in the angular portion. The ante room created provided no direct access to</p>	F 461			

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F 461	<p>Continued From page 56</p> <p>the windows, and contained the doorway to the bathroom for the residents occupying the room. In most of the other resident rooms, this area was arranged as a sitting area, providing the residents with a division between their sleeping and living quarters, as well as ample space for personal furniture and effects.</p> <p>On 1/27/14 at 3:15 PM, Resident #8 was observed in her room, in bed. Resident #8's bed was located in the ante room portion, placed in the left corner. The head and left side of the resident's bed were both against walls. There was a privacy curtain drawn around the right hand side and foot of the bed. The bed was encased completely by the wall and the curtain. As the bed was placed, when the resident was lying in bed, even without the curtain drawn she would be facing the angular wall dividing the ante room from one of her roommate's portions of the room. The door to hallway was behind the wall at the head of her bed, about 3 feet to her right. The resident's wheelchair was against her bed, with the seat of the wheelchair touching the bed. An overbed table was placed with the base underneath the bed, and the table portion extending over the bed. The space was so snug that the placement of these objects caused the curtain to bulge. A television was mounted on the wall at the foot of the bed, just inside the privacy curtain. There were no lights on in this portion of the room, and even at mid-afternoon the space had a dusky hue. The only light in the resident's enclosed space was coming from the television. Two other residents also occupied the room, each with their beds placed so as to face a window; the blinds in the room were open, with daylight pouring into those areas of the room. Aside from the bed and overbed table, the only</p>	F 461		
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F 461	<p>Continued From page 57</p> <p>other furnishings in the ante room occupied by Resident #8 were a portable wardrobe, and one of her roommate's oxygen concentrators. Resident #8 was lying in a fetal position, facing the wall. Here eyes were closed; at first glance she appeared to be sleeping. However, when the surveyor knocked on the door, the resident readily responded, and invited the surveyor to come in to visit. The resident stated she did not have a chair to offer, and asked if the surveyor would mind sitting in the wheelchair, "if there's room for you to get back here." The only item in the entire ante room space which could have been considered a personal effect was a single picture hanging on the wall over the bed.</p> <p>During this observation, the surveyor interviewed the resident about her situation in the facility, in terms of her room and mood state. Initially, the resident stated, "I like my room. If I roll over in bed just so, I can watch people go by in the hall." The surveyor asked the resident how she could see into the hall with the privacy curtain drawn so tightly and her bed in the corner of the room. The resident stated, "Oh. Well. I haven't felt good today. Sometimes, when I feel better, I have them open it and I look out. I was out for lunch today." The surveyor asked the resident about the lack of a view out the window from her portion of the room. The resident stated, "I used to garden. And it would be nice to see the outside once in a while. I went outside last summer; we had a garden here." The surveyor asked the resident if there had been an opportunity since that time for her to connect with the outdoors. The resident then stated, "I used to take all 5 of my kids hiking in the [nearby mountains]. We would hike in all the canyons, and collect rocks. We made a little coffee table out of some of the rocks. Just a small</p>	F 461		

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F 461	<p>Continued From page 58</p> <p>one, about 2 feet square. I sure would like to see it again. It would be nice to have it here. Do you think they'd let me have it here?" The resident stated she had experienced increased depression since she had come to the facility. When asked if lack of access to an outside window was a factor in her depression, the resident stated, "I hadn't thought about that. Maybe it would help (to have access to a window). I do like seeing people go by in the halls. But I guess it would be nice to look out the window too."</p> <p>On 1/28/14 at 3:00 PM, Resident #8 was in her room, in bed, again with the room dark and the privacy curtain completely drawn. The television was not on, and the resident's eyes were closed. She did not respond when the surveyor knocked.</p> <p>On 1/28/14 at 6:05 PM, Resident #8 was observed reclining in her bed, eating her evening meal from her overbed table. The privacy curtain was open to the side of the bed, but drawn around the foot of the bed. The television was not on, with the resident looking at the privacy curtain as she ate.</p> <p>On 1/29/14 at 8:15 AM, the SSD and DNS were interviewed regarding Resident #8. The SSD stated when the resident was first admitted to the facility, the "C" bed was the only one available, so the resident was placed in that bed. The SSD stated the resident was admitted to that room before the CMS waiver came, so an assessment was not completed at that time. When asked about the lag time between the CMS waiver on 4/2/13 and the assessment done for Resident #8 on 6/7/13, the DNS stated she would have to investigate the timeline. When the surveyor asked for the resident-specific explanation of how</p>	F 461		

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F 461	<p>Continued From page 59</p> <p>placement in the "C" bed did not have a negative impact on the resident's quality of life, the DNS stated the facility's pre-admission explained to the resident how placement in that room could have a negative effect, and the resident's signature served as proof she had been informed of this. When asked what the facility response should be if any of the "negative effects" outlined on the facility's assessment form, such as withdrawal from activities or depressed mood state, were noticed, the DNS stated, "The resident should be offered a new room. But she declined." The DNS stated such a conversation would have been documented by the SSD. The DNS stated she had completed the original assessment on 6/7/13, although she had not signed it. The DNS and SSD were asked if the changes noticed by the facility - such as increased depression - or reported by the resident - such as decreased appetite and withdrawal from socialization - had been addressed with the resident as potentially related to her room placement, the DNS stated, "No." When asked how the effect of being placed in a room without access to the window had been monitored for this resident, the DNS stated, "I think we thought our quarterly review was the monitoring piece." The DNS stated, "Yes, she had changes in her mood state and her activities. But we were so focused on the pain we didn't consider anything else as a factor."</p> <p>NOTE: Please see F 309 as it pertains to pain.</p> <p>Continuing with the interview, the SSD was asked if the resident's psychologist had been made aware the resident was placed in a room requiring a waiver due to the lack of a view to the outside, and asked to assess that factor as part of her treatment. The SSD stated, "I don't know. I</p>	F 461		

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F 461	<p>Continued From page 60</p> <p>doubt it. He's never brought it up with us." The SSD was asked about what the facility knew about Resident #8 as an individual. The SSD stated, "We know she likes hiking, flowers, and collecting rocks." However, when asked if those items had been incorporated into Resident #8's plan of care, the SSD stated, "No."</p> <p>On 1/29/14 at 1:40 PM, the resident was observed lying in bed. Her room was dark, with the privacy curtain drawn tightly around the bed. The resident was lying on her back, with her eyes closed. The television was not on. The resident responded to the surveyor's knock. The surveyor asked again about the resident's preference to be located in that particular room. The resident stated, "You mean this black little hole I'm in?"</p> <p>On 1/29/14 at 11:45 AM, the Activities Director (AD) was interviewed about Resident #8. The AD was asked if she had any knowledge regarding Resident #8's room preference. The AD stated, "I personally would not prefer that area of the room, it feels like there wouldn't be much privacy. But I hear that she likes it. She likes to watch out into the hallway, and she can see what's going on in activities. I've never asked her directly (about access to a window), she just says she likes it." The AD was asked how the resident could see into the activities room, which was located across the hall from the resident's room, when the resident's bed was positioned in the corner of the room. The AD stated, "Oh, it (the bed) used to be somewhere else in the room, but now they've moved it. She probably couldn't see from where she is now."</p> <p>NOTE: Please see F 252 as it pertains to homelike environment.</p>	F 461		

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

PRINTED: 05/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/31/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
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F 461	<p>Continued From page 61</p> <p>On 1/30/14 between 1:00 and 1:30 PM, the Administrator, DNS, SSD, and facility psychologist met with the surveyors:</p> <p>*The Administrator stated the resident liked her current room, had repeatedly requested to be in that room, and wanted to be in that room. The Administrator stated if the privacy curtain was not drawn, he felt the resident could look out the window of the room. The Administrator stated the facility had used this room arrangement with various residents over a number of years, but was only required last year to get a waiver. The Administrator stated the facility needed more time to adapt to the information they would be required to provide to show compliance with the waiver. The Administrator further stated the "C" beds in the rooms were problematic if they were the only beds the facility had to show when the families of prospective residents came to tour the facility, as those beds were not as attractive as the beds with access to the window, so prospective residents would usually choose a different facility if the "C" bed was the only option.</p> <p>*The SSD stated while she had not consistently documented conversations with the resident's family about the room placement, she called the resident's son earlier that day, and the son remembered having been asked about a room change before. The SSD stated the resident's son stated she had battled depression her whole life, and he did not want the resident to be moved. The SSD stated she had placed a progress note in the resident's chart on 1/28/14 summarizing these conversations.</p> <p>*The psychologist stated he was not aware the space in the room occupied by the resident required a waiver, and while he had not assessed specifically for that, he felt if the waiver were not</p>	F 461		

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F 461	<p>Continued From page 62</p> <p>continued and the resident was required to move into a bed by the window, this move would be "detrimental" to her. The psychologist stated the resident was satisfied with maintaining a connection with her previous outdoor lifestyle through "guided imagery", and would not benefit from actually being able to see outside. A few minutes later, the psychologist stated the resident has a goal of walking and being outdoors, but he did not see the value of incorporating a view to the outside from the resident's bedroom as part of this goal.</p> <p>On 1/30/14 at 3:45 PM, the Administrator and the DNS were informed of the surveyor's concerns. On 2/4/14 the facility faxed additional information to BFS. However, the additional information did not resolve the surveyor's concerns.</p>	F 461		

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 at your facility. The survey was conducted from January 27-31, 2014. The survey was conducted by: Nina Sanderson, BSW, LSW, Team Coordinator Susan Gollobit, RN	C 000		
C 355	02.108,06,b,iii Handling to Prevent Cross Contamination iii. Soiled linen shall be handled and stored in such a manner as to prevent contamination of clean linen. This Rule is not met as evidenced by: Refer to F441 related to handling of soiled linen.	C 355	Refer to F441	3/7/14
C 399	02.120,05,c,iv Window Permits Viewing While Seated iv. It shall be so located as to permit the patient/resident a view from a sitting position. This Rule is not met as evidenced by: Please see F 461 as it pertains to resident access to an outside window.	C 399	Refer to F461	3/7/14
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining	C 644	Refer to F441	3/7/14

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FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>S. D. Chinchurreta, Adm.</i>	TITLE	(X6) DATE 5/27/14
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C 644	Continued From page 1 sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 related to handwashing.	C 644		
C 652	02.150,01,b Employee Infection Surveillance b. Employee infection surveillance and actions. This Rule is not met as evidenced by: Refer to F441 related to employee surveillance of illness.	C 652	<i>Refer to F441</i>	3/7/14
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 the Infection control Committee (ICC) attendance records, it was determined the facility did not ensure the meetings were attended by the Maintenance Services Representative. This deficient practice had the potential to cause negatives outcomes 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 2:30 pm, LN#10, Infection Control designee, was interviewed about the Infection Control program. LN#10 was asked, how often and who attended the meetings, she replied, "We	C 664	Beginning February 13, 2014, Maintenance Director will be added to the Performance Improvement Committee which meets monthly. Refer to F 441	3/7/14

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C 664	Continued From page 2 meet quarterly and are due to meet again in February. The Medical Director, Administrator, DON, Health Information, Dietary Manager/ Housekeeping representative, Nurse Practice Educator, Social Services and Pharmacist," attend the meetings. When asked if the Maintenance Services Representative attended, she stated, "He attends the safety meeting, but does not come when we talk about Infection control." The Performance Improvement Committee Meeting, attendee lists were provided, reviewed and it was determined the Maintenance Service Representative was not present at the 8/8/13 and 11/14/13, quarterly meetings. On 1/30/14 at 4:00 pm, the Administrator, DON and CNC were informed of the findings. No additional information was provided.	C 664		
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and	C 674	<i>Refer to F248</i>	3/7/14

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C 674	Continued From page 3 religious activities. This Rule is not met as evidenced by: Please see F 248 as it pertains to the facility activities program.	C 674		
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 328 as it pertains to oxygen management..	C 784	<i>Refer to F309 + F328</i>	3/7/14
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 related to the development of Pressure Ulcers.	C 789	<i>Refer to F314</i>	3/7/14
C 811	02.200,04,g,vii Medication Errors Reported to Physician vii. Medication errors (which shall be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Refer to F332, the facility had a greater than 5%	C 811	<i>Refer to F332</i>	3/7/14

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C 811	Continued From page 4 medication error rate.	C 811		
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F431 related to labeling of medications.	C 832	<i>Refer to F431</i>	3/7/14



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
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March 12, 2014

G. David Chinchurreta, Administrator
Sunny Ridge
2609 Sunnybrook Drive
Nampa, ID 83686-6332

FILE COPY

Provider #: 135102

Dear Mr. Chinchurreta:

On **January 31, 2014**, a Complaint Investigation survey was conducted at Sunny Ridge. Nina Sanderson, L.S.W. and Susan Gollobit, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the Recertification and State Licensure survey that was conducted January 27 through 31, 2014.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006008

ALLEGATION #1:

The complainant, reporting party (RP), stated an unidentified resident(s) received Glucerna, rather than Jevity 1.2 as ordered, via feeding tube.

FINDINGS:

At the time the complaint was investigated, there was only one resident in the facility with a feeding tube. The resident had orders for Jevity 1.2. The facility reported a period of three days, between July 1, 2013 and July 4, 2013, when Jevity 1.2 was not available from the provider. The facility followed their protocol for such an eventuality. The physician was notified and the dietician consulted. Per the recommendation of the dietician, they physician ordered Glucerna

G. David Chinchurreta, Administrator
March 12, 2014
Page 2 of 3

1.2 be given to the resident until Jevity 1.2 was available. The dietician determined the two products to be nutritionally equivalent, and the resident did not experience any negative outcome. The resident received Jevity 1.2 since July 4, 2013, without interruption or further incident.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The RP stated the facility did not have the correct wound supplies to allow for wound treatment on the night shift for an unidentified resident(s).

FINDINGS:

Staff interviews and resident reviews were conducted.

At the time the complaint was investigated, there were no residents in the facility requiring dressing changes to their wounds. Several licensed staff, the Director of Nursing and the administrator were interviewed. There was no evidence that the facility had difficulty obtaining wound supplies when needed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The RP stated leg braces for unidentified resident(s) were stored in the residents' food storage freezer.

FINDINGS:

Observations were made of the residents' food storage freezer twice daily, from January 27, 2014 through January 30, 2014. The freezer was observed to hold only food items, labeled and dated for specific residents use. All food was noted to be within the allowed dates of usage. Several staff members were interviewed regarding items to be stored in the freezer. All staff interviewed stated only residents' food items could be kept in the freezer.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

G. David Chinchurreta, Administrator
March 12, 2014
Page 3 of 3

ALLEGATION #4:

The RP stated the facility had one licensed nurse and two certified nurse aides (CNAs) on night shift for 45 residents.

FINDINGS:

Three weeks' worth of staffing records were reviewed. Individual resident's interviews were conducted, as well as a group resident interview. Facility's incident reports were reviewed. Staff interviews were conducted with the night shift staff. Surveyors' observations were made of the night shift.

Staffing records documented staffing ratios within the required parameters. Residents interviewed stated they felt adequate amounts of staff were available to ensure assistance, even at night. Surveyors' observations of night shift indicated staff was responding to resident requests for assistance. Two CNAs and one licensed nurse interviewed from the night shift stated they felt they were able to meet residents' needs with the staffing ratios in place. Staff identified there were occasional call-ins on night shift, but the facility had a system in place to ensure coverage in that event. No incident trends were identified as specific to night shift.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As only one of the complaint's allegations was substantiated, but not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



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

LKK/dmj