



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 1010 0002 0836 1819**

March 13, 2014

Richard F. Cartney, Administrator  
Owyhee Health & Rehabilitation Center  
108 West Owyhee, PO Box A  
Homedale, ID 83628-2040

FILE COPY

Provider #: 135087

Dear Mr. Cartney:

On **February 28, 2014**, a Recertification and State Licensure survey was conducted at Owyhee Health & Rehabilitation Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 26, 2014**. Failure to submit an acceptable PoC by **March 26, 2014**, may result in the imposition of civil monetary penalties by **April 15, 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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **April 4, 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 **April 4, 2014**. A change in the seriousness of the deficiencies on **April 4, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 4, 2014** includes the following:

Denial of payment for new admissions effective **May 28, 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 **August 28, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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Regional Office or the State Medicaid Agency beginning on **February 28, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **March 26, 2014**. If your request for informal dispute resolution is received after **March 26, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LT/dmj  
Enclosures

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

PRINTED: 06/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/28/2014
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NAME OF PROVIDER OR SUPPLIER  OWYHEE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey of your facility. This report reflects changes resulting from the Informal Dispute Resolution (IDR) process.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP Rebecca Thomas, RN</p> <p>The survey team entered the facility on February 24, 2014 at 7:30 a.m., and exited the facility on February 28, 2014.</p> <p>Survey Definitions: ADLs = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing IDT = Interdisciplinary Team LN = Licensed Nurse MDS = Minimum Data Set assessment MG = Milligram MAR = Medication Administration Record PRN = As Needed RN = Registered Nurse R/T = Related To</p> <p>F 221 483.13(a) RIGHT TO BE FREE FROM SS=D PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Owyhee Health &amp; Rehabilitation Center</b> does not admit that the deficiency listed on this form exist, 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."</p> <p>The Facility wishes to express its disagreement with the Summary Statement of Deficiencies ("SSD") in connection with the care and treatment provided to Resident #3, especially related to the wound treatment. The Facility wishes to express its disagreement with the Summary Statement of Deficiencies ("SSD") in 4/4/14 connection with the care and treatment provided to Resident #1 and #2, especially related to the prevention of falls. The Facility expressly reserves the right to challenge same as incomplete, inaccurate or otherwise substantively deficient.</p>	
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**RECEIVED**  
**JUL - 7 2014**  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 7/7/14
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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 221	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and record review, it was determined the facility failed to assess resident safety for those residents who used physical restraints. This was true for 1 of 9 sampled residents (#1). This created the potential for harm from entrapment. Findings included:</p> <p>Resident #1 was admitted to the facility on 8/22/11 with multiple diagnoses which included senile dementia with depressive features, dementia with behavioral disturbances, anxiety, and osteoarthritis.</p> <p>The latest MDS Quarterly Assessment, dated 2/18/14, and Comprehensive Assessment, dated 8/21/13, both documented the resident was severely impaired for daily decision making.</p> <p>Interpretive guidance regarding restraints defines physical restraints as any physical or mechanical device which restricts freedom of movement or normal access to one's body, material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily.</p> <p>The resident's care plan for the focus of potential for falls, dated 6/12/13, documented an intervention "Lap buddy [restraint] when in w/c [wheelchair] to help prevent falls d/t [due to] leaning forward."</p> <p>The record included a Progress Note, dated 1/13/14 at 1:50 AM, which documented, "Did find the resident, after being put to bed, with her feet over the side rail."</p>	F 221	<p><u>F-221</u></p> <ol style="list-style-type: none"> <li>1. Res #1-Safety assessment for the side rails and posey hugger were immediately conducted by nursing and DOR.</li> <li>2. All other residents utilizing a restraint/enabling device could be affected. Safety assessments for all residents using side rails, posey huggers or other enabling devices have been completed. LNs were in-serviced on the need to include safety information on all restraint/enabling assessments.</li> <li>3. The IDT will review that all the restraint/enabling devices upon admission, or initiation of the intervention to ensure safety assessment, are completed. This information will be added to the 24hr report and viewed daily.</li> <li>4. The DNS or management designee will review the assessments 3X weekly X2 months, then weekly and ongoing starting 4/1/2014. This will be reported to QA committee monthly.</li> <li>5. Compliance will be achieved by April 4, 2014.</li> </ol>

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F 221	<p>Continued From page 2</p> <p>The record contained two "Restraint/Enabling Device/Safety Device Reviews." One review, dated 11/18/13, was for a Posey Hugger and side rails X 2. The second review, dated 2/18/14, was for side rails X 2. Neither review addressed a lap buddy. Further, neither of these documented the devices were assessed for safety for this resident with dementia.</p> <p>The resident was observed in bed with full length side rails up X 2 on: 2/24/14 at 10:20 AM; 12:40 PM; and 1:55 PM, 2/25/14 at 1:30 PM; 2:11 PM; 3:12 PM; and 4:31 PM. 2/26/14 at 08:35 AM; 10:00 AM and 1:30 PM.</p> <p>NOTE: The resident was laying on her back and was scooting her legs directly next to and working her legs approximately half-way up to the top of the side rail when observed on 2/25/14 at 4:31 PM.</p> <p>The resident was observed in a high back wheelchair with a lap buddy in place on 2/25/14 at 09:50 AM; 11:50 AM; and 5:15 PM.</p> <p>On 2/26/14 at 11:30 AM, LN #2 was interviewed regarding the side rail and Posey Hugger assessment dated 2/18/14. She stated the side rails were used only for positioning of the air bed and she did not consider them to be a restraint. She stated the risks and benefits had been discussed with the family but the facility did not have an assessment the side rails had been assessed to be safe for this resident. Additionally, she stated the resident no longer used a Posey Hugger but used a lap buddy instead. She explained the device was used for positioning in a</p>	F 221		
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F 221 Continued From page 3  
high back wheelchair and she did not consider it to be a restraint.  
  
NOTE: Record review did not reveal a Restraint/Enabling Device/Safety Device Review for the use of a lap buddy. Record review included a Physical Therapy Evaluation, dated 12/6/13, which documented the lap buddy was needed when the resident was in the wheelchair to help prevent falls due to leaning forward.

F 221

On 2/26/14 at 2:15 PM, the DON and LN #2 were made aware the Restraint/Enabling Device/Safety Device Reviews for using side rails, a Posey Huger or lap buddy had not been assessed to be safe for this resident. The facility did not provide any additional documentation.

F 225  
SS=D 483.13(c)(1)(ii)-(iii), (c)(2) - (4)  
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

F 225

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and

4/4/14

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F 225	<p>Continued From page 4</p> <p>to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Occurrence Reports, policy review and staff interview, the facility failed to ensure injuries of unknown origin were investigated thoroughly, specifically a resident had a large bruise to a knee. This was true for 1 of 9 (#2) sampled residents. There was a potential for physical and psychological harm when a facility failed to investigate unknown injuries in order to rule out physical abuse or neglect. Findings include:</p> <p>The "Policy/Procedure - Nursing Administration" policy number NARR 06 WA "Abuse Prevention and Reporting", revised 05/2007, was reviewed. The "Policy" portion failed to include any language about "injuries of unknown source." The policy section on "Definitions" failed to define injuries of an unknown source. The "Procedures:" documented:</p>	F 225	<p><u>F-225</u></p> <ol style="list-style-type: none"> <li>1. Res #2-Staff on duty the 72 hours prior to the incident were interviewed and abuse/neglect were ruled out based on the findings.</li> <li>2. Any Resident experiencing injury of unknown origin could be affected by this practice. A review of all incidents of injury of unknown origin has been completed and updated as indicated. An in-service was conducted for all LN staff to follow investigative protocol and to initiate use of investigation form.</li> <li>3. 24 hour reports will be reviewed by IDT as incidents/accidents occur. Events resulting in injury of unknown origin will be reviewed by IDT within 72 hours by an IDT member to ensure that all interviews/investigations have been started/completed.</li> <li>4. The Administrator or Management designee will review injury of unknown origin I&amp;A reports and audits will be conducted weekly X2 months, then monthly X 3 months starting on 4/1/14. Findings will be reported to the QA committee monthly.</li> <li>5. Compliance will be achieved by April 4, 2014.</li> </ol>	

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F 225	Continued From page 5 "1. Any staff member who has reasonable cause to believe or reason to suspect any situation that may be considered abuse or neglect along with injuries of unknown origin (including any bruises, skin tears, or other injuries) will immediately report to the Charge Nurse. 2. The charge Nurse will be notified immediately, and" "c. Will complete an initial investigation to attempt to determine the cause of the injury through interviews of staff, resident and witnesses. Statements should include all details, i.e., date, time of day, location, exactly what occurred. If verbal behavior was involved, exact words need to be included. Witnesses are encouraged to give a signed statement. Obtain Name, address and phone number of all witnesses." "d. If possible, and permission obtained, take pictures of all physical evidence. If a resident has a bruise, laceration, etc., try to get a quality photo of this and date it. Maintain security of all evidence." "f. Document in the nurses notes as to what happened. What interventions were attempted, any injuries, plan to prevent recurrence (i.e., increased supervision, move to another room/closer to nurse's station, etc.) and follow-up."  The facility failed to investigate an unknown injury to Resident #2. The findings include:  Resident #2 was admitted to the facility on 4/14/08 and readmitted on 11/18/13. The resident had diagnoses of aftercare following joint replacement, depressive disorder, anxiety and dementia unspecified with behavior disturbances.  On 9/26/13 at 7:00 a.m. the Occurrence Report	F 225			

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F 225	Continued From page 6 documented: "Who observed Accident? (attach witness statement), Unknown." "Describe what happened and any injuries: called to residents room during cares. Dark Purple Bruise found on Right knee and pettechia [sic] looking spots on right lower shin and foot. Resident states she 'must have bumped it somewhere."  The report failed to have any statements by staff or an investigation as to what happened. There was a conclusion on the last page that documented,"? if bruising is from fall on 9/23/13 Resident seems unaware of what happened."  The 9/23/13 Occurrence Report was reviewed and the resident fall was found at 2:00 p.m. The fall was not observed and was described as, "Resident was in the BR [bathroom] when she stood up she lost her balance and slid down the wall onto her bottom."  The 9/23/13 or 9/26/13 incidents were not investigated according to the facility policies.  The DON was interviewed on 2/26/14 at 10:00 a.m. She was asked about the lack of investigation of the large bruise on the resident's knee. She said the bruise was caused by the previous fall and didn't feel it needed to be investigated.  The Administrator and DON were informed on 2/27/14 at 4:00 p.m. No further information was provided.	F 225			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		4/4/14	

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F 241	<p>Continued From page 7</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility failed to promote a respectful dining experience when CNA's were talking amongst themselves when assisting residents to eat. This was true for 1 of 9 sampled residents (#1) and three random residents (#11, #12, and #13). This failed practice created the potential for residents to experience loss of self esteem and self worth. Findings included:</p> <p>Resident #1 was admitted to the facility on 8/22/11 with multiple diagnoses which included senile dementia with depressive features, dementia with behavioral disturbances, anxiety, and osteoarthritis.</p> <p>On 2/25/14 at 12:00 PM, during the lunch meal at the table where Resident #1 was sitting, CNAs #3 and #4 were observed to assist residents to eat and maintain a personal conversation throughout the meal. The residents did not initiate this discussion and did not participate. A family member who was assisting her mother to eat (Resident #11) was involved in the conversation. The topics discussed included gardening and enjoying the sunshine, getting caught up with laundry, a gentleman at a store who seemed like a really nice guy, a son who was starting baseball, spring cleaning and getting up early that morning. CNAs #3 and #4 were observed to</p>	F 241	<p><b>F-241</b></p> <ol style="list-style-type: none"> <li>1. For residents #1, #11, #12, #13, staff was in-serviced immediately on this dignity issue via written in-service that they understand and are aware of the expectations in the dining room.</li> <li>2. Other non-verbal/cognitively impaired residents could be affected by this practice. All nursing and management staff were inserviced on resident dignity.</li> <li>3. Nurse in charge to be readily accessible to the dining room for meal observation and immediate correction of dignity issues. Documentation of immediate training will be provided to the DNS for review for possible disciplinary action.</li> <li>4. Audits will begin on 4/1/2014. Management team, excluding dietary, to audit dining room for appropriate conduct/dining room ethic, 3X weekly X2 months, then monthly ongoing, incorporating RD dining room monthly audit. Findings will be reported to the QA committee monthly.</li> <li>5. Compliance will be achieved by April 4, 2014.</li> </ol>	

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F 241	<p>Continued From page 8</p> <p>continue a personal conversation after the family member left the table.</p> <p>On 2/25/14 at 12:40 PM, the CDM (Certified Dietary Manager) joined in the table conversation, talking about her dog and heating bills. One of the staff members suggested using a certain model of heater.</p> <p>Random residents #12 and #13 were also seated at this table.</p> <p>On 2/27/14 at 3:40 PM, the DON was made aware of the observation during the lunch meal. She stated the facility had recently given an inservice regarding dignity with the staff.</p> <p>On 3/3/14 a fax was received from the facility which included an inservice from the CDM along with staff signatures, dated 2/24/14, and documented there had been recent complaints about the noise and chaos in the dining room. The CDM stated in the inservice, "Communication in the dining room should be between you and your resident, not conversations with other CNA's about personal things."</p> <p>NOTE: This inservice was given the day before the meal observation.</p> <p>Additionally, the fax included a personal statement written by the CDM which documented she "did not observe at any time the aides not being attentive to their residents" during the meal service of 2/24/14 to 2/28/14. The faxed inservice documented the staff were made aware of the noise and chaos in the dining room and were informed their conversation should be between them and the resident.</p>	F 241		

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F 253 SS=B	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure: - damaged flooring to a multiple resident room was repaired, and - a bathtub for two rooms was serviceable. This affected 1 of 1 (Rooms 6 &amp; 7 tub) bath tub room and 1 of 26 (Room #20) resident rooms. Findings include:</p> <p>1. During the initial tour of the facility on 2/24/14 at 8:00 a.m. the surveyor observed a bathing area in the entry section area to rooms 6 and 7. There was a bathtub in the area but the faucet head was corroded, cracked and rusted out, and the handle to turn the water on was missing.</p> <p>2. While observing the environment on 2/24/14 at 10:15 a.m., Room #20 was observed to have multiple, too many to count, deep cuts measuring from 2 feet to 6 feet long in the linoleum floor. The cuts appeared to be from the door to the residents' beds. This was an area of approximately 10 feet long by 8 feet wide.</p> <p>On 2/26/14 at 10:00 a.m. the maintenance person was informed of the areas. The DON and Administrator were informed on 2/27/14 at 4:00 p.m. No further information was provided.</p>	F 253	<p><u>F-253</u></p> <p>1. A. The identified faucet head was replaced during survey. B. The flooring was replaced in room 20 on 3/21/14.</p> <p>2. Other bathing facilities and linoleum floors in the building could also be affected.</p> <p>3. All flooring and bath fixtures have been assessed for damage and replaced as needed. The items will be added to the weekly maintenance review form.</p> <p>4. Beginning 3/24/12 the Administrator or Business Office Manager will audit bath faucets and floors weekly x 1 and twice per month x 2 and findings will be reported to the QI Committee.</p> <p>5. Compliance will be achieved by April 4, 2014.</p>	4/4/14	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p>	F 280		4/4/14	

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F 280	<p>Continued From page 10</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to review and revise care plans after there was a change in the resident's status. This was true for 1 of 9 sampled residents (#1). This had the potential to result in harm should residents not receive appropriate care due to lack of direction in the care plan. Findings include:</p> <p>Resident #1 was admitted to the facility on 8/22/11 with multiple diagnoses which included senile dementia with depressive features, dementia with behavioral disturbances, anxiety, and osteoarthritis.</p>	F 280	<p><b>F-280</b></p> <ol style="list-style-type: none"> <li>1. Resident #1's sleep medication had been discontinued on 12/31/13. The monitoring was discontinued on the TAR but not removed from the care plan until 3/17/14. Resident #1's diet order changes were made on 2/24/14 and included an upgrade to thin liquids. The care plan was updated on that same day.</li> <li>2. All other residents experiencing diet and medication changes could be affected. A review of all care plans comparing current physician orders has been completed and changes made as applicable.</li> <li>3. All department heads and licensed nurses have been in serviced on care planning timely in response to physician order changes. The DNS or designee will verify care plan updates based on 24 hours report changes</li> <li>4. Beginning 4/1/14, audits of care plans for update will be completed by the RN/SS designee or medical records twice weekly x 2 months, then once per week x 1 month and findings will be reported to the QI Committee monthly.</li> <li>5. Compliance will be achieved by April 4, 2014.</li> </ol>	

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F 280	<p>Continued From page 11</p> <p>A. Record review of the resident's care plan for the focus of mood problems with potential for psychosocial distress documented an intervention to "monitor and record sleep hours per day and night."</p> <p>Record review of the Physician All Active Orders (Recapitulation Orders) for the months of January and February, 2014, did not document an order to monitor and record sleep hours per day and night.</p> <p>Record review of the resident's TAR (Treatment Administration Order) for the months of January and February, 2014, did not document to monitor and record sleep hours per day and night.</p> <p>On 2/26/14 at 11:30 AM, LN #1 was interviewed regarding the care plan intervention to monitor and record sleep hours per day and night. LN #1 stated the facility is not monitoring sleep as indicated on the care plan since the sleeping medication, Trazodone, was discontinued on 11/16/13. She stated the facility quit tracking the sleep hours as of 12/31/13. LN #1 stated the care plan was not updated.</p> <p>B. The resident's care plan indicated a potential for fluid deficit r/t [related to] need for nectar thick liquids, dated 1/29/14.</p> <p>A Physician's Order for change of diet, dated 2/24/14, documented a new diet order, "Puree Solids, thin liquids, NEM (Nutritionally Enhanced Meals).</p> <p>On 2/26/14 at 2:40 PM, LN #2 was interviewed regarding the change of diet to thin liquids with</p>	F 280		

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F 280	Continued From page 12 NEM. LN #2 stated she had spoken with Dr. Brown who ordered a thin liquid diet after the resident had a swallowing evaluation on 2/24/14. LN #2 provided a copy of the evaluation and stated the resident did not have any problems during the evaluation. She stated the resident's diet was changed, however, the care plan had not been updated.  On 2/27/14 at 3:40 PM, the DON was informed of the care plan issues. No further documentation was provided that resolved the issue.				
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure: - a resident's sore on the coccyx that was healed did not reoccur, - a resident with a recurrent pressure sore was repositioned every 2 hours as care planned. - a catheter strap was not positioned and tight to cause a pressure blister on the leg.  These issues were found on 1 of 9 (#3) sampled				
		F 280	Without specifically agreeing that the wound at issue was a pressure ulcer, the Facility provides as follows relative to its Plan of Correction for the alleged deficient practice identified at F314:  <b>F-314</b> 1. Resident #3-Resident was reassessed on the Braden Scale to reflect actual risk issues. Interventions in place and care plan were reviewed, however, not changed. Multiple interventions were enhanced for clarification only. 2. Residents with wounds were evaluated for appropriate assessment, intervention, and care-plan documentation. LN staff was in-serviced on wound identification, measurement and intervention. 3. Monthly LN in-service education on wound identification, location, intervention and appropriate UDA documentation will be conducted. 4. Starting 4/1/14, audits of all skin/wound documentation will be conducted by the DNS or LN management designee 2X week X 4 weeks, then weekly ongoing. Results of audit will be reported to the QI committee monthly. 5. Compliance will be achieved by April 4, 2014.	4/4/14	

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F 314	<p>Continued From page 13 residents. Findings include:</p> <p>Resident #3 was admitted to the facility 12/11/09 with diagnoses of congestive heart failure, diabetes mellitus (DM), dementia and depressive disorder.</p> <p>The annual MDS, dated 11/21/13, documented the resident:</p> <ul style="list-style-type: none"> <li>- had moderate cognitive impairment with a BIMS of 9,</li> <li>- required total assistance with transfers, toileting, and bathing,</li> <li>- required extensive assistance with bed mobility, dressing, personal hygiene.</li> <li>- had a catheter,</li> <li>- did not have any identified skin problems.</li> </ul> <p>The resident had a care plan dated 2/20/13 that documented a problem of "Skin Tear (recurring) to coccyx." The interventions were: [Note: none of the interventions were dated.] "-Turn with turn sheet only - Requires 2 person for safety. Turn slow and gentle - do not pull on skin. - Nurse to monitor repositioning and peri-care each time doing et offer education to DCS [direct care staff] during cares. Vitamin C and Zinc per orders et added protein in diet."</p> <p>The resident's current care plan had multiple areas where skin issues were documented. Examples were: Problem: Diabetes Mellitus (initiated 10/4/13) Interventions: [Note: none of the interventions had a date associated with it.] - Check all of body for breaks in skin and treat promptly as ordered by doctor.</p>	F 314			

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F 314	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>- Check skin when assisting with ADLs.</li> <li>- Dietary consult for nutritional regimen and ongoing monitoring.</li> <li>- Ensure socks/hosiery are clean absorbent every day. Make sure that they are not too tight to hinder circulation.</li> <li>- Monitor/document/report to MD PRN for s/sx of infection to any open areas: Redness, Pain, Heat, swelling or pus formation.</li> </ul> <p>Problem: Has potential impairment to skin integrity r/t decreased mobility and DM. (initiated 10/4/13)</p> <p>Interventions: [Note: none of the interventions had a date associated with it.]</p> <ul style="list-style-type: none"> <li>- Air Mattress overlay on bed.</li> <li>- Assist resident to turn and reposition q 2 hrs. [every two hours]</li> <li>- Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short.</li> <li>- Educate resident/family/caregivers of causative factors and measures to prevent skin injury.</li> <li>- Encourage good nutrition and hydration in order to promote healthier skin.</li> <li>- Follow facility protocols for treatment of injury.</li> <li>- Identify/document potential causative factors and eliminate/resolve where possible.</li> <li>- Keep skin clean and dry. Use lotion on dry skin.</li> <li>- Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD.</li> <li>- Need assistance to apply protective garments: geri sleeves.</li> <li>- Needs pressure relieving pad in w/c and on bed to protect the skin.</li> <li>- Needs pressure relieving/reducing mattress and pillows to protect the skin while in bed.</li> <li>- Obtain blood work such as CBC with Diff, Blood</li> </ul>	F 314		

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F 314	<p>Continued From page 15</p> <p>Cultures and C&amp;S of any open wounds as ordered by Physician.</p> <ul style="list-style-type: none"> <li>- Pad bed rails, wheelchair arms or any other source of potential injury if possible.</li> <li>- Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.</li> </ul> <p>Problem: Has Congestive Heart Failure. (initiated 12/11/13)</p> <p>Interventions:</p> <ul style="list-style-type: none"> <li>- Reposition or encourage resident to change positions every 2 hours.</li> </ul> <p>Problem: Has actual impairment to skin integrity r/t fragile skin on both upper thighs. (initiated 2/20/14)</p> <p>Interventions: [Note: none of the interventions had a date associated with it.]</p> <ul style="list-style-type: none"> <li>- Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short.</li> <li>- Encourage good nutrition and hydration in order to promote healthier skin.</li> <li>- Follow facility protocols for treatment of injury.</li> <li>- Identify/document potential causative factors and eliminate/resolve where possible.</li> <li>- Keep skin clean and dry. Use lotion on dry skin. Apply Duoderm per order.</li> <li>- Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD.</li> <li>- Pad sling to prevent rubbing and monitor for any other source of potential injury.</li> <li>- Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp object or hard surface.</li> </ul> <p>The February 2014 physician recapitulation</p>	F 314		
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F 314	<p>Continued From page 16</p> <p>orders documented:</p> <ul style="list-style-type: none"> <li>- Geri - Gloves to bilateral arms daily for protection on in AM off at HS. order date: 7/2/10 start date: 6/24/13</li> <li>- Nurse to observe all pericare, turning, and repositioning each shift. Nurse to educate aide on providing tender care to protect skin. order date: 2/27/13 start date 6/24/13</li> </ul> <p>On 2/22/14 a Braden Scale for Predicting Pressure Risk was completed and the resident scored a 16.0. This score was equal to Low Risk for pressure sores.</p> <p>The resident was admitted to the facility on 12/11/09 and the admission note by the LN documented: "...3.5 cm crack noted to coccyx..."</p> <p>The physician's "New Patient History and Physical Examination" dated 12/14/2009 documented at "Plan:" "8. The patient does have some skin issues of denuded skin. The Nystatin is being applied and otherwise this should improve with hygiene and skin care." The facility was able to heal the area.</p> <p>On 10/15/2012 the physician documented during a "Nursing Home Visit" the resident had a "linear split at her coccyx region and it is a little bit sore and they want me to see the area..." The physician's "Physical Examination:" documented, "Extremities:...On the patient's upper gluteal cleft is approximately a 2.5 cm linear fissure like split at the upper gluteal cleft..." The "Assessment:" documented "1. Linear ulceration at the upper gluteal cleft." The facility was able to heal the ulceration with treatment.</p> <p>A review of the interdisciplinary progress notes</p>	F 314		

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F 314	<p>Continued From page 17</p> <p>(IDTPN) and LN-Skin assessment (LNSA) revealed the "slit" returned and also a catheter strap was too tight and caused a sore on her leg. Not all of the documentation will be included, only information specific to status of the slit and pertinent resident activities related to her skin issues. The documentation was:</p> <p>On 8/3/13 at 1:01 a.m. the IDTPN documented, "Barrier cream applied to split to buttocks...Aids [sic] educated to use draw sheet when turning resident and not to pull on skin..."</p> <p>On 8/7/13 at 1:10 a.m. the IDTPN documented, "No change in split inner buttocks crease below coccyx. Whitish in color but remains open however it is improving....Report stated she did not lay down hardly at all today. Air Mattress, position changes, heels floated,..."</p> <p>On 8/8/13 at 11:14 p.m. the IDTPN documented, "Inner buttocks split cleansed and skin paste applied...Leg strap for catheter. Has not wanted to lay down right after meals spending a lot of time in the wheelchair..."</p> <p>On 8/13/13 at 11:11 p.m. the IDTPN documented, "split to inner buttocks crease near total resolution again. Whitish in color but no open areas noted tonight with treatment....Resident sat up quite a bit this afternoon through supper and complained of legs bothering her. She does have complaints of pain when she does set up too long at any given time..."</p> <p>On 8/30/13 at 4:21 a.m. the LNSA documented the "Coccyx healing split measured .5 cm x .2 cm x .05 cm." The note failed to stage the area. The narrative documentation was, "Split in buttocks slightly opened .5 cm...Air bed in place and working. Repos[itioned] [every] 1 1/2 hours and [as needed]."</p> <p>On 9/1/13 at 7:04 p.m. the IDTPN documented,</p>	F 314		

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F 314	<p>Continued From page 18</p> <p>"Split inner buttocks crease is open slightly....Encouraged to lay down between meals but frequently wants to stay up...."</p> <p>9/12/13 at 3:15 a.m. the LNSA documented, "Coccyx area remains closed but fragile..." [Note: there was no documentation describing when the area on the coccyx closed.]</p> <p>On 10/10/13 at 3:15 a.m. the LNSA documented, "...Has .4 cm raised area anterior left thigh and also one above it. Placed catheter strap on opposite right leg to prevent friction....Coccyx intact..."</p> <p>On 10/15/13 at 3:22 a.m. the LNSA documented, "5 cm split to coccyx..."</p> <p>On 10/18/13 at 3:04 a.m. the LNSA documented, "Split on coccyx smaller than a few days ago at 2.5 cm..."</p> <p>On 10/25/13 at 3:04 a.m. the LNSA documented, "...Split on coccyx 2.0 cm (improved from last week and very superficial)....Left groin and left anterior thigh is pink. Leg strap was changed to right side..."</p> <p>On 10/28/13 at 9:33 a.m. the IDTPN documented, "It was reported to me that resident has a line of fluid filled blisters on the front of her right thigh where the catheter strap was sitting. it appears the strap was too tight..."</p> <p>On 11/8/13 at 3:04 a.m. the LNSA documented, "...Split on coccyx 3.0 cm....Left and right groin has 3 cm split noticed after shower...Healing blister 1 cm left right thigh..."</p> <p>On 11/15/13 at 3:04 a.m. the LNSA documented, "...Coccyx is now healed..."</p> <p>On 12/6/13 at 2:27 a.m. the LNSA documented, "Sacrum: fold split superficial, 6 cm..." [Note: no other information about this open area]</p> <p>On 12/13/13 at 2:27 a.m. the LNSA documented, "Sacrum: Superficial split 2 cm, Sacrum: Superficial split 1 cm." [Note: no other information</p>	F 314		
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F 314	<p>Continued From page 19 about these open areas was documented.] On 12/14/13 at 2:29 a.m. the IDTPN documented, "...Buttock crease has two small open areas but the rest whitish and fragile. Will continue treatments as ordered until resolved." On 1/3/14 at 4:34 a.m. the LNSA documented, "Residents skin much improved...split in buttocks crease have resolved...." On 2/14/14 at 2:30 A.M. the LNSA documented, "Coccyx, skin tear, 4 cm x 0.5 cm, x 0.1 cm., Superficial open area noted to coccyx that was fragile in previous weeks...." On 2/21/14 at 4:16 a.m. the LNSA documented, "Superficial split in coccyx area is closed at this time but fragile..."</p> <p>At the time of the survey the resident's area on the coccyx was closed according to the nursing staff. Observation of the area was not done.</p> <p>The facility policies for "Skin Monitoring and Management - Pressure Ulcers" and Skin Monitoring and Management/ Non-Pressure Ulcers," dated 7/2010 were reviewed. Both policies had a section about assessment of wounds and open areas. These policies documented that the assessments should include: "a. Measurements... b. Staging... c. Describing the nature... d. Describing the location... e. Describing the characteristics... f. Describing the progress with healing, and any barriers to healing which may exist. g. Identifying any possible complications or signs/symptoms consistent with the possibility of infection."</p>	F 314		

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F 314	<p>Continued From page 20</p> <p>The documentation of the slit area on the coccyx failed to follow the policies, there was lacking documentation about section "f." information.</p> <p>The resident initially was observed during the survey on 2/24/14 at 8:05 a.m. in bed waiting for staff to get her up. The Aides got the resident up but the LN was administering medications and did not go and watch them transfer the resident to the wheelchair. The resident was observed to be returned to bed at 10:15 a.m. The resident had an air mattress overlay on her bed and a 1 1/2 inch cushion in her wheelchair. At 11:35 a.m. the resident was observed in the living area engaged in a balloon activity. The sling for the lift was noted to be in the wheelchair at that time. Resident #3 went to lunch in the dining room and after lunch at 12:45 p.m. was brought to the hallway and interacting with staff that walk by. The afternoon activity was B; ingo starting at 1:30 p.m. and the resident was involved in the activity. The resident was observed playing Bingo at 1:55 p.m. She had been out of bed since 11:35 a.m., a period of 2 hours, 20 minutes.</p> <p>On 2/25/14 at 9:45 a.m. Resident #3 was in the dining room with another resident. The resident attended resident group meeting held by the surveyors from 10:00 a.m. until 10:45 a.m. then went to the dining area where snacks were served. The resident remained up until after lunch; she was observed in the dining room at 12:24 p.m. She had been up in the wheelchair for at least 2 hours, 39 minutes. The resident was observed in bed on her back awake at 2:45 p.m. At 4:40 p.m. the resident was up in the living area watching a television program with other residents.</p>	F 314		

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F 314	Continued From page 21 On 2/27/14 at 2:20 p.m. the DON was interviewed about the recurrent sore on the resident's coccyx. The DON indicated the resident had the open area to the coccyx when she was admitted to the facility in 2009. The area was fragile and breaks down frequently, the resident was diabetic, had renal insufficiency, had decreased mobility requiring a mechanical lift and was obese. The facility had put in place an air mattress, a pad in the resident's wheelchair, and a special sling for the mechanical lift. The lack of documentation was discussed and the DON indicated there should have been documentation for the areas lacking.  The facility submitted additional information on 2/28/14 and that information was added to the information contained in the deficiency.  The facility failed to: - position the resident off the coccyx every 2 hours as care planned. - document wound information identified in policy, - keep the coccyx clean and dry.  The Administrator and DON were informed of the issue on 2/27/14 at 4:00 p.m. Additional information was submitted and used in this report.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		4/4/14

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F 323	Continued From page 22  This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of Occurrence Reports, it was determined the facility failed to provide staff supervision and increase the frequency of that supervision for residents at high risk for falls, develop and follow appropriate care plans, complete a root cause analysis and monitor the safety of equipment. This was true for 2 of 9 sampled residents (#1 and #2). This failed practice resulted in harm when Resident #2 fell and fractured a hip. Findings included:  1. Resident #2 was admitted to the facility on 4/14/08 and readmitted on 11/18/13. The resident had diagnoses of aftercare following joint replacement, depressive disorder, anxiety, and dementia unspecified with behavior disturbances.  The 2/11/14 quarterly MDS documented the resident: - had severe cognitive impairment (BIMS = 6), - needed extensive assistance of two for bed mobility, transfers, walking in her room, personal hygiene and bathing, - was frequently incontinent of bowel and bladder, - had two falls since previous assessment.  The February 2014 physician recapitulation orders documented an original order dated 9/29/10 of, "Use bed alarm and motion monitor on at all times to help prevent falls R/T unassisted transferring from bed...."  The resident's care plan, dated 9/20/11,	F 323	<b>F-323</b> 1.A: Res #1- was referred to P/T for evaluation for seating. Assessment was done for Restraint/Enabling devices and included safety information. B: Res #2- Care plan was revised following the injury fall to reflect changes. The resident was on every 15 minute checks at the time of both falls cited in the 2567. 2. Other residents at high fall risk could be affected. LN in-service was conducted to review/re-train nursing on fall risk assessment, interventions and completion of occurrence reports. All other residents that are high risk for falls have had care plans reviewed for appropriate interventions. 3. All residents at high risk for falls will receive a level of supervision and intervention as determined by quarterly fall risk assessment and care plan. The IDT will do root cause analysis in fall committee for residents sustaining falls. 4. Audits will begin on 4/1/2014. The fall committee will audit all fall assessments for accuracy and all care plans for residents at high risk for appropriate interventions. Audits will occur weekly X2 month then monthly		

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F 323	<p>Continued From page 23</p> <p>documented, "Potential for falls and injury." The care plan was reviewed every three months with the last review dated 9/30/13. The care plan was then changed to an electronic care plan. The approaches for the electronic care plan were:</p> <ul style="list-style-type: none"> <li>- Monitor safety issue at all times-keep walkways free of obstacles that could cause tripping,</li> <li>- Provide adequate lighting, including a night light if needed,</li> <li>- Keep call bell within reach and answer as promptly as possible,</li> <li>- Monitor for medication side effects that could contribute to falls,</li> <li>- Assist resident to toilet as per schedule, see inc[ontinent] care plan,</li> <li>- Assess and medicate for pain as ordered by MD to keep comfortable,</li> <li>- Encourage resident to wear glasses if needed,</li> <li>- Encourage that resident uses walkers, cane, or other needed devices,</li> <li>- Siderail order: 1/2 SR [side rail] [up] x 1 to assist [with] bed mobility,</li> <li>- Ambulation status: Ambulate ad lib [with] close supervision in common areas.</li> <li>- Devices needed for ambulation: Tab alarm in recliner et [and] while in bed, Floor alarm DC'd [discontinued] d/t tripping risk, Amb[ulate] [with] walker - Tends to walk too fast and needs cues to slow down." <p>The resident's electronic medical record had a fall care plan, with a date initiated of 9/23/13, that documented: "Has had an actual fall with Left hip fracture." [Note: the resident fell on 9/23/13 but fractured the left hip on 11/5/13 after a fall.] The interventions were: [Note: none of the interventions were dated so it was not possible to identify when they were initiated.]</p> <p>"- bed in lowest position.</p> </li></ul>	F 323	<p>for 3 months. Results will be reported to the QI committee monthly.</p> <p>5. Compliance will be achieved by April 4, 2014.</p>	

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F 323	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>- check range of motion.</li> <li>- For no apparent acute injury, determine and address causative factors of the fall.</li> <li>- Monitor/document/report to MD for s/sx: pain, bruises, Change in Mental status. New onset: confusion, sleepiness, inability to maintain posture, agitation.</li> <li>- Neuro-checks as ordered.</li> <li>- Provide activities that promote exercise and strength building where possible. Before lunch group activity [resident name] enjoys.[sic]</li> <li>- Vital signs as ordered."</li> </ul> <p>The electronic medical record had another fall care plan, with a date initiated of 10/4/13, that documented: "At risk for falls r/t decreased agility and safety judgement." The interventions were: [Note: none of the interventions are dated so it is not possible to identify when they were initiated.]</p> <ul style="list-style-type: none"> <li>"- Re-evaluate as needed for continued appropriateness and to ensure least restrictive device or restraint.</li> <li>- Anticipate and meet needs.</li> <li>- Avoid rearranging furniture.</li> <li>- Be sure the call light is within reach and encourage to use it to call for assistance as needed.</li> <li>- Bed in lowest position.</li> <li>- Educate resident/family/ and care givers about safety reminders and what to do if a fall occurs.</li> <li>- Encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility.</li> <li>- Ensure resident is wearing appropriate footwear when ambulating or wheeling in w/c.</li> <li>- Keep needed items, water, etc, in reach.</li> <li>- Maintain a clear pathway, free of obstacles.</li> <li>- Needs a safe environment: floors free from spills and/or clutter; adequate, glare-free light; a</li> </ul>	F 323			

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F 323	<p>Continued From page 25</p> <p>working and reachable call light, the bed in low position at night; side rails as ordered, handrails on walls, personal items within reach.</p> <ul style="list-style-type: none"> <li>- Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes.</li> <li>- Tab alarm on when in bed."</li> </ul> <p>On 09/09/13 the physician saw the resident during a "Nursing Home Visit" and documented, "She is at risk for falls at time due to poor safety awareness...." The physician under "Assessment:" documented: "... 2. Recurrent falls with poor safety awareness and impulsivity...."</p> <p>On 10/21/13 the physician saw the resident during a "Nursing Home Visit." The resident had a fall on 9/23/13, however the physician failed to address the fall. The Physician's "Assessment:" documented: "... 2. Recurrent falls with poor safety awareness and impulsivity...."</p> <p>On 12/2/13 the physician saw the resident during a "Nursing home Visit" and documented a "Nursing Home Readmission History and Physical Examination." The documentation read: "...She is an elderly female who initially had a fall on 11/05/2013, at which time she was noted to have left hip pain and a left hip fracture was suspected so she was sent...where a left hip fracture was confirmed....She does have advanced dementia and is quite forgetful. She just recently has her hip surgery and has not really recovered very much from that..." The "Social History:" documented: "...She is a high fall risk and has had several falls. She remains impulsive with poor safety awareness..." The</p>	F 323		

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F 323	<p>Continued From page 26</p> <p>"Assessment: documented: "...5. Fall with hip fracture and open reduction, internal fixation on 11/06/2013. 6. Recurrent falls with poor safety awareness and impulsivity..."</p> <p>Review of the Occurrence Reports, medical record interdisciplinary (IDT) notes and additional information, dated 2/28/14, provided by the DON, documented a history of resident falls and impulsivity and risks the resident exhibited that were not care planned. These documents showed the following dates for falls.</p> <p>May 16, 2013 September 23, 2013 November 5, 2013 - fall with a fractured left hip. December 28, 2013 December 30, 2013 January 26, 2014</p> <p>The documentation provided the following information:</p> <p>* On 5/9/13 at 5:44 p.m. an LN completed a fall risk assessment. The resident scored an 11 and the LN documented the resident was "High Risk." * On 6/3/13 at 10:33 a.m. an LN documented in progress notes, "...She continues to be a risk for falls, she has a motion monitor at night to alert staff to assist her with toileting at night for safety. Will review with therapy to see if has she may [sic] need to increase her strength to make her safer with is (sic) impulsivity gets up to do things to help prevent falls with her, she does have dementia with history of anxiety and depression which symptoms are controlled at this time..."</p> <p>NOTE: The fall care plans provided did not address impulsivity, for example, a care plan intervention to implement hourly staff rounds to</p>	F 323		
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F 323	<p>Continued From page 27</p> <p>check on the resident's needs. If hourly was determined to be inadequate, more frequent checks could be implemented based on on-going assessment.</p> <p>* On 6/5/13 at 2:50 p.m. an LN documented, "...Resident has been having more balance issues when standing, Resident has had a recent falls (sic), and is weak with all ADL's will review with the IDT team and decide what next step with her." [Note: the most recent documented fall prior to this note was 5/16/13]</p> <p>* On 8/14/13 at 8:53 p.m. an LN completed a fall assessment on the resident. The resident scored a 12 and the document indicated the resident was "High Risk."</p> <p>* The 8/16/13 annual MDS assessment documented a BIMS of 7 which equates to severe cognitive impairment.</p> <p>* On 9/1/13 at 12:23 a.m. an LN documented, "...Toileted every two hours and staff does wash and dry applying skin barrier. They follow her to her room when seeing her head towards it when observed. Has a tendency to attempt self toileting. Uses a walker and walks very fast. Reminders to slow down so she does not fall..." [Note: The "Reminder to slow down" was on the 9/20/11 care plan but not on the most recent care plans provided to surveyors.]</p> <p>* On 9/18/13 at 12:28 a.m. an LN documented, "...Resident has a tendency to try to take herself to the bathroom herself and staff will intervene when seeing her and give assist..."</p> <p>* On 9/23/13 at 3:58 p.m. an LN documented, "Resident was in the BR [bathroom] she stated when she stood up she lost her balance and slid down the wall onto her bottom....No difficulty noted with ambulation. No evidence of injury noted..."</p>	F 323		

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F 323	<p>Continued From page 28</p> <p>* On 9/23/13 at 2:00 p.m. an Occurrence Report documented, "Who was the last person to see resident before accident occurred if accident was not witnessed (attach statement)? Was in the DR [dining room] for lunch." The report continued with, "Describe what happened and any injuries: Resident was in the BR [bathroom] when she stood up she lost her balance and slid down the wall onto her bottom." The report further documented the resident was not a "High Risk" for falls, did have a history of falls and was being treated with antibiotics for a urinary tract infection. [Note: The unwitnessed fall was not fully investigated.]</p> <p>* On 11/5/13 at 9:00 a.m. an Occurrence Report documented, "Describe what happened and any injuries: Resident was ambulating from dining room to living room. Heard resident yell from living room. She was lying on the floor." The report further documented the resident was not a "High Risk" for falls and did not have a history of falls.</p> <p>* On 11/5/13 at 6:10 p.m. an LN documented, "[Name] fell this morning while ambulating from the dining room to the living room. Staff heard her yell and responded quickly to find her on the floor. She c/o hip pain and was noted to have external rotation of L foot...." [Note: The Occurance Reports for 9/23/13 and 11/5/13 documented the resident was not at high risk for falls but fall risk assessments for 5/9/13 and 8/14/13 documented the resident was at high risk.]</p> <p>The resident was admitted to the hospital and required an open reduction internal fixation of the left hip. The resident returned to the facility on 11/9/13 and IDT notes documented the resident did not feel well. The resident was readmitted to the hospital on 11/16/13 with cholelithiasis</p>	F 323		
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F 323	<p>Continued From page 29</p> <p>[gallstones]. The resident returned to the facility on 11/18/13 on antibiotics.</p> <p>* On 11/20/13 at 4:36 a.m. an LN documented, "...Did attempt to get up one time to toilet. Safety alarm sounded and assisted to the bedside commode by staff...."</p> <p>* On 12/14/13 at 6:14 p.m. an LN documented, "... Repositioned every 1 1/2 hour....Transferring with assist of 1 person with walker and gait belt and walking short distance from w/c to bed, or bed to BSC [bedside commode] and pivots..."</p> <p>* On 12/28/13 at 8:15 p.m. an Occurrence Report documented, "Heard someone calling out - went to check - [Name] was on the floor on wheelchair cushion, w/c behind her, Tab alarm disconnected. resident denied hitting head." [Note: no nursing note for the fall.]</p> <p>* On 12/30/13 at 6:00 a.m. an Occurrence Report documented, "Resident was trying to take herself to the BR [bathroom] and slid off of the side of the bed with the blankets on her. Resident had removed the tab alarm on her right side and the alarm on her left side was still intact."</p> <p>* On 12/30/13 at 9:35 a.m. an LN documented, "At 0600 I was called to resident's room and found resident sitting on her buttocks on the floor. stated 'I was fooling around trying to get over there' and pointing to her bedside commode. resident had been incontinent at the time...resident assisted up to commode with gait belt and max assist of 2..."</p> <p>* On 1/4/14 at 2:30 a.m. an LN documented, "...Will be working with therapy d/t recent falls. Motion monitors in place to alert staff of unassisted transfers. Did try to ambulate self to BR [bathroom] tonight. Will continue to anticipate residents needs...Extensive assistance with transfers, toileting, and bed mobility...."</p>	F 323		
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F 323	<p>Continued From page 30</p> <p>* On 1/26/14 at 7:30 a.m. an Occurrence Report documented, "Resident trying to self transfer to BSC and slid off of bed, [No] injury."</p> <p>* On 1/26/14 at 10:59 a.m. an LN documented, "Resident found sitting at the side of her bed on the floor by a CNA student. No apparent injury noted on assessment. Lifted from floor after assessment by 2 CNAs using gait belt and placed into wheelchair. Resident had been toileted 15-20 minutes prior to being found and had been put back to bed per her request with alarm in place. Resident had removed the alarm and was attempting to transfer herself to BSC [bedside commode]. Resident has dementia and did not realize she had just been toileted. Neurological checks initiated and resident placed on every 15 minute checks."</p> <p>* On 1/28/14 at 10:59 p.m. an LN documented, "...Forgetful and confusion continues per her norm, significant cognitive deficits and does not remember what has been said or talked about. Poor safety awareness and has set her tab alarm off many times this evening trying to get up from her wheelchair. She did not know what she wanted..."</p> <p>* On 2/11/14 at 4:50 p.m. an LN documented, "Resident making progress to increase her mobility, and able to ambulate with one person assist and walker, with gait belt. She continues to show improvement with transfer and short distance ambulation. Continue current rehab plan, and encourage resident to do as much as she can for herself. Cueing by staff is needed d/t resident dementia. Current rehab plan to help increase resident function level."</p> <p>On 2/26/14 at 9:45 a.m. the DON was interviewed about the resident's falls and specifically the fall on 11/5/13, where the resident fell and required</p>	F 323		
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	<p>Continued From page 31</p> <p>surgery due to a fractured left hip. The DON stated the resident came out of the dining room with her walker and turned right and headed to the day area where she liked to go after breakfast. The resident went by the LN who was at the medication cart. The resident went into the living area and fell on the floor fracturing the left hip. Staff responded within 30 seconds from the time they heard the resident yelling. The resident was evaluated and transferred to her bed until the ambulance arrived. The DON provided further information on 2/28/14, portions of which were included in the documentation.</p> <p>The facility failed to:</p> <ul style="list-style-type: none"> <li>- Provide supervision for the resident who was at "high risk" for falls, such as hourly rounding to check on the resident's needs.</li> <li>- Increase the frequency of supervision checks when the resident continued to fall.</li> <li>- Develop a care plan for the resident that recognized the resident's severe cognitive impairment as it related to fall supervision.</li> <li>- Complete a root cause analysis for the resident's falls as per resident care plan.</li> </ul> <p>The DON and administrator were informed of the issue on 2/27/14 at 4:00 p.m. Additional information was provided and included in the deficiency citation.</p> <p>2. Resident #1 was admitted to the facility on 8/22/11 with multiple diagnoses which included senile dementia with depressive features, dementia with behavioral disturbances, anxiety,</p>			

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F 323	<p>Continued From page 32 and osteoarthritis.</p> <p>The 2/18/14 Quarterly MDS Assessment documented the resident:</p> <ul style="list-style-type: none"> <li>- was severely impaired for daily decision making;</li> <li>- was totally dependent on staff for bed mobility, transfers, locomotion on and off unit, dressing, eating, toilet use, personal hygiene and bathing;</li> <li>- was always incontinent of bowel and bladder; and,</li> <li>- had no falls since Admission/Entry or Reentry or Prior Assessment.</li> </ul> <p>The resident's Fall Risk Evaluation, dated 11/13/13, documented the resident was at high risk for falls.</p> <p>The resident's care plan, dated 6/12/13, with a focus of "Potential for falls r/t impaired mobility and cognitive loss r/t Alzheimers documented:</p> <ul style="list-style-type: none"> <li>- Lap buddy when in w/c [wheelchair] to help prevent falls d/t [due to] leaning forward. Check q [every] 30 minutes. Release q 2 hours and for cares;</li> <li>- Tab alarm on bed and w/c."</li> </ul> <p>An Occurrence Report, dated 11/27/13, documented an unwitnessed fall at 7:45 PM. CNA #6 was assigned to Resident #1's care and was the last person to see the resident before the accident occurred. The description of what happened documented the resident was in her chair in her room. CNA #6 left to find help from another aide and when they entered the room, the resident was on the floor. The report documented the resident was identified as "HIGH RISK" for falls and had a history of falls.</p>	F 323		
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F 323	<p>Continued From page 33</p> <p>The report included CNA #6's handwritten statement, dated 11/27/13, in which she documented putting the resident in her nightgown with the lap buddy on and asked for help with putting the resident to bed. CNA #6 documented as soon as another aide was free they went to the resident's room and found the resident "on the floor with the lap buddy under her head."</p> <p>The report included CNA #7's handwritten statement, undated, in which she documented CNA #6 was helping her with a random resident when CNA #6 asked for help with Resident #1. She documented when she walked into the resident's room the resident "was on the floor with lap buddy."</p> <p>The report documented the probable cause of the accident as "wt [weight] of body caused lap buddy to fail - sides were weak." The facility documented the following interventions: Changing the lap buddy and staff education.</p> <p>NOTE: The Occurrence Report did not investigate how long the resident had been left alone in her room, what kind of education was given to the staff, nor was there an attached in-service with CNA signatures. The report did not mention the resident's weight at the time of the fall.</p> <p>Record review documented the resident weighed 102.2 pounds on 11/25/13.</p> <p>A Progress Note by LN #8, dated 11/27/13 at 23:35 PM, documented, "At 7:45 this evening resident slid out of her chair in her room. Not witnessed. Will do neuro checks and report any</p>	F 323		

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F 323	<p>Continued From page 34</p> <p>issues...Small superficial 2 cm scratch like mark noted mid spine level. Not open just discolored pink. No other injury noted at this time."</p> <p>NOTE: There was no mention of a scratch on the Occurrence Report.</p> <p>Progress notes over the next two days documented there was no evidence of further injury related to the fall and neuro checks were within normal limits.</p> <p>On 2/26/14 at 2:15 PM, the DON was interviewed regarding the resident's fall on 11/27/13. The DON stated she was not sure how long the resident had been left alone or how long she might have been on the floor. The DON stated the resident was referred to physical therapy for an evaluation and now has a high backed wheelchair with a lap buddy.</p> <p>A Physical Therapy Evaluation, dated 12/6/13, documented "Reason for Referral: Staff reporting pt's [resident's] positioning in w/c is declining as w/c is too large with pt leaning laterally and scooting fwd [forward] out of chair with 1 fall."</p> <p>On 2/27/14 at 3:40 PM, the DON and administrator were made aware of the issue regarding falls.</p> <p>On 3/3/14 a fax was received from the facility in which the DON documented, "the weight of her [resident's] body on the lap buddy caused it to come loose. The lap buddy was not put in place to restrain [resident's name] in her chair, but rather assist with her positioning in the chair." The DON further documented, "Given her prior history, this fall could not have been predicted or</p>	F 323			

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F 323	Continued From page 35 prevented."  NOTE: The resident's care plan for the focus of potential for falls, dated 6/12/13, documented an intervention "Lap buddy when in w/c [wheelchair] to help prevent falls d/t [due to] leaning forward."  The facility failed to: - Assess and identify the resident's position in the wheelchair was declining and the wheelchair was too large; - Assess the lap buddy, which was considered a restraint, according to the interpretive guidance regarding restraints, in spite of the fact it was care planned to "help prevent falls;" and, - Assess the lap buddy was safe and in good working order for a resident weighing 102 pounds.	F 323	<b>F-329</b> 1. Res 1 & 8 legal representatives were informed of the black box warning and signed informed consents were obtained. 2. Other residents prescribed psychotropic medication could be affected. All resident's records were reviewed to ensure appropriate informed consents were in place. 3. Black box warning information has been included on the consent forms for psychotropic medication and will be checked for the designated signer's attention, if applicable. LN staff in-serviced on the need for black box education for residents and their family. 4. Audits will begin on 4/1/2014. The DNS or LN designee (not SS) will audit consents for all residents receiving psychotropic medications for completion 1X weekly X 2mo then 2X monthly for 2 months. Findings will be reported to QI committee monthly. 5. Compliance will be achieved by April 4, 2014.		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		4/4/14	

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F 329	<p>Continued From page 36</p> <p>record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to consider the risks identified in the FDA black box warning for residents with dementia who received antipsychotic drugs. This was true for 2 of 9 residents (#1 and #8) sampled for unnecessary drugs. This failure presented the potential for harm as unnecessary drugs can lead to adverse reactions and health decline. Findings included:</p> <p>Resident #1 was admitted to the facility on 8/22/11 with multiple diagnoses which included senile dementia with depressive features, dementia with behavioral disturbances, anxiety, and osteoarthritis.</p> <p>The 2/18/14 Quarterly MDS Assessment documented the resident: - was severely impaired for daily decision making; - had no behaviors; and, - was receiving psychoactive medications</p> <p>The All Active Orders for February, 2014, recapitulation orders, documented an order for Zyprexa (Olanzapine) 5 milligrams orally at HS (hour of sleep) with a start date of 11/17/13 for the diagnosis of psychosis.</p>	F 329	

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F 329	<p>Continued From page 37</p> <p>The resident's physician documented on 2/3/14 the current status/diagnosis for the use of Zyprexa as "Alzheimer's dementia with organic mental syndrome with delusions/psychosis." The MAR for February, 2014, documented the resident received Zyprexa daily.</p> <p>Record review of Resident's #1 chart did not include documentation the resident or the legal representative were informed of the black box warning. The FDA has found that older residents treated with Zyprexa had a higher chance for death than residents who did not take the medication.</p> <p>On 2/26/14 at 11:30, LN #1 was interviewed and stated they had a consent for the medication but did not have documentation of the black box warning.</p> <p>On 2/27/14 at 8:00 AM, LN #1 provided a copy of the consent for treatment for Zyprexa which included the black box warning but was dated 2/27/14.</p> <p>On 2/27/14 at 4:00 PM, the Administrator and DON were informed of the black box warning issue.</p> <p>2. Resident #8 was a 73 year old admitted to the facility on 1/6/12 with diagnoses of malignant neoplasm colon, diabetes mellitus, depressive disorder, senile dementia with delirium, and dementia with behavior disturbances.</p> <p>The 12/5/13 quarterly MDS assessment documented the resident:</p> <ul style="list-style-type: none"> <li>- had moderate cognitive impairment with a BIMS of 10,</li> <li>- had no behaviors,</li> </ul>	F 329		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 38 - was receiving psychoactive medications.  The physician's February 2014 recapitulation orders documented the resident was receiving Zyprexa (Olanzapine) 5 milligrams orally twice a day.  The medical record was lacking documentation of the risks verses benefits discussion with the resident's power of attorney. Zyprexa had an FDA warning that elderly residents with dementia related psychosis were at risk for death when using the medication. As of survey there was no evidence this information had been discussed with the resident or family.  The social service designee (SSD) was interviewed on 2/26/14 at 4:15 p.m. and knew about the FDA warning but had not met with the resident's family and discussed it with them.  The Administrator and DON were informed on 2/27/14 at 4:00 p.m.	F 329			
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by: Based on observation, menu review and staff interview, the facility dietary staff failed to follow	F 363	<b>F-363</b> 1. Residents #1-9 meals had already been served. The RD reviewed and signed off the substitutions for the coming weeks. 2. All residents eating in the facility dining room could be affected. The RD reviewed and signed off approving substitutions for the coming weeks. 3. Dietary staff was in-serviced on the necessity of spreadsheets for all substitutions. RD reviewed/approved menus will be followed as closely as possible, with substitutions made according to facility policy/procedure. Necessary food changes to be made using RD pre-approved exchange list, to be retained by CDM. 4. Audits will begin on 4/1/2014. The Administrator or Management designee (not CDM) will audit menus for approved substitutions and spreadsheets 2X weekly X 1 months, then weekly X2 months. Results will be reported to the QI committee monthly. 5. Compliance will be achieved by April 4, 2014.	4/4/14	

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F 363	<p>Continued From page 39</p> <p>the menus approved by the registered dietitian. This had the potential to affect most all residents in the facility and specifically 9 of 9 (#s 1 - 9) sampled residents. There was a potential for harm when menus were not followed, potentially residents would not receive the correct amount of daily calories required. Findings include.</p> <p>On 2/25/14 at 11:50 a.m. the white board in the dining room had the lunch choices written on it. These were: "Swiss steak Mashed potatoes Green beans Bread pudding Alternate: Cream of potato soup Crackers BLT Sandwich [bacon lettuce and tomato sandwich]"</p> <p>The menu was reviewed. The menu was approved by the Registered Dietitian (RD) on 10/3/13. The planned menu items for the lunch alternate were different. The menu specified, "Turkey Mornay and Seasoned Green Peas." The spreadsheet documented the serving sizes for the Alternate on the menu, not what was actually served.</p> <p>On 2/25/14 at 4:40 p.m. the white board in the dining room had the dinner choices written on it. These were: "Breaded fish [Note: This was a cod patty.] Tarter Sauce Mixed Veg Fruit Cup Alternate: Chicken Casserole</p>	F 363		

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F 363	Continued From page 40 Garlic Bread Tomatoe slice" The board also had "fries" written sideways across it.  The menu was reviewed. The posted menu items were different than what had been approved by the dietitian. The menu specified, "Salmon Croquettes, Seasoned Baby Carrots, White Bread, Margarine Pat, and Chilled Pineapple" the alternate was: "Grilled Cheese Sandwich and Marinated Tomato Salad." This was not what was served.  On 2/26/14 at 11:00 a.m. the alternate listed on the white board was "Chicken Bowl, made with chicken mashed potatoes gravy corn." The menu documented the alternate was "Veal Marengo and Seasoned Broccoli cuts." The residents received the chicken bowl as the alternate.  On 9/26/14 at 9:15 a.m. the RD was interviewed about the changes. She indicated that she had no idea that the changes had been made. The CDM joined the interview and indicated that she didn't have to notify the RD of the changes when the planned menu items did not arrive and they had to make changes. The RD indicated that she was not aware of the changes and said "they will have to do some work." She informed the CDM that she should have talked with her when the changes were needed.  The Administrator and DON were informed of the menu issues on 2/27/14 at 4:00 p.m. No additional information was provided.	F 363			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		4/4/14	

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F 441	<p>Continued From page 41</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p><u>F-441</u></p> <p>1. A. Residents #3 &amp; #4 were assessed for signs &amp; symptoms of infection and none were found. B. Residents #1-#9 assessed for signs &amp; symptoms of infections</p> <p>2. A. CNA #5 was immediately re-educated on glove use and hand washing. B. Laundry personnel were educated on the location and use of PPE.</p> <p>3. Infection control will be emphasized in weekly CNA meeting agendas with hand washing included. PPE use will in serviced quarterly at housekeeping meetings.</p> <p>4. Observation of CNA hand washing will be conducted by licensed nursing staff twice per shift for 3 weeks x 1 month, then weekly x 2 months, with audits beginning on 4/1/14. B. Licensed nursing staff will confirm, through observation, availability of PPE in the laundry area daily x 2 months beginning on 4/1/14. Findings will be reported to the QI Committee.</p> <p>5. Compliance will be achieved by April 4, 2014.</p>	

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F 441	<p>Continued From page 42</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure standard precautions were used, including effective hand washing practices to reduce the spread of infection and prevent cross-contamination for 2 of 9 sampled residents (#3 and #4). Additionally, the facility failed to provide gowns for laundry personnel when working with dirty laundry to protect all residents who reside at the facility, including 9 of 9 (#s 1 - 9) sampled residents. This practice created a potential risk to contaminate all residents' clean laundry with infectious organisms. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 9/29/07 with multiple diagnoses which included debility, acute gastric ulcer with perforation and obstruction.</p> <p>The resident's most recent Quarterly MDS assessment, dated 11/29/13, documented she required extensive assistance of 2 persons for bed mobility, transfers, toilet use, and bathing.</p> <p>During an observation on 2/24/14 at 10:35 AM, CNA #5 was observed helping transfer Resident #4 from the bed to the lounge chair. Then CNA #5 removed her gloves, picked up the trash bag and left the room without washing her hands. She threw the trash bag away in the dirty laundry and proceeded to Resident #3's room. CNA #5 was observed to put gloves on without washing her hands and to empty Resident #3's catheter drainage bag. Then CNA #5 removed her gloves and was observed to wash her hands.</p> <p>On 2/24/14 at 10:40 AM, the surveyor asked CNA</p>	F 441		

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F 441	<p>Continued From page 43</p> <p>#5 about hand washing after resident cares and before helping another resident. CNA #5 stated "I might not have, I don't know. I know I should."</p> <p>On 2/27/14 at 3:30 PM, the DON was informed of the above hand hygiene issue and stated CNA #5 had made her aware of the issue. No further information was provided.</p> <p>2. During the environmental tour of the facility on 2/26/14 at 10:00 a.m. the laundry area was observed. The following information was obtained by interview with the maintenance supervisor and observation of the laundry area. The laundry had two areas in use - the washing area was located in the main building and housed two washing machines. Dirty laundry would arrive, be sorted and washed in this area. When the washing was completed the contents of the machines were put in covered containers and pushed outside to another building that housed the two gas dryers, where the loads were dried and sorted. The facility did all the laundry, including sheets and residents' personal clothing that was not done by a resident's family. During this observation, a laundry staff person was observed transporting clean laundry from the washing machine to the dryer. It was a chilly day and she was wearing a coat to keep warm when outside. In the washing machine area, where the dirty laundry arrived, the surveyor did not observe any gowns, aprons or other protective equipment to protect a laundry worker from getting contaminated when sorting the dirty laundry. In the dryer area, the surveyor did not observe any protective clothing to protect the laundry from contact with the staff's potentially contaminated clothing.</p>	F 441		

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F 441	Continued From page 44  The Administrator and DON were informed of the findings on 2/27/14 at 4:00 p.m. The maintenance person informed administrative staff that the person doing the laundry was not the permanent laundry worker. The regular laundry worker had collected and washed resident gowns, but had failed to transfer that clothing to the dryer before taking the day off. No other information was provided.	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001660</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OWYHEE HEALTH &amp; REHABILITATION CENTE!</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>108 WEST OWYHEE HOMEDALE, ID 83628</b>
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C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey of your facility.  The surveyors conducting the survey were: Arnold Rosling, RN, BSM, QMRP Rebecca Thomas, RN  The survey team entered the facility on February 24, 2014 at 7:30 a.m., and exited the facility on February 28, 2014.	C 000	<b>C-123</b> – Refer to F-221.	
C 123	02.100,03,c,vii Free from Abuse or Restraints  vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to himself or to others;  This Rule is not met as evidenced by: Please refer to F-221 as it refers to physical restraints	C 123	<b>C-125</b> – Refer to F-241.	
C 125	02.100,03,c,ix Treated with Respect/Dignity  ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for	C 125		

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**MAR 26 2014**  
**FACILITY STANDARDS**

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_  
STATE FORM 6899 91R411 If continuation sheet 1 of 6

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C 125	Continued From page 1  his personal needs; This Rule is not met as evidenced by: Please refer to F-241 as it refers to dignity.	C 125	<b>C-147</b> – Refer to F-329.	
C 147	02.100,05,g Prohibited Uses of Chemical Restraints  g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please refer to F-329 as it refers to unnecessary drugs and black box warnings.	C 147	<b>C-274</b> 1. Residents #1-9 meals had already been served. The RD reviewed and signed off the substitutions for the coming weeks. 2. All residents eating the in facility dining room could be affected. The RD reviewed and signed off approving substitutions for the coming weeks. 3. Dietary staff was in-serviced on the necessity of spreadsheets for all substitutions. RD reviewed/approved menus will be followed as closely as possible, with substitutions made according to facility policy/procedure. Necessary food changes to be made using RD pre-approved exchange list, to be retained by CDM. 4. Audits will begin on 4/1/2014. The Administrator or Management designee (not CDM) will audit menus for approved substitutions and spreadsheets 2X weekly X 1 month, then weekly X2mo. Results will be reported to the QA committee monthly. 5. Compliance will be achieved by April 4, 2014.	
C 274	02.107,01,e,ii Review/Approve Menus/Diet Plans  ii. Review and approve menu and diet plans; This Rule is not met as evidenced by: Based on observation and staff interview the RD was not consulted nor had she approved the menu and diet plan changes for the facility. This had the potential to effect all resident that reside in the facility including 9 of 9 (#s 1 - 9) sampled residents. Findings include:  On 2/25/14 at 11:50 a.m. the white board in the dining room had the lunch choices written on it. These were:"Swiss steak, Mashed potatoes, Green beams, and Bread pudding. Alternate: Cream of potatoe soup, Crackers, and BLT Sandwich [bacon lettuce and tomato	C 274		

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C 274	<p>Continued From page 2 sandwich]"</p> <p>The menu was reviewed. The menu was approved by the Registered Dietitian (RD) on 10/3/13. The menued items for lunch alternate were different. The menu specified, "Turkey Mornay and Seasoned Green Peas." The spreadsheet documented the serving sizes for the Alternate ended not what was served.</p> <p>On 2/25/14 at 4:40 p.m. the white board in the dining room had the dinner choices written on it. These were: "Breaded fish [Note: These were cod patty], Tarter Sauce, Mixed Veg, and Fruit Cup. Alternate: Chicken Casserole, Garlic Bread , Tomatoe slice" The board also had "fries" written sideways across it.</p> <p>The menu was reviewed. The menued items were different then what had been approved by the dietitian. The menu specified, "Salmon Croquettes, Seasoned Baby Carrots, White Bread, Margarine Pat, and Chilled Pineapple" the alternate was: "Grilled Cheese Sandwich and Marinated Tomato Salad." This was not what was served.</p> <p>On 2/26/14 at 11:00 a.m. the alternate listed on the white board was "Chicken Bowl, made with chicken mashed potatoes gravy corn." The menu documented the alternate was "Veal Marengo and Seasoned Broccoli cuts."</p> <p>On 9/26/14 at 9:15 a.m. the RD was interviewed about the changes, she indicated that she had no idea that the changes had been made. The CDM joined the interview and indicated that she didn't have to notify the RD of the changes when the items menued did not arrive and they had to</p>	C 274		

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C 274	Continued From page 3  make changes. The RD indicated that she was not aware of the changes and said "they will have to do some work." She informed the CDM that she should have talked with her when the changes were needed.  The Administrator and DON were informed of the menu issues on 2/27/14 at 4:00 p.m. No additional information was provided.	C 274		
C 422	02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas  vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water. This Rule is not met as evidenced by: Based on observation, resident interviews, and staff interview, it was determined that the facility did not provide 1 tub or shower for every 12 licensed beds. Findings included:  On 2/26/14 at 10:00 a.m. the Maintenance Supervisor (MS) accompanied the surveyor during the General Observations of the Facility tour. There was one tub and 2 showers in the main shower room. The surveyor asked the MS if there were any resident rooms with a tub or shower or any other tubs or showers other than those observed in the main shower room. The MS replied with, "This is it, our only one."	C 422	<b>C-422</b> – This facility requests the continuance of the waiver that has existed for many years in this facility.	

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C 422	Continued From page 4  On 2/28/14 at 10:30 a.m., the Administrator requested that a waiver be granted to the facility because the only tub/shower room used in the facility contained one tub and 2 showers. This was the same as the last annual survey conducted 2/1/13.  The facility was licensed for 49 beds. The tub and showers only met the requirement for 36 beds.	C 422	<u>C-670</u> – Refer to F-441.  <u>C-671</u> – Refer to F-441.		
C 670	02.150,03,a Aseptic/Isolation Techniques  a. Applied aseptic or isolation techniques by staff. This Rule is not met as evidenced by: <b>REFER TO F441 REGARDING HAND WASHING AND DIRTY LAUNDRY ISSUES. BB</b>	C 670	<u>C-782</u> – Refer to F-280.		
C 671	02.150,03,b Handling Dressings, Linens, Food  b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Please refer to F-441 as it relates to infection control	C 671			
C 782	02.200,03,a,iv Reviewed and Revised  iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F-280 as it relates to review and revision of Care Plans .	C 782	<u>C-790</u> – Refer to F-323.		
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or	C 790			

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91R411

If continuation sheet 5 of 6

**PER PHONE CONVERSATION WITH ADMINISTRATOR ON 4/4/14 AT 11:15 AM, REFER TO STATEMENT IS ACCEPTABLE  
BB**

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001660</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>OWYHEE HEALTH &amp; REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>108 WEST OWYHEE HOMEDALE, ID 83628</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 790	Continued From page 5  injury; This Rule is not met as evidenced by: Please refer to F-323 as it refers to falls and accidents	C 790		