



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 1833

March 4, 2014

Mark S. High, Administrator  
Life Care Center of Idaho Falls  
2725 East 17th Street  
Idaho Falls, ID 83406-6601

Provider #: 135091

Dear Mr. High:

On **February 14, 2014**, a Recertification and State Licensure survey was conducted at Life Care Center of Idaho Falls by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 17, 2014**. Failure to submit an acceptable PoC by **March 17, 2014**, may result in the imposition of civil monetary penalties by **April 7, 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 **March 21, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 21, 2014**. A change in the seriousness of the deficiencies on **March 21, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 21, 2014** includes the following:

Denial of payment for new admissions effective **May 14, 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 14, 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 14, 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 17, 2014**. If your request for informal dispute resolution is received after **March 17, 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: 03/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF IDAHO FALLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</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) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual Federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator; Karen Marshall, MS RD LD; and Amy Barkley, BS RN.</p> <p>The survey team entered the facility on Monday, 2/10/14 and exited the facility on Friday, 2/14/14.</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living CNA = Certified Nurse Aide DNS/DON = Director of Nursing Services/Director of Nursing ED = Executive Director (Administrator) LPN = Licensed Practical Nurse LTM = Long Term Memory MOHO = Pressure relieving wheelchair cushion MDS = Minimum Data Set assessment OT = Occupational Therapy PRN = As needed PT = Physical Therapy RDCS = Regional Director of Clinical Services SLP = Speech Therapy STM = Short Term Memory W/C = Wheelchair</p>	F 000	<p>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p>	
F 157 SS=D	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in</p>	F 157	<p><b>Specific Resident</b></p> <p>Resident #9 family and physician notified by management upon discovery of area of concern. Any further</p>	

RECEIVED  
MAR 31 2014  
FACILITY STANDARDS

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

TITLE

(X6) DATE



Executive Director

3/28/14

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

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F 157	<p>Continued From page 1</p> <p>injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</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 notify the resident's physician and family member when a Stage II pressure wound was identified on a resident's right buttocks. This was true for 1 of 9 (#9) sampled residents. This had the potential for harm when the resident's physician and family were not able to make decisions based on the resident's needs. Findings include:</p>	F 157	<p>changes of condition will be reported to family and MD immediately upon discovery.</p> <p><b>Other Residents</b></p> <p>Residents that reside in the facility that experience a significant change in their physical, mental, or psychosocial status will have their family and MD notified immediately upon discovery.</p> <p><b>Systemic Changes</b></p> <p>In-service conducted with nursing staff and department managers of requirement to notify the resident, responsible party and physician of significant changes of condition, in particular development of pressure ulcers. The DON and/or designee will review the 24 hour report for changes of condition and ensure family/MD notification completed. Individual</p>		

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F 157	<p>Continued From page 2</p> <p>Resident #9 was admitted to the facility with multiple diagnoses to include, diabetes mellitus, late effects of CVA (cerebrovascular disease), peripheral neuropathy, dementia, and chronic pain.</p> <p>During a resident care observation on 2/11/14, at 12:55 PM, the resident was observed to have a quarter size open wound to her right buttocks. The surveyor asked CNA #1 about the open area on the resident's buttocks. The CNA stated, "I think she [the resident] got it from not being changed enough. Other CNAs bring her to her room and transfer her to her recliner without changing her." The CNA then applied a thick layer of Calmoseptine to the resident's buttocks and applied a new brief. The surveyor asked the CNA when she first noticed the open area on the resident's buttocks and if she (the CNA) had notified the nurse about it. The CNA said she noticed the open area the week before and had notified the nurse about it, but could not remember which nurse she told.</p> <p>Note: Please refer to F 314 as it relates to the open wound on the resident's buttocks.</p> <p>During a shower observation on 2/12/14, at 10:00 AM, CNA #1 pulled the call light and RN #3 came into the shower room to perform a skin check on the resident. RN #3 asked CNA #1 if she (the CNA) had noticed any new skin issues on the resident. The CNA stated, "She has a sore on her bottom, but you already know about that." RN #3 stated, "I'm not sure; I have been off for a few days."</p> <p>NOTE: There was no further dialogue between the nurse and the CNA related to the open area</p>	F 157	<p>education/training provided to RN #3 and also CNA #1 related to proper notification and reporting.</p> <p><b>Monitoring</b></p> <p>The DON and/or Nurse managers to complete audits of alert charting/24 hour report for family/MD notification of changes in condition. Monitoring will begin 3/20/2014. Audits will be conducted weekly X4, every 2 weeks X4 and then monthly X3. Results of audits will be brought to QA/PI by DON with further education audits to be determined based on trends identified.</p>	3/21/2014	

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F 157	Continued From page 3 on the resident's buttocks.  The resident's Nursing Progress Note dated 2/7/14 at 6:17 PM, documented the following, "Res[ident] had skin check with shower today. Noted...redness to buttocks. Calmoseptine applied to area. Will continue to monitor." Nursing Progress notes reviewed from 2/8/14 to 2/12/14 did not document concerns related to the resident's skin. Additionally, there was no documentation the physician nor family had been notified related to the resident's change of condition.  NOTE: On 2/12/14, CNA #1 notified RN #3 about the resident's open area on her right buttocks; however, there was no documentation in the resident's clinical record related to the open area on the resident's right buttock.  On 2/12/14 at approximately 3:00 p.m., the surveyor reviewed the resident's "Weekly Skin Integrity Data Collection (WSIDC) form. The resident's WSIDC form did not provide evidence the resident's WSIDC was completed by RN #3 on 2/12/14.  On 2/13/14, at approximately 12:45 PM, the DNS and wound nurse were asked to accompany the surveyor to Resident #9's room. The DNS and wound nurse, with the assistance of CNA #3, observed the open area to the resident's right buttocks. The DNS and wound nurse both stated neither one of them were aware of the open area prior to "today."	F 157			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241			

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F 241	<p>Continued From page 4</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, medical record review, and staff and resident interview, it was determined the facility failed to ensure residents were treated with dignity and respect during their dining experience when they were not offered a choice between a clothing protector or a cloth napkin. This was true for 2 of 9 sampled residents (#s 3 &amp; 8) and 4 random residents (#s 17, 19, 20, 21) observed during meals. Additionally, Resident #8 was not treated with dignity and respect when she was pulled backward in her wheel chair without any warning or conversation from staff. This failed practice created the potential for the residents to experience a decreased self esteem. Findings include:</p> <p>1. Resident #8 was admitted to the facility with multiple diagnoses including Alzheimer's disease, depressive disorder, and psychosis.</p> <p>Resident #8's Communication care plan, dated 11/26/13, documented the following: - Face [Resident's name] when speaking to her and talk to her left ear. - Adjust tone of your voice as needed - Repeat yourself as needed and give her time to comprehend what is being said to her.</p> <p>On 2/11/14, the following was observed in the Hall 3 activity room:</p>	F 241	<p><b>Specific Resident</b></p> <p>Residents #3, 8, 17, 19, 20, 21 will be offered a choice between the clothing protector and cloth napkin and/or both. These residents will have preferences care planned. Resident #8 will be alerted by staff when they approach her to move her broda chair and will be pushed forward, not pulled backward.</p> <p><b>Other Residents</b></p> <p>Residents within the facility going to the dining area have the potential to be affected. Residents will be offered a choice between a shirt protector and/or cloth napkin prior to meals and/or upon request. Residents that require their clothing protected during meals but are unable to voice consent will have family input if available and care plan to reflect.</p>		

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F 241	<p>Continued From page 5</p> <p>- 8:30 AM, the resident was observed on Hall 3, sitting in the activity room in her Broda chair. The resident's chair was facing the television in the far corner of the room and the back of the chair was towards the door and the hall.</p> <p>- 8:45 AM, CNA #12 approached the Resident's w/c from behind and pulled her out of the room backwards approximately 5 feet and then wheeled her to her room.</p> <p>Note: CNA #12 did not face the resident prior to moving her backwards out of the room, nor did she explain to the resident what she was doing prior to doing it.</p> <p>On 2/11/14, at 9:00 AM, CNA #12 was interviewed related to the above observation. The CNA stated she should have faced the resident and explained to the resident what she was doing before moving the resident.</p> <p>On 2/11/14, at 9:15 AM, LPN #13 was interviewed related to the above observation and asked by the surveyor if it was okay to pull a resident backwards in his/her chair. The LPN stated it was not okay to pull a resident out of a room backwards and staff should always walk around to the front of the resident to identify themselves and explain what was being done before it was done.</p> <p>On 2/13/14, at 4:30 PM the Administrator and DNS were informed related to the above findings and no further information was provided to resolve this concern.</p> <p>2. On 2/12/14, during lunch, in Hall 3's dining room, the following was observed:</p> <p>- 12:10 PM, RN #7 asked Resident #19 if she could put the clothing protector on him, while she</p>	F 241	<p><b>Systemic Change</b></p> <p>Staff in-serviced on offering choices between clothing protectors and cloth napkins to residents. Education to include proper dispensing of these items to residents and education on proper terminology related to clothing protectors. Staff in-serviced on protecting residents dignity when moving them in broda or wheel chair by notifying the resident of what they are doing and push them forward not backwards whenever possible.</p> <p><b>Monitoring</b></p> <p>Nurse Managers to perform audits during various meals and dining rooms determine if proper dispersing of clothing protectors and/or cloth napkins performed. Nurse managers to do audits in various halls to</p>		

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F 241	<p>Continued From page 6</p> <p>was already in the process of placing the clothing protector on the resident. The RN did not offer the resident a choice between the clothing protector or a cloth napkin.</p> <p>-12:15 PM, RN #7 was observed to place a clothing protector on Resident #8. Resident #8 was totally dependent on staff to eat and therefore it is unclear why the resident needed a clothing protector.</p> <p>3. On 2/12/14, during dinner, at 5:35 PM, in Hall 5's independent dining room, CNA #8 assisted Resident #20 to his chair. After the resident sat down the CNA placed a clothing protector on the resident without asking the resident if he wanted a clothing protector or cloth napkin.</p> <p>On 2/13/14, at 4:30 PM, the DNS was interviewed about the resident's in the Hall 3 assisted dining room wearing clothing protectors. The surveyor asked her why those residents who required assistance dining and were assisted by staff needed to wear clothing protectors. The DNS responded she had no idea why the residents requiring assistance with dining needed to wear the clothing protectors.</p> <p>4. Resident #3 was admitted to the facility with multiple diagnoses which included dementia; depression; progressive debility; and, history of stroke.</p> <p>The resident's annual MDS assessment, dated 1/1/14 coded, in part:</p> <ul style="list-style-type: none"> <li>* usually understood by others and usually able to understand others;</li> <li>* severe cognitive impairment, with a BIMS score of 4; and,</li> <li>* supervision and setup help only with eating.</li> </ul>	F 241	<p>ensure proper pushing of wheelchairs/broda chairs by staff. Monitoring will begin 3/20/2014. Audits will occur weekly X4 then every 2 weeks X4 and then monthly X3 Results of audits will be brought to QA/PI by DON with further education audits to be determined based on trends identified.</p>	3/21/2014	

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF IDAHO FALLS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</b>
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F 241	<p>Continued From page 7</p> <p>The resident's care plan, dated 1/2/14, identified the cognitive loss problem. Approaches to the problem included:</p> <ul style="list-style-type: none"> <li>* "Explain all care before providing it;"</li> <li>* "Promote dignity. Converse with resident...while providing care;" and,</li> <li>* "Involve resident in decision making process &amp; [and] provide choices."</li> </ul> <p>On 2/12/14 at 5:15 p.m., during the evening meal observation in the 300 Hall dining room, CNA #2 placed a clothing protector on the resident without asking if she wanted the clothing protector and without saying anything at all to the resident.</p> <p>On 2/13/14 at 4:35 p.m., the Administrator, DNS, and RDCS were informed of the dignity issue. No other information was received from the facility which resolved the issue.</p> <p>5. On 2/11/14 at 12:35 p.m. during lunch, CNA #21 was observed placing clothing protectors (bibs) on residents in the Hall 5 assisted dining room. The CNA walked up to several residents and stated, "Can I help you put this [bib] on?" The CNA placed a bib on Resident #17 and Resident #21.</p> <p>On 2/11/14 at 12:45 p.m., eighteen residents in the assisted dining room were wearing bibs.</p> <p>Note: The CNA was not observed asking residents whether they wanted a bib or a cloth napkin while eating their meal.</p> <p>On 2/11/14 at 12:15 p.m., in the Hall 5 independent dining room, bibs were observed folded and placed on tables where residents sat</p>	F 241		
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F 241	Continued From page 8 during their meals.	F 241			
F 246 SS=D	<p>On 2/14/14 the ED and the DON were informed of the observation.</p> <p><b>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</b></p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure residents received positioning support and devices unique to their needs. This affected 1 of 9 (# 4) residents sampled for positioning devices. This practice created the potential for more than minimal harm due to possible hyper-extension of Resident #4's neck. Findings included:</p> <p>Federal guidelines at F246 stated, in part, "...The facility is responsible for evaluating each resident's unique needs...ensuring that the environment accommodates the resident to the extent reasonable...This includes making adaptations..."</p> <p>Resident #4 was admitted to the facility with multiple diagnoses including, traumatic brain injury.</p>	F 246	<p><b>Specific Residents</b></p> <p>Resident #4's care plan has been updated for accuracy in correlation with MD orders for positioning. Therapy referral completed to evaluate positioning devices to best accommodate positioning support.</p> <p><b>Other Residents</b></p> <p>Residents within the facility requiring WC have the potential to be affected. Occupational therapy evaluations will be requested for residents with positioning difficulties, i.e. leaning. Any accommodations put in place will be care planned.</p>		

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F 246	<p>Continued From page 9</p> <p>The resident's 12/5/13 quarterly MDS coded severely impaired cognition and two person extensive assistance for ADLs.</p> <p>The resident's 2/14 Physician's Orders (recapitulation orders) contained, in part, 6/14/12: soft cervical collar to be on when up in wheelchair.</p> <p>The resident's care plan contained a 9/24/13 problem, self care deficit, (Resident #4) required total assist with self care and mobility. One of the problem approaches was a 1/10/14 handwritten and initialed entry, "Soft neck pillow for comfort and support while up in w/c [wheelchair]."</p> <p>Note: The soft cervical collar was not listed as a problem approach on the resident's current care plan. Please refer to F280 as it related to care plan updates.</p> <p>On 2/11/14 at 12:38 p.m., the resident was observed sitting in her wheelchair in the Hall 5 assisted dining room. A black cloth collar was around the resident's neck. The resident's head was leaning to the right and was almost horizontal to the resident's shoulders.</p> <p>Note: The resident was not observed with a soft neck pillow during the above observation.</p> <p>On 2/11/14 at approximately 2:00 p.m., the resident was observed in her wheelchair. The resident's head was leaning to the right side and was almost horizontal to the resident's shoulders. The soft neck pillow was not observed in use. The surveyor informed LN #16 about the observation of the resident's head almost horizontal to the resident's shoulders. The LN</p>	F 246	<p><b>Systemic Change</b></p> <p>In-service to be completed to nursing staff and therapy staff for WC positioning with accommodations if necessary and the importance of the care plan reflecting appropriately those needs.</p> <p><b>Monitoring</b></p> <p>Nurse Managers to monitor interventions are in place that are ordered to accommodate proper wheel chair positioning. Monitoring to begin 3/20/2014. Audits will occur weekly X4, every 2 weeks X4 and then monthly X3. Results of audits will be brought to QA/PI by DON with further education audits to be determined based on trends identified.</p>	3/21/2014

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F 246	Continued From page 10 stated, "The resident has the soft cervical collar on."  On 2/12/14 at 12:00 p.m., the surveyor informed the DON about Resident #4's head almost horizontal to her shoulders and the soft neck pillow was not observed in use. The DON stated, "I will have to check and see if both can be used at the same time."  On 2/14/14 at 9:15 a.m., the ED was informed of the observations.	F 246			
F 248 SS=D	<b>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</b>  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to post the activity calendar in a resident's room to give the resident reminders of scheduled activities. This affect 1 of 9 (#4) residents sampled for activities. The potential existed for Resident #4 to not attend activities based on her daily preferences and experience boredom or a loss of interest in herself. Findings included:  Resident #4 was admitted to the facility with multiple diagnoses including, traumatic brain injury.	F 248	<b>Specific Resident</b>  Resident #4's activity calendar is posted in room in visual site for resident.  <b>Other Residents</b>  Residents within the facility whom are care planned to have an activity calendar posted in their room have the potential to be affected. Residents whom are to have activity calendars posted in their rooms will have the calendar posted in an area the resident can easily visualize.		

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F 248	<p>Continued From page 11</p> <p>The resident's 12/5/13 quarterly MDS coded severely impaired cognitive skills and two person extensive assistance for all ADLs.</p> <p>The resident's care plan contained a 12/12/13 problem, "(Resident #4) is unable to communicate...but likes to go to activities." The problem approaches were: "post calendar in room, give her friendly reminder of activities, respect her right to refuse, assist her to and from activities, all activities when she is awake, and may read, lotion, ROM [range of motion], talk about her kids, listen to her music with {sic} and visit."</p> <p>On 2/11/14 at 7:23 a.m., at 10:18 a.m., and on 2/12/14 at 12:10 p.m., the February 2014 activities calendar was not observed in the resident's room.</p> <p>On 2/12/14 at 12:12 p.m., the surveyor asked LN #16 if the activities calendar was posted in the resident's room. The surveyor and the LN went into the resident's room. The LN stated, "The calendar should be inside the closet door." The LN looked inside the closet however the calendar was not there. The surveyor then asked the LN how the resident would visualize the calendar when it was located or posted inside the closet door. The LN did not reply. The resident's closet was not located where the resident could read or visualize the on-going daily activities.</p> <p>Federal guidance at F248 indicated, in part, "Determine if the resident's care plan... Includes needed adaptations that address resident conditions and issues affecting activities participation..."</p>	F 248	<p><b>Systemic Change</b></p> <p>Individual education to be provided with activity director related to posting activity calendars in easily visualized areas. In-service to be provided with activity staff related to posting of activity calendars in easily visualized areas.</p> <p><b>Monitoring</b></p> <p>Executive Director to audit that residents have activity calendars posted in their room in easily visualized area. Monitoring to begin 3/20/2014. Audits to be completed weekly X4, every 2 weeks X4 and then monthly X3 Results of audits will be brought to QA/PI by ED with further education audits to be determined based on trends identified.</p>	3/21/2014	

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F 248	Continued From page 12 Resident #4's care plan contained an approach to post the activity calendar in room. This approach was not followed therefore the resident would not be able to visualize the activities for the day and indicate to staff her preference to attend or not attend scheduled activities.	F 248			
F 279 SS=D	On 2/14/14 at 9:15 a.m., the ED and the DON were informed of the concern. The facility did not provide any additional information. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it	F 279	<b>Specific Resident</b>  Resident #6 had her care plan for impaired vision completed during survey.  <b>Other Residents</b>  Resident within the facility having an MDS completed has the potential to be affected. Residents that have areas triggered by the RAI process that are determined by the assessment to need care planned interventions, such as vision will have those areas reflected accurately in the care plan as indicated.		

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F 279	Continued From page 13 was determined the facility failed to ensure care areas triggered by the RAI process and identified as care planned were actually care planned. This was true for 1 of 13 residents (#6) whose care plans were reviewed. This failure created the potential for the resident's assessed needs to not be met due to lack of direction in the care plan. Findings included:  Resident #6 was admitted to the facility on 1/13/12 with multiple diagnoses including, muscle weakness and lack of coordination.  The resident's 10/25/13 annual MDS Section V Care Area Assessment (CAA) Summary identified the visual function care area triggered and was care planned. The 10/25/13 CAA Summary Analysis of Findings section documented, in part, "...impaired vision...care plan will address vision..."  Review of the resident's current care plan did not provide evidence the triggered visual function care area was care planned.  On 2/12/14 at 10:17 a.m., the surveyor asked the MDS Coordinator to review the resident's current care plan for the visual function care area. The MDS Coordinator reviewed the care plan and stated, "Vision is not care planned."  On 2/14/14 at 9:15 a.m., the ED and the DON were informed of the concerns. The facility did not provide any additional information.	F 279	<b>Systemic Change</b>  MDS coordinator and all departments included in the MDS process in-serviced on the RAI process and requirement to care plan any triggered areas if indicated.  <b>Monitoring</b>  The DON and/or MDS coordinator to audit based on MDS schedule 20% of completed CAA area triggers to ensure these triggers have been care planned if indicated. Monitoring to begin 3/20/2014. Audits to be conducted weekly X4, every 2 weeks X4 and then monthly X3 Results of audits will be brought to QA/PI by DON with further education audits to be determined based on trends identified.	3/21/2014	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged	F 280			

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F 280	<p>Continued From page 14</p> <p>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 observations, record review and staff interviews, it was determined the facility failed to ensure care plans were updated when changes occurred. This affected 3 of 9 (#s 4, 6, &amp; 7) sampled residents and 1 of 6 (#18) random residents. This practice created the potential for Resident #s 4, 6, &amp; 7 to experience unmet resident needs. Random Resident #18 was placed at risk for decreased nutritional intake when the diet change was not updated on the care plan. Findings included:</p> <p>1. Random Resident #18 was admitted to the facility with multiple diagnoses including gluten intolerance.</p>	F 280	<p><b>Specific Resident</b></p> <p>Resident #18's care plan updated to reflect accurate diet texture per MD order. Communication sent to dietary staff when discrepancy discovered.</p> <p>Resident #4's medical chart reviewed including care plan and updated to reflect accuracy of interventions related to wearing of cervical collar.</p> <p>Resident #6's chart reviewed including care plan and updated for accuracy related to resident's use of nose cups during meals. Care plan to be adjusted to reflect resident's swallowing concerns.</p> <p>Resident #7's chart reviewed and care plan updated to reflect discontinued bed trapeze.</p> <p><b>Other Residents</b></p> <p>Residents within the facility</p>		

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F 280	<p>Continued From page 15</p> <p>The resident's Physician's Orders (recapitulation orders) contained in part, "11/22/13: Diet:... Texture: Mech [mechanical] soft..."</p> <p>The resident's care plan contained a 12/23/13 problem, potential alteration in nutrition related to gluten intolerance, variable intakes, and elevated body mass index. One of the problem approaches was, "Provide NAS [no added salt] diet with mechanical soft textures per MD order."</p> <p>The resident's care plan also contained a handwritten entry, "1/9/14 ST [speech therapy] per MD order." The entry was signed by the Director of Therapy.</p> <p>On 2/12/14 at 5:55 p.m., the resident was observed eating the evening meal. The resident's diet card located on the table where the resident was dining documented "mechanical soft diet." The resident was observed eating a cucumber salad. The pieces of cucumber appeared chopped into 1/2 inch sections. The resident did not exhibit signs and symptoms of choking on the 1/2 inch cucumber pieces.</p> <p>The facility's menu documented, for a mechanical soft diet, the cucumber pieces in the cucumber salad were to be "1/4 [one-quarter] inch diced pieces."</p> <p>Note: Please refer to F367 as it related to other residents on a mechanical soft diet who received the cucumber salad cut into 1/2 inch pieces.</p> <p>On 2/13/14 at 9:21 a.m., the DON provided the surveyor with Resident #18's 2/6/14 speech language pathologist (SLP) order. The SLP order documented in part, "...diet texture to be</p>	F 280	<p>requiring care plan updates for diet texture changes, cervical collars, nose cups or swallowing problems have the potential to be affected. Care plans to be updated if indicated to reflect new orders and/or new interventions placed.</p> <p><b>Systemic Changes</b></p> <p>In-service to be conducted with department leaders and Licensed staff on updating care plans with indicated changes and ensuring accuracy of care planned interventions including discontinuing interventions as ordered.</p> <p><b>Monitoring</b></p> <p>Audits to be completed by DON and/or Nurse manager to ensure changes to residents' current medical and/or treatments are reflected in care plan related to correct diet textures, nose cups with</p>		

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F 280	<p>Continued From page 16</p> <p>upgraded to regular texture [with] thin liquids..."</p> <p>The resident's physician signed the order on 2/6/14. The DON stated, "SLP evaluated Resident #18 on 2/6/14 and upgraded the diet texture to regular. This [the change in diet texture] was not communicated to staff."</p> <p>On 2/6/14 Resident #18's diet texture was changed from mechanical soft to regular texture. However, the change in diet texture was not communicated to dietary services and the resident's care plan was not updated with the diet texture change.</p> <p>On 2/14/14 at 9:15 a.m., the ED and the DON were informed of the concerns. The facility did not provide any additional information.</p> <p>2. Resident #4 was admitted to the facility with multiple diagnoses including, traumatic brain injury.</p> <p>The resident's 12/5/13 quarterly MDS coded severe cognitive impairment and one to two person extensive physical assistance for all ADLs.</p> <p>The resident's Physician's Orders (recapitulation orders) contained, in part, "6/14/12 order date: soft cervical collar to be on when up in wheelchair [wc]."</p> <p>On 2/11/14 at 12:20 p.m., on 2/11/14 at 2:00 p.m., on 2/12/14 at 12:11 p.m., and on 2/13/14 at 1:10 p.m., the resident was observed up in the wc with the soft cervical collar around her neck.</p> <p>Review of the resident's current care plan did not provide evidence the soft cervical collar was care</p>	F 280	<p>meals, positioning devices in WC and/or bed trapeze used.</p> <p>Monitoring to begin 3/20/2014.</p> <p>Audits to be conducted weekly X4, every 2 weeks X4 and then monthly X3. Results of audits will be brought to QA/PI by DON with further education audits to be determined based on trends identified.</p>	3/21/2014	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF IDAHO FALLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</b>		
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F 280	<p>Continued From page 17 planned for the resident.</p> <p>On 2/12/14 at 1:20 p.m., the surveyor informed the MDS Coordinator the soft cervical collar was not on Resident #4's care plan. The MDS Coordinator stated, "I'll check the care plan." The MDS Coordinator did not provide any information that provided evidence the soft cervical collar was care planned.</p> <p>3. Resident #6 was admitted to the facility with multiple diagnoses including, memory loss, late effects of cerebrovascular disease, muscle weakness, and lack of coordination.</p> <p>The resident's 1/24/14 quarterly MDS coded moderately impaired cognition and a minimum of one person extensive assistance for ADLs, one person extensive physical assistance to dine, loss of fluids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals, complaints of difficulty or pain with swallowing, no weight loss, and mechanically altered diet.</p> <p>a. On 2/11/14 at 8:00 a.m. and on 2/11/14 at 1:04 p.m., the resident was observed in the dining room. CNA #6 assisted the resident to drink from a nousey cup.</p> <p>Review of the resident's care plan did not provide evidence the nousey cup was care planned for the resident.</p> <p>On 2/12/14 at 9:00 a.m., the surveyor discussed the use of the nousey cup with the Regional Director of Clinical Services (RDCS) and the ED. The RDCS reviewed the resident's care plan and</p>	F 280			

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F 280	<p>Continued From page 18</p> <p>stated, "I do not see it [nosey cup] on the care plan."</p> <p>On 2/12/14 at 11:12 a.m., the Medical Records Director provided the surveyor with a 3/16/12 Diet Order &amp; Communication (DOC) form. The DOC form was signed by a speech language pathologist and contained the handwritten entry, "nosey cups."</p> <p>b. In addition, according to the resident's 1/24/14 quarterly MDS Section K0100 Swallowing Disorders, the resident had loss of fluids from mouth when eating or drinking, held food in mouth/cheeks or residual food in mouth after meals, coughed or choked during meals, and complained of difficulty or pain with swallowing.</p> <p>Note: These problem areas or problem approaches were not identified on the resident's care plan to assist staff who provided dining assistance and care for the resident.</p> <p>Resident #6's care plan was not updated for the use of a nosey cup while dining or for the swallowing issues identified on the 1/24/14 MDS.</p> <p>4. Resident #7 was admitted to the facility with multiple diagnoses including major depression affective disorder.</p> <p>The resident's 11/29/13 quarterly MDS coded moderately impaired cognition and two or more person extensive assist for bed mobility.</p> <p>The resident's care plan identified a 12/10/13 problem, At risk for falls related to decreased mobility. One of the problem approaches was, "Trapeze over bed to increase independence with</p>	F 280			

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F 280	Continued From page 19 repositioning."  The resident's 2/14 Physician's Orders (recapitulation orders) contained, in part, an order, "5/31/11: Trapeze over head." The order was yellow highlighted and "d/c [discontinue]" was handwritten next to the yellow highlighted order. There were no initials or dates indicating when the trapeze order was dc'd.  Note: Please refer to F514 as it related to accuracy of clinical records.  On 2/13/14 at 1:10 p.m., the resident stated, "I remember having a trapeze over my bed and head. I'd grab ahold of it and use it to move around in bed."  On 2/13/14 at 1:13 p.m., LN #16 stated, "The resident quit using the trapeze so we removed it from the room."  On 2/14/14 at 9:15 a.m., the DON and the ED were informed of the concerns. The facility did not provide any additional information.	F 280			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced	F 309	<b>Specific Resident</b>  Resident #6 is to be offered geri-sleeves and tubi-grip per MD orders. Care plan reviewed to reflect accuracy. TAR reviewed and resident monitored for proper placement per MD order.		

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F 309	<p>Continued From page 20</p> <p>by:</p> <p>Based on observation, record review, and staff interviews, it was determined the facility failed to ensure physician's orders, care plan problem approaches were followed, and an interim care plan included mechanical lift transfers identified during the first week of a resident's staff in the facility. This affected 4 of 9 (#s 1, 6, 7, &amp; 8) sampled residents. This practice created the potential for compromised skin integrity for Resident #6, transfers not provided as needed due to lack of direction in Resident #1's care plan, and Resident #8 to experience a lack of self-worth due to the manner in which a CNA assisted the resident during cares. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 1/13/12 with multiple diagnoses including, memory loss, late effects of cerebrovascular disease, and lack of coordination.</p> <p>The resident's 1/24/14 quarterly MDS coded moderately impaired cognition and one to two person extensive assistance for ADLs.</p> <p>The resident's 2/14 Physician's Orders (recapitulation orders) contained, in part, - "3/26/12: Geri sleeves to bilat [bilateral] upper extremities for skin protection and - 3/28/12: Tubi-Grip (size C) to BLE [bilateral lower extremities] for skin protection"</p> <p>The resident's care plan contained the 1/8/14 problem area, At risk for break in skin integrity related to, in part, memory loss. The problem approaches included, in part, "[Resident #6] at times refuses to wear geri-sleeves and tubigrip...Notify LN of refusals...Geri-sleeves to</p>	F 309	<p>Resident #7 is to have TED hose applied per MD orders. Care plan reviewed for accuracy. TAR reviewed and resident monitored for proper placement per MD order</p> <p>Resident #1's care plan updated to reflect proper transfer requirements.</p> <p>Care plan reviewed for resident #8 for accuracy. Resident to be approached during cares as reflected in the care plan.</p> <p><b>Other Resident</b></p> <p>Residents with specialized interventions of geri- sleeves, tubigrips, TED hose, mechanical lift transfers and residents with specific approaches for care have the potential to be affected and will have these interventions followed as care planned and MD order. A house wide audit was completed of treatment</p>		

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F 309	<p>Continued From page 21</p> <p>BUE [bilateral upper extremities] and Tubi-grip size C to BLE for skin protection for fragile skin..."</p> <p>On 2/11/14 at 11:45 a.m., CNA #15 was observed getting the resident out of bed. The resident was not wearing geri-sleeves or tubi-grips. The CNA did not attempt to place the geri-sleeves or tubi-grips on the resident. At 11:55 a.m., the CNA wheeled the resident to the hallway medication cart and left the resident with LN #9. The LN wheeled the resident to the television viewing area. The surveyor asked the LN to verify the resident had tubi-grips to BLE. The LN checked the resident and stated, "No tubi-grips." The surveyor then informed the LN the resident did not have geri-sleeves to bilateral upper extremities. At this time the resident was being assisted to the dining room by a different staff member. The LN did not comment about the geri-sleeves.</p> <p>On 2/12/14 at 1:20 p.m., the DON and the surveyor discussed CNA #15 getting the resident out of bed. The CNA was not observed offering or attempting to place the geri-sleeves or tubi-grips on the resident. The CNA did not tell LN #9 the resident refused the geri-sleeves or tubi-grips. The DON stated, "The resident often refuses to wear the geri-sleeves and tubi-grips."</p> <p>The surveyor reviewed the resident's 2/14 TAR located on the medication cart. There were no refusals documented on the resident's 2/14 TAR for the use of geri-sleeves or tubi-grips.</p> <p>Review of the resident's Progress Notes from 1/30/14 through 2/11/14 did not provide evidence the resident refused geri-sleeves and or tubi-grips.</p>	F 309	<p>administration records to care plans to the resident and their environment to ensure that interventions are followed per orders and care plan.</p> <p><b>Systemic Changes</b></p> <p>In-service to be provided to staff on following care plans and/or directives specifically for transfers, geri sleeves, tubigrips, Ted Hose as care planned. Included in the inservicing was education regarding on what to do for resident refusals of interventions and reporting refusals. Education will include non-verbal signs and symptoms of pain during cares and notifying residents of what they are going to do before starting it. Individual education/training provided with CNA #12.</p> <p><b>Monitoring</b></p> <p>DON and/or Nurse manager to</p>		

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F 309	<p>Continued From page 22</p> <p>2. Resident #7 was admitted to the facility with multiple diagnoses including major depressive affective disorder, severe degree.</p> <p>The resident's 11/29/13 MDS coded moderately impaired cognition and extensive one person assistance for dressing.</p> <p>The resident's 2/14 Physician's Orders (recapitulation orders) contained, in part, "10/2/12: Place TED [therapeutic embolic device] hose on every morning and off at night."</p> <p>The resident's care plan contained a 12/10/13 problem, At risk for impaired skin integrity related to episodes of edema. One of the problem approaches was, "Knee high TED hose on in am and off at HS [bed time]."</p> <p>On 2/11/14 at 11:35 a.m., the resident was observed awake in bed and appeared to be watching television. The surveyor asked CNA #15 if the resident had TED hose on. The CNA asked and the resident gave permission for the CNA to check the resident's legs. The resident's legs were without TED hose.</p> <p>On 2/14/14 at 9:15 a.m., the ED and the DON were informed of the concerns.</p> <p>3. Resident #1 was admitted to the facility 1/29/14 with multiple diagnoses which included septic knee joint at the operative site following right total knee replacement.</p> <p>The resident's 2/5/14 admission MDS assessment coded, in part: * intact cognition, with a BIMS score of 15;</p>	F 309	<p>audit compliance with interventions of geri sleeves, tubigrip, Ted hose, mechanical lift transfers, care plan approaches of how to approach residents. Monitoring will begin 3/20/2014. Audits will be completed weekly X4, every 2 weeks X4 and then monthly X3. Results of audits will be brought to QA/PI by DON with further education audits to be determined based on trends identified.</p>	3/21/2014

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F 309	<p>Continued From page 23</p> <ul style="list-style-type: none"> <li>* Extensive 2 person assistance for transfers; and,</li> <li>* functional limitation in range of motion in one lower extremity.</li> </ul> <p>The resident's interim care plan, dated 1/29/14, identified the potential for physical injury from falls. One intervention was, "Assist of 2 for transfers."</p> <p>A visit note by the orthopedic surgeon, dated 2/6/14, documented, "Today's x-rays show the femoral condylar spacers rotated and completely out, so it is sitting anteriorly. The knee has predominately a bloody effusion..."</p> <p>On 2/11/14 at 8:00 a.m., the resident stated that on 2/6/14 the orthopedic surgeon instructed no weight bearing on the right lower extremity because of the dislocated spacers in the knee. The resident stated that after the 2/6/14 visit to the orthopedic surgeon, the facility staff used only "the Hoyer [type of mechanical lift]" for transfers.</p> <p>On 2/12/14 at 2:55 p.m., CNA #4 and the Activity Director (AD) were observed in the process of transferring the resident from a wheelchair to the bed using a mechanical lift. A moment later, CNA #5 arrived, relieved the AD, and the two CNAs completed the mechanical lift transfer.</p> <p>The care plan did not include the use of a mechanical lift for transfers.</p> <p>On 2/13/14 at 12:00 p.m., the DNS was asked about the resident's transfer interventions. The DNS confirmed that use of the mechanical lift was necessary to transfer the resident. The DNS reviewed the resident's care plan then confirmed</p>	F 309			

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F 309	<p>Continued From page 24</p> <p>that mechanical lift transfers were not included in the care plan. She stated, "No it's not on there."</p> <p>No other information was received from the facility which resolved the issue.</p> <p>4. Resident #8 was admitted to the facility with multiple diagnoses to include, memory loss, Alzheimer's disease, depressive disorder, and psychosis.</p> <p>The resident's 11/18/13 Quarterly MDS assessment coded, in part:</p> <ul style="list-style-type: none"> <li>- STM/LTM memory impairment;</li> <li>- Daily decision making is severely impaired;</li> <li>- Extensive assist of 2 persons for bed mobility;</li> <li>- Frequency of pain, constant;</li> </ul> <p>Resident #8's Communication care plan, dated 11/26/13, documented the following:</p> <ul style="list-style-type: none"> <li>- Face [Resident's name] when speaking to her and talk to her left ear.</li> <li>- Adjust tone of your voice as needed</li> <li>- Repeat yourself as needed and give her time to comprehend what is being said to her.</li> </ul> <p>The resident's "Cognitive 1" care plan, dated 11/22/13, documented, "Approach res[ident] warmly and positively."</p> <p>The resident's "Communication care plan, dated 11/26/13, documented:</p> <ul style="list-style-type: none"> <li>- "Face [Resident's name] when speaking to her and talk to her left ear;</li> <li>- Adjust tone of your voice as needed; and</li> <li>- Repeat yourself as needed and give her time to comprehend what is being said to her." <p>The resident's "Comfort" care plan, dated 2/3/14, documented, "Monitor for s/s of non verbal pain</p> </li></ul>	F 309		

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F 309	<p>Continued From page 25 (facial grimacing, restlessness, crying, grinding gums, [and] yelling out," and report it to the nurse.</p> <p>On 2/11/14 the following was observed: - 8:45 AM, CNA #12 was observed to pull Resident #8 out of the Hall 3 activity room backwards in her broda chair, and take her to her room. The CNA hooked the resident's hoier sling up to the hoier lift and proceeded to raise the lift, without explaining to the resident what she was doing. The CNA positioned the hoier over the resident's bed and lowered the resident onto her bed. - 8:48 AM, CNA #12 with gloved hands, rolled Resident #8 to her right side and pushed the hoier pad underneath the resident and then, pulled the resident back towards her (to the left) and pulled the hoier sling out from underneath the resident. The CNA in an abrupt motion pulled the resident's pants down and as the CNA did this the resident moaned and had facial grimacing. Once the resident's pants were down the CNA continued to move the resident from side to side in an abrupt motion as she performed peri-care. Each time the CNA rolled the resident from side to side the resident was heard to moan and display facial grimacing. After the CNA was finished providing cares to the resident, she removed her gloves, positioned the resident on her right side, covered the resident with a blanket, lowered the bed, and placed a mat on the floor.</p> <p>On 2/11/14, at 9:00 AM, CNA #12 was interviewed related to the above observation. The CNA stated she should have approached the resident from the front and explained what she was going to do before doing it. The CNA stated, "The resident always stiffens up and moans during cares and I'm not really sure what to do</p>	F 309		
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F 309	Continued From page 26 when it happens. I should probably ask for help or get the nurse."  On 2/11/14, at 9:15 AM, the surveyor interviewed the Hall 3 Unit Manager (UM) related to the above observation. The UM stated, "Go to the front of the resident and explain to the resident what you are doing before doing it. If the resident has facial grimace, moans, or stiffens up during cares the CNA should stop, make sure the resident is safe, ask for additional help, and notify the nurse."  On 2/13/14, at 4:30 PM, the Administrator and DNS were notified related to the above observation. The Administrator stated he was already aware as the CNA had come to him after the surveyor interviewed her. No further information was received from the facility regarding this concern.	F 309			
F 314 SS=D	<b>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b>  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, record review and staff interviews, it was determined the facility failed to: a. implement care planned pressure reduction	F 314	<b>Specific Resident</b>  After discovery of stage II ulcer facility assessed the area, provided treatment, assessed pain, notified MD and family of discovery and obtained treatment plan for resident #9. Also a bed was placed in the resident's room due to resident had previous bed removed related to sleeping preference in recliner only. Staff to		

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F 314	<p>Continued From page 27</p> <p>strategies,</p> <p>b. identify open pressure ulcers, and</p> <p>c. notify the physician, obtain treatment orders, and provide treatment as ordered in order to prevent the development of pressure ulcers and properly treat those that had developed. This was true for 2 of 4 (#s 6 &amp; 9) residents sampled for pressure ulcers. This failure created the potential that residents would develop additional avoidable pressure ulcers. Findings include:</p> <p>1. Resident #9 was admitted to the facility with multiple diagnoses to include, diabetes mellitus, late effects CVA (cerebrovascular disease), peripheral neuropathy, edema, and venous peripheral insufficiency.</p> <p>The resident's most recent quarterly MDS, dated 1/13/14, coded the following:</p> <ul style="list-style-type: none"> <li>- BIMS (Brief Interview Mental Status) = 4 or severely impaired;</li> <li>- Extensive Assist of one person for most ADLs;</li> <li>- No functional limitations in Range of Motion;</li> <li>- Risk of Pressure Ulcers; and,</li> <li>- No Stage 1 or higher unhealed pressure ulcers.</li> </ul> <p>a) The resident's "Skin 1" care plan, dated 1/8/14, documented, in part:</p> <ul style="list-style-type: none"> <li>- Prefers to sleep in recliner often preferring to keep feet on the floor.</li> <li>- LN to evaluate skin weekly</li> <li>- Observe and report any red areas found during adl's (activities of daily living) to LN</li> <li>- Refuses cushion on recliner but allows one to her w/c</li> <li>- Sleeps in recliner per her request</li> <li>- Encourage to reposition every two hours or more frequently. Extensive to limited assist of one</li> </ul>	F 314	<p>encourage resident to sleep in and/or spend time in bed to elevate potential areas of pressure. Individual nurse and cna involved provided education.</p> <p>Resident #6's care plan reviewed and updated to indicate no padded foot pedals.</p> <p><b>Other Residents</b></p> <p>Residents residing in the facility that prefer to sleep in their recliners, require repositioning or develop pressure areas have the potential to be at risk. Residents to have a risk vs. benefit explained to themselves and family related to potential skin issues related to sleeping in the recliner. Residents who develop pressure ulcers in the facility have the potential to be affected and will have the skin concern reported to the appropriate individuals and treatment provided. Residents requiring repositioning will</p>	

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F 314	<p>Continued From page 28 to two for bed mobility/ positioning.</p> <p>b) The resident's Fall care plan, dated 1/8/14, documented, "Recliner against wall to prevent sliding." The resident's Skin care plan, dated 1/8/14, documented the following: - "Sleeps in her recliner per her request. - 2 step Coban wrap to bilat[eral] LE (lower extremities) for edema management. - Encourage and assist [Resident's name] to reposition every two hours or more frequently." The resident's Comfort care plan, dated 1/8/14, documented, "Offer to reposition for comfort per [Resident #9] instruction."</p> <p>Note: The care plan did not specify how the resident was supposed to "Reposition every two hours or more frequently" if all she had was a wheelchair and a recliner that she was not physically able to recline. Additionally, the back of the recliner was observed against the wall preventing the footrest from being raised.</p> <p>The resident's Physician's Orders (recapitulation orders) dated 2/1/14-2/28/14 contained, in part, the following: - Hand written entry, "Check every shift for cushion in wc &amp; recliner."</p> <p>Note: It could not be determined who wrote the entry, when the entry was written as there was no signature or date.</p> <p>The resident was observed in the recliner, with the back of the recliner against the wall, and or the w/c as follows: - 2/11/14, from 8:30 AM to 10:30 AM, sitting upright in recliner with feet on floor, from 12:15</p>	F 314	<p>have approaches in care plan. Residents who have padded areas to wheelchairs for skin interventions that are discontinued will have them removed from the care plan.</p> <p><b>Systemic Changes</b></p> <p>In-service provided to include the following: MD orders and/or care plan directives for repositioning to be followed, this includes need to provide pressure relief for residents sleeping in recliners. Staff to discuss with family and/or residents the risks vs. benefits of sleeping in recliner and document the residents wishes. Education to nursing staff included notification of treatment Nurse and Nurse Managers with any skin areas of concern and obtaining appropriate treatment to promote healing of skin area. Nursing staff was also provided</p>		

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F 314	<p>Continued From page 29</p> <p>PM to 1:15 PM, sitting in w/c in the Hall 3 dining room; and at 2:55 PM sitting upright in recliner with feet on the floor.</p> <p>- 2/12/14, 9:30 AM and 11:00 AM sitting upright in recliner with feet on the floor; 12:00 PM and 1:00 PM sitting in w/c; 2:00 PM and 3:15 PM sitting upright in recliner with feet on the floor.</p> <p>On 2/13/14, similar observations were made related to the resident's positioning.</p> <p>On 2/11/14 at 12:55 PM, the resident was observed with a nickel-size open wound to the right buttock. The surveyor asked CNA #1, who was providing peri-care, about the open area on the resident's buttock. The CNA stated, "I think she got it from not being changed enough. Other CNAs bring her to her room and transfer her into the recliner without changing her." The CNA then applied a thick layer of Calmoseptine to the resident's buttocks and a new brief. The surveyor asked the CNA when she first noticed the open area on the resident's buttocks and if she (the CNA) had notified the nurse about it. The CNA said she noticed the open area the week before and had notified the nurse about it. However, the CNA said she could not remember which nurse she told.</p> <p>On 2/12/14 at 10:00 AM, during a shower observation, CNA #1 pulled the call light and RN #3 came into the shower room to perform a skin check on the resident. RN #3 asked if the CNA had noticed any new skin issues. The CNA stated, "She has a sore on her bottom, but you already know about that." RN #3 stated, "I'm not sure, I have been off for a few days."</p> <p>On 2/12/14, at 3:45 PM, the surveyor asked RN #3 where the nurse documented that a resident's</p>	F 314	<p>education of requirement to notify resident, family or responsible party, and physician if pressure ulcer is noted. Nursing staff inserviced if padded area of wheelchair removed to update care plan.</p> <p><b>Monitoring</b></p> <p>DON and/or Nurse manager to audit interventions are followed per MD order and/or care plan directives related to padding of assistive devices and related care plans accurate. Audits to be performed for proper documentation and/or education provided to resident and family related to preference of sleeping in a recliner. Treatment nurse to audit that resident, family or responsible person and physician have been notified when she is notified of new skin concern. DON/designee to</p>		

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F 314	<p>Continued From page 30</p> <p>skin check had been completed. RN #3 stated, the nurse initials skin checks on the Treatment Administration Record (TAR), and then fills out the weekly skin integrity data collection sheet. If the nurse identifies a skin issue/concern then the nurse fills out a "pink Skin Care Alert form" and puts it in the wound nurse's box so she can determine what treatment needs to be done.</p> <p>Note: On 2/13/14, at approximately 10:00 AM the surveyor reviewed the TAR, the TAR did not contain initials indicating a skin check had been performed on 2/12/14. Additionally, there was not a weekly skin integrity data collection form filled out, nor was there a "pink" skin care alert form filled out for the resident.</p> <p>On 2/13/14 a handwritten document was provided to the surveyor, by the DNS, that documented the following, "I [DNS] spoke with RN #3 on 2/13/14. RN #3 had been [given report] from CNA #1 on 2/12/14 related to area on [Resident #8's] buttocks. RN #3 stated that she did "look" at the resident's skin, but did not do a through investigation. She [RN #3] stated the area appeared to be hemorrhoids."</p> <p>The resident's Weekly Skin Integrity Data Collection form documented, in part:</p> <ul style="list-style-type: none"> <li>- 1/24/14, skin intact, redness under [right] breast tx (treatment) applied.</li> <li>- 1/31/14, redness under right breast tx (treatment) applied.</li> <li>- 2/7/14, skin intact, bruises, redness. In addition, there was an anatomical diagram of a person with the buttocks circled and a handwritten word, "Red."</li> <li>- There was no entry on the resident's "skin condition" form, dated 2/12/14, which identified</li> </ul>	F 314	<p>audit treatment book to ensure documentation, care plans, and notifications are accurate.</p> <p>Monitoring to begin 3/20/2014.</p> <p>Audits to be completed weekly X4, every 2 weeks X4 and then monthly X3. Results of audits will be brought to QA/PI by DON with further education audits to be determined based on trends identified.</p>	3/21/2014	

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F 314	<p>Continued From page 31 the skin check was completed.</p> <p>The resident's Nursing Progress Note dated 2/7/14 at 6:17 PM, documented the following, "Res[ident] had skin check with shower today. Noted...redness to buttocks. Calmoseptine applied to area. Will continue to monitor." There was no further documentation in the resident's record related to worsening or resolving redness on the resident's buttocks.</p> <p>On 2/13/14, at approximately 12:45 PM, the DNS and wound nurse were asked to accompany the surveyor to Resident #9's room. The DNS and wound nurse, with the assistance of CNA #3, observed the open area to the resident's right buttocks. The DNS and wound nurse both stated they were not aware of the open area prior "to today."</p> <p>On 2/13/14 at 12:55 p.m., the surveyor observed the wound nurse measure the resident's open wound. It measured 1.9 centimeters (cm) by 1.5 cm. The wound nurse cleansed the wound and applied a non-adherent dressing.</p> <p>On 12/13/14 at approximately 1:00 PM, the DNS was interviewed related to the above observations. The surveyor asked how did staff reposition or assist the resident to off load her weight when the resident was always sitting in the upright position in her w/c and/or recliner. The DNS stated the resident can't be repositioned nor can she offload her weight and she (the DNS) would be addressing the issue today.</p> <p>Note: The DNS said the resident's bed was taken out of her room, related to her "refusal" to use it; however, there was no documentation in the</p>	F 314		

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F 314	<p>Continued From page 32</p> <p>resident's record indicating how staff had determined the resident preferred to keep her feet on the floor, or why she preferred to sleep in her recliner. Furthermore, it could not be determined the resident and the resident's legal representative had been educated related to the risk vs. benefits of the resident sitting upright continuously in her chair with her feet on the floor.</p> <p>On 2/13/14 at 6:10 p.m., the resident's room was observed. There was a twin sized bed, the recliner, and the resident's craft table in the room.</p> <p>In summary, Resident #9 developed a stage II pressure ulcer to her right buttock. Review of the resident's clinical record did not provide evidence the physician was notified, treatment orders were requested or provided, or that the care plan was updated. And although a CNA reported the condition of the resident's skin to a nurse on duty, the condition of the resident's skin was not communicated to other nursing staff, the DON, or the wound nurse.</p> <p>2. Resident #6 was admitted to the facility with multiple diagnoses including, memory loss, late effects of cerebrovascular disease, muscle weakness, and lack of coordination.</p> <p>The resident's 1/24/14 quarterly MDS coded moderately impaired cognition and a minimum of one person extensive assistance for ADLs.</p> <p>The resident's care plan contained the 1/8/14 problem area, At risk for break in skin integrity. The problem approaches included, in part, "W/C [wheelchair] pedals padded."</p> <p>On 2/11/14 at 7:28 a.m., the resident was observed in her wc. The resident's feet were</p>	F 314			

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F 314	Continued From page 33 resting on the wc pedals and the pedals were not padded.  On 2/12/14 at 1:20 p.m., the surveyor and the DON reviewed the resident's wc. The pedals were not padded according to the care plan. The DON stated, "I think at one time the pedals were padded but now there is no need for padded wc pedals for Resident #6."  The facility failed to follow the resident's care plan for padded wc pedals.  On 2/14/14 at 9:15 a.m., the ED was informed of the concerns. The facility did not provide additional information.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the brakes worked on resident wheelchairs (w/c). This was true for 1 of 11 sample residents (#10) reviewed for w/c use. The failure created the potential for more than minimal harm should the resident fall during transfer into or out of her geriatric w/c. Findings included:	F 323	<b>Specific Resident</b>  Resident #10 was assessed and WC exchanged until completion of brake repair.  <b>Other Residents</b>  Residents in the facility using geri-chairs or wheelchairs have the potential to be affected. A house wide audit to be completed by maintenance director of all geri-chairs and wheelchairs to identify any other chairs that have brake repair issues. Facility staff will exchange wheel chairs/geri-chairs that require repair with		

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F 323	<p>Continued From page 34</p> <p>Resident #10 was admitted to the facility in 2009 with multiple diagnoses, which included dementia; obsessive-compulsive disorders; anxiety state unspecified; and, chronic pain.</p> <p>The resident's most recent quarterly MDS assessment, dated 11/18/13, coded, in part:</p> <ul style="list-style-type: none"> <li>* short and long-term memory problems;</li> <li>* severe cognitive impairment;</li> <li>* extensive assist of 1 person for transfers;</li> <li>* functional limitation in range of motion in both upper and both lower extremities; and,</li> <li>* wheelchair use.</li> </ul> <p>On 2/12/14 at 3:10 p.m., LN #3 was observed as she placed the resident's geri-chair along side the head of the resident's bed, stepped on the brakes on the two back wheels of the geri-chair, then used a gait belt to transfer the resident from the bed to the geri-chair. However, during the transfer, when the resident was about to sit down, the geri-chair moved backward about 4 inches (it was stopped by the wall behind the head of the bed) and the resident's buttocks slid to the front edge of the seat and her body laid backward onto the seat. The LN immediately moved to the back of the chair and pulled the resident up onto the chair. Afterward, the LN said one of the brakes was "broken" and the other brake "did not hold." The LN stated, "I wonder if the aides are using something to block the wheels." The LN also stated, "I'll let maintenance know." The LN wheeled the resident out of the room and the Activities Director took the resident to an activity. At that point, the LN asked CNA #11 about the brakes on the resident's geri-chair. CNA #11 stated, "One brake works and it was okay last time I used it."</p>	F 323	<p>functioning equipment until repairs are completed if required service poses a threat to resident safety.</p> <p><b>Systemic Change</b></p> <p>Education to be provided on reporting wheel chair brake repair needs to maintenance department and the need for exchanging chairs as needed if prompt repairs are not completed. Maintenance staff in-serviced on the need to promptly repair wheel chair brakes. Wheel chair/ geri-chair maintenance to be placed on TELS system for preventative maintenance.</p> <p><b>Monitoring</b></p> <p>Maintenance director or designee will audit 10% of wheel chairs/geri-chairs to ensure the brakes are in working order. Monitoring will begin 3/20/2014. Audits to be</p>		

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F 323	Continued From page 35  At 3:25 p.m., LN #3 stated, "Maintenance already knew about the broken brake and already ordered parts for it. But the other brake was working earlier today." The LN stated, "We are going to get a different geri-chair and have 2 people transfer her so the chair won't roll out from under her."  On 2/12/14 at 4:00, the DNS was informed of the observation noted above. The DNS agreed to provide documentation of the part ordered for the broken brake.  At 4:10 p.m., the DNS stated, "The maintenance man called it in and the company is going to fax documentation of the request to us."  A copy of the ordered part was not received and no other information was received regarding the issue.	F 323	conducted weekly X4, every 2 weeks X4 and then monthly X3.  Results of audits will be brought to QA/PI by ED with further education audits to be determined based on trends identified.	3/21/2014	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced	F 328	<b>Specific Resident</b>  Care plan reviewed for accuracy for resident #1 related to Cpap use. MD clarification orders obtained.  Resident #12's oxygen order was clarified for continuous oxygen with adjustments to care plan accordingly.  Resident #7's oxygen was adjusted to MD orders and care plan reviewed for accuracy.		

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F 328	<p>Continued From page 36</p> <p>by:</p> <p>Based on observation, resident and staff interviews, and record review, it was determined the facility failed to ensure CPAP (continuous positive airway pressure) was not used without a physician's order and care plan and that oxygen (O2) was provided as ordered by the residents' physicians. This was true for 3 of 13 sample residents (#s 1, 7, and 12). These failures created the potential for more than minimal harm when there were no orders or care plan for Resident #1's CPAP; Resident #7's O2 was higher than ordered; and, Resident #12's O2 saturations were not monitored to determine the need for O2 administration on a PRN, or as needed, basis. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 1/29/14 with multiple diagnoses which included obstructive sleep apnea.</p> <p>CPAP equipment was observed on Resident #1's bedside table as follows: * 2/11/14 at 7:25 a.m., 8:00 a.m., 8:25 a.m., 9:00 a.m., 10:10 a.m., 1:15 p.m., and 2:55 p.m.; and, * 2/12/14 at 10:05 a.m.</p> <p>On 2/11/14 at 10:10 a.m., when asked about the CPAP, the resident stated, "I used it last night and I slept good." When asked who managed the care of the CPAP equipment, the resident's spouse stated, "We're letting them [facility staff] do that."</p> <p>Review of the resident's clinical record revealed there were no orders and no care plan for the CPAP.</p> <p>On 2/12/14 at 12:00 p.m., the DNS was asked if</p>	F 328	<p><b>Other Residents</b></p> <p>Residents within the facility requiring supplemental oxygen or Cpap use could potentially be affected. The facility will administer oxygen per MD order and administer Cpap per appropriate MD order. Residents requiring Cpap machine will have clarification orders obtained and care plan to reflect usage.</p> <p><b>Systemic Changes</b></p> <p>Nursing staff In-serviced on requirements of supplemental oxygen and following the MD order for use. Also in-serviced that documentation on the TAR must be accurate and if a order reads to keep saturation at a certain level the O2 must be adjusted per the MD order. Audits to be completed to ensure oxygen is administered to the resident per MD order and clarification orders</p>		

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F 328	<p>Continued From page 37</p> <p>the resident's CPAP was ordered by the physician and if it was care planned. The DNS reviewed the resident's clinical record then stated, "No, I don't see it [an order] and no, it's not on there [the care plan]." The DNS indicated the resident's family may have brought the CPAP equipment in without the facility's knowledge. She agreed, however, that facility staff should have noticed when the resident wore the CPAP mask during the night.</p> <p>No other information was received from the facility which resolved the issue.</p> <p>2. Resident #12 was admitted to the facility with multiple diagnoses including, chronic airway obstruction.</p> <p>The resident's 12/18/13 admission MDS coded cognitively intact and no oxygen therapy. The MDS Section V Care Area Assessment (CAA) Summary triggered for dehydration but did not trigger for delirium.</p> <p>On 2/5/14 the resident's physician ordered, in part, the following.</p> <ul style="list-style-type: none"> <li>- "Check O2 sats prn for s/s [oxygen saturation levels as needed for signs and symptoms of] respiratory distress.</li> <li>- O2 per standing orders, and</li> <li>- If O2 sats less than 88% [percent] may titrate 1-4 LPM via NC/mask [one to four liters per minute by way of nasal cannula or mask]."</li> <li>- Change O2 tubing, bag, clean filter, change humidifier bottle every 2 weeks and prn.</li> </ul> <p>The resident's care plan contained the 12/23/13 problem, chronic obstructive pulmonary disease. One of the problem approaches was,</p>	F 328	<p>obtained if required. Nursing and Admission staff in-serviced to ensure care plan and MD orders reflect use if Cpap is in residents room. Cpap orders and use to be clarified with resident on admission and care planned accordingly.</p> <p><b>Monitoring</b></p> <p>Nurse Managers to audit that oxygen is administered to resident per MD order. Audits to be completed on all residents using Cpap in facility to ensure there are correlating MD orders and care plan. Monitoring to begin 3/20/2014. Audits to be completed weekly X4, every 2 weeks X4 and then monthly X. Results of audits will be brought to QA/PI by DON with further education audits to be determined based on trends identified.</p>	3/21/2014	

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F 328	<p>Continued From page 38</p> <p>"Medication, including nebulizer tx [treatment], per MD order."</p> <p>The resident's 2/14 Treatment Administration Record (TAR) contained the following handwritten entries.</p> <ul style="list-style-type: none"> <li>- "Check O2 Sats prn for s/s resp [respiratory] distress sob [shortness of breath]."</li> <li>- "Titrate 1-4 LPM via nc/mask if sats [are] less than 88%."</li> </ul> <p>Note: The above orders, on the TAR, were not dated or initialed. Please refer to F514.</p> <p>The resident's 2/14 TAR was reviewed. Next to the order, Check O2 sats prn for s/s of respiratory distress shortness of breath, were the following handwritten entries:</p> <ul style="list-style-type: none"> <li>--2/5/14, O2 sats 76</li> </ul> <p>Note: The TAR did not provide evidence the resident was administered oxygen for the O2 sats less than 88%.</p> <ul style="list-style-type: none"> <li>--2/6/14, O2 sats 83</li> </ul> <p>Note: The TAR did not provide evidence the resident was administered oxygen for O2 sats less than 88%.</p> <ul style="list-style-type: none"> <li>--2/7/14, O2 sats 90 at 2 L/NC (2 liters per minute via NC)</li> <li>--2/8/14, O2 sats 99</li> </ul> <p>Next to the order, Titrate 1-4 LPM via NC/mask if sats less than 88%, were the following handwritten entries:</p> <ul style="list-style-type: none"> <li>--2/6/14, O2 sats 97 at 5L via mask</li> <li>--2/7/14, O2 sats 90 at 2L via NC</li> <li>--2/8/14, O2 sats 99</li> </ul> <p>The 2/14 TAR did not contain any other handwritten entries for the O2 administration.</p>	F 328			

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F 328	<p>Continued From page 39</p> <p>Review of the resident's Progress Notes revealed, in part:</p> <ul style="list-style-type: none"> <li>- 2/5/14 at 4:49 p.m., "...O2 sats between 89-92% on 1LPM [LPM]."</li> <li>- 2/6/14 at 2:51 p.m., "...O2 sat 90% @ [at] 1L per NC..."</li> <li>- 2/7/14 at 12:54 p.m., "...O2 sat 90% @ 2L per [by way of] NC."</li> <li>- 2/8/14 at 10:52 a.m., "...O2 on 2L/NC [LPM via NC] sats 99%..."</li> <li>- 2/9/14 at 12:04 p.m., "...O2 on 2 L/NC, sats 95%..."</li> <li>- 2/10/14 at 11:37 a.m., "...no s/s of respiratory distress noted. [Resident #12] continues on oxygen via nasal cannula at 2 liters with an O2 sat of 92%..."</li> <li>- 2/11/14 at 4:50 a.m., "...Sats 92% on 1 L/min [liter per minute] via NC."</li> <li>- 2/11/14 at 3:08 p.m., "...no s/s of respiratory distress noted...continues on oxygen at 2 liters with an O2 sat of 98%..."</li> </ul> <p>Note: The 2/14 TAR documentation of O2 administration and the documentation in the resident's Progress Notes did not provide evidence the nursing staff consistently assessed the resident's O2 saturations prior to administering O2. In addition, it was not clear what hte nursing interventions were when the resident's O2 sats were 76 on 2/5/14 and 83 on 2/6/14.</p> <p>On 2/12/14 at 2:26 p.m., the resident was observed with O2 at 2LPM via NC.</p> <p>On 2/12/14 at 4:35 p.m., the surveyor discussed the resident's O2 orders with LN #10. The surveyor and the LN reviewed the O2 order</p>	F 328		

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F 328	<p>Continued From page 40</p> <p>specifically, "titrate" and reviewed the care plan for the administration of the O2. The LN agreed the physician ordered O2, "titrated based on O2 sats [less than 88%]."</p> <p>On 2/13/14 at 9:06 a.m., the resident was observed without O2 via NC. The resident said, "I do not need it now because it [my O2 sats] is high enough."</p> <p>On 2/13/14 at 9:21 a.m., the surveyor discussed with the DON, the resident's O2 orders, the 2/14 TAR documentation for O2 administration, progress notes documentation of "continues on O2," and the observations of the resident. The DON stated, "We will work on the administration of O2 and make sure O2 is administered according to MD orders."</p> <p>3. Resident #7 was admitted to the facility with multiple diagnoses including chronic airway obstruction.</p> <p>The resident's 4/8/13 annual and 11/29/13 quarterly MDSs both coded moderately impaired cognition and received oxygen therapy.</p> <p>The resident's 2/14 Physician's Orders (recapitulation orders) contained in part, "9/20/12, O2 at 2 LPM continuous via nasal cannula."</p> <p>The resident's care plan identified a 12/10/13 Oxygen problem, required O2 due to diagnosis of chronic obstructive pulmonary disease. One of the problem approaches was, "O2 per MD orders."</p> <p>On 2/11/14 at 7:32 p.m., the resident was observed with nasal cannula on and appeared</p>	F 328			

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F 328	<p>Continued From page 41</p> <p>asleep while in bed. The concentrator next to the resident's bed was turned on and the O2 liter flow was, "3 LPM."</p> <p>On 2/11/14 at 7:48 a.m., the surveyor and LN #9 checked the resident's O2 order on the 2/14 TAR located on the medication cart. The LN then checked the concentrator. The LN stated, "...3 LPM...hum." The LN then set the O2 flow level on the concentrator to 2 LPM.</p> <p>On 2/11/14 at 12:45 p.m., the resident was sitting in her wheelchair eating her mid-day meal. The resident was wearing nasal cannula. The surveyor asked and the resident agreed to allow the surveyor to look at the O2 companion tank on the back of the resident's chair. The O2 liter flow was, "4 LPM." At 1:20 p.m., the surveyor asked the DON to look at the O2 liter flow on the resident's companion tank. The O2 liter flow was, "4 LPM." The DON stated, "I will check the resident's O2 order." The DON then provided the surveyor with a copy of the resident's "Physicians Standing Orders" signed by the resident's physician on 1/23/14. The Orders contained, in part, an O2 order, "...If O2 saturation is less than 88 [percent] may titrate 1-4 L/min via nasal cannula and/or mask..."</p> <p>The resident's Progress Notes were reviewed to determine whether the resident experienced shortness of breath (SOB), respiratory distress, O2 sats less than 88%, or adverse reactions to the O2 administration at liter flow greater than ordered. The Notes did not provide evidence of SOB, respiratory distress, O2 sats less than 88%, or adverse reactions to the O2 liter flow greater than 2 LPM.</p>	F 328			

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F 328	Continued From page 42 On 2/14/14 at 9:15 a.m., the ED was informed of the findings and observations. The facility did not provide any additional information.	F 328			
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN  Therapeutic diets must be prescribed by the attending physician.  This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, it was determined the facility failed to ensure physician's orders were followed for residents prescribed a mechanical soft texture diet. This affected 1 of 6 (# 16) random residents, had the potential to affect Random Resident #17 and 1 of 9 (#6) sampled residents, and any other residents whose physician prescribed a mechanical soft diet. This practice created the potential for residents to experience choking, chewing, and swallowing difficulties. Findings included:  1. Resident #6 was admitted to the facility with multiple diagnoses including, memory loss and dysphagia.  The resident's 1/24/14 quarterly MDS coded moderately impaired cognition, extensive one person physical assistance to dine, loss of fluids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals, complaints of difficulty or pain with swallowing, no weight loss, and mechanically altered diet.	F 367	<b>Specific Resident</b>  Accuracy of Care plan, MD diet order and tray card reviewed and updated if necessary for resident #6. Monitored at the time of meal for signs/symptoms of choking and/or difficulty swallowing and/or chewing with none observed. Ordered diet texture observed for accuracy with no areas of concern.  Accuracy of Care plan, MD diet order and tray card reviewed and updated if necessary for resident # 16. Monitored at time of meal for signs/symptoms of difficulty chewing, swallowing, and/or choking with none observed. Ordered diet texture observed for accuracy with no areas of concern. Speech orders		

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F 367	<p>Continued From page 43</p> <p>The resident's 2/14 Physician's Orders (recapitulation orders) contained, in part, 9/11/12: "Diet...Texture: mechanical soft."</p> <p>The resident's current care plan contained two dietary problems. The problems documented, in part:</p> <ul style="list-style-type: none"> <li>- 1/8/14, (Resident #6) refused puree diet, will take the mechanical soft diet with nectar thick liquids.</li> <li>- 1/8/14, Potential alteration in nutrition related to past history of poor by mouth intakes and swallowing problem. Problem approaches included, encourage {sic} by mouth intakes, assist as needed, and provide "mechanical soft diet" per MD order.</li> </ul> <p>On 2/12/14 at 5:45 p.m., CNA #22 observed sitting at the table next to Resident #6. Resident #6 was not eating. The resident's plate contained cucumber salad pieces approximately 1/2 inch in length. The surveyor then informed the DM of the observation. The DM told the CNA to not allow the resident to eat the cucumber salad and another salad would be provided from the kitchen. The resident did not exhibit any chewing, swallowing difficulties or signs and symptoms of choking.</p> <p>On 2/12/14 at 5:50 p.m., the surveyor and the Dietary Manager (DM) observed all the residents in the dining room to determine what other residents were on a mechanical soft diet according to the residents' diet cards on the table next to the residents. Both Random Residents #16's and #17's diet cards documented diet texture, "mechanical soft." Both residents had cucumber salad pieces approximately 1/2 inch in length on their plates.</p>	F 367	<p>obtained for resident #16 and diet upgraded. Diet upgrade reflected in care plan.</p> <p>Accuracy of Care plan, MD diet order and tray card reviewed and updated if necessary for resident #17. Resident monitored at time of meal for signs/symptoms of difficulty chewing, swallowing and/or choking with none observed. Ordered diet texture observed for accuracy with no areas of concern.</p> <p><b>Other Residents</b></p> <p>Residents within the facility requiring mechanical soft diets could be potentially affected. These residents will have Accuracy of Care plan, MD diet order and tray card reviewed and will have appropriate textures provided for meals.</p> <p><b>Systemic Changes</b></p> <p>In-service to be provided to dietary staff related to proper</p>		

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F 367	<p>Continued From page 44</p> <p>The surveyor and the DM reviewed the facility's menu. The Menu documented the cucumber salad texture for mechanically soft diets should have been, "1/4 [one quarter] inch diced pieces."</p> <p>2. Random Resident #17 was admitted to the facility with multiple diagnoses including, dementia.</p> <p>The resident's 1/2/14 quarterly MDS coded severely impaired cognition, extensive one person physical assistance to dine, no swallowing disorders, and mechanically altered diet.</p> <p>The resident's 2/14 Physician's Orders (recapitulation orders) contained, in part, "Diet...Texture: 10/20/12 mechanical soft..."</p> <p>On 2/12/14 at 5:50 p.m., CNA #17 was observed assisting the resident to dine. The DM told the CNA not to allow the resident to eat the cucumber salad and a different cucumber salad would be provided from the kitchen. The resident did not exhibit any chewing, swallowing difficulties or signs and symptoms of choking.</p> <p>3. Random Resident #16 was admitted to the facility with multiple diagnoses including, congestive heart failure.</p> <p>The resident's 1/30/14 quarterly MDS coded moderately impaired cognition, limited assistance of one person for dining, no swallowing disorders, prescribed weight gain regimen, and mechanically altered diet.</p> <p>The resident's 2/14 Physician's Orders (recapitulation orders) contained, in part,</p>	F 367	<p>preparation of mechanical soft texture; specifically related to cucumber salad. In-service to be completed with dietary/nursing staff related to ensuring the proper diet is served to all residents. Individual education/training to be completed with cook whom prepared evening meal on 2/12/14.</p> <p><b>Monitoring</b></p> <p>Audits to be completed by Executive Director or designee to ensure proper diet textures are being served to residents with mechanical soft textures. Monitoring to begin 3/20/2014. Audits to be completed weekly X4, every 2 weeks X4 and then monthly X3. Results of audits will be brought to QA/PI by ED with further education audits to be determined based on trends identified.</p>	3/21/2014
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F 367	Continued From page 45 11/13/13: "Diet...Texture: Mech. soft [mechanical soft]."  On 2/12/14 at 5:50 p.m., Resident #16 was observed eating independently. The resident had consumed approximately 90% of the cucumber salad. The remaining cucumber salad pieces were approximately 1/2 inch in length. The resident did not exhibit any chewing, swallowing difficulties or signs and symptoms of choking.  On 2/12/14 at 5:52 p.m., the surveyor informed LN #16 of the mechanical soft texture concerns for Resident #16. The LN stated, "I will watch the resident."  On 2/12/14 at 6:15 p.m., the survey team informed the DON and the ED about the residents who received cucumber salad in 1/2 inch pieces, not 1/4 inch diced. The DON stated, "I know. I was told. I went to the kitchen and measured the cucumber pieces with a measuring tape. The cucumber salad pieces were mostly 1/2 inch in size." The DON went on to state, "After the CNAs heard about the cucumber salad pieces being too large, there were resident trays on the hall cart. The CNAs checked every resident's room tray for the correct diet texture before the hall cart left the dining room."	F 367			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	<b>Specific Resident</b>  The meat slicer, overhead hood fire extinguisher sprockets and backsplash located behind the range/grill have been cleaned.		

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F 371	Continued From page 46  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food contact and non-food contact surfaces were cleaned. This affected 13 of 13 (#s 1-13) sampled residents and any resident who requested and received sliced ham. This practice created the potential for residents to be exposed to disease causing pathogens. Findings included:  On 2/10/14 at 1:53 p.m., the Dietary Manager (DM) accompanied the surveyor during the initial tour of the facility's kitchen. The following was observed:  1. The meat slicer blade had visible, opaque colored debris build-up around the entire edge of the blade.  2. One of three overhead hood fire extinguisher sprockets had visible debris build-up.  3. The backsplash located behind the range and grill had debris build-up and was tacky to the touch.  On 2/10/14 at 2:05 p.m., the DM stated, "We will correct these areas. The meat slicer had a plastic cover that indicated it was cleaned and ready for use. However, the debris on the blade appeared to be from ham. We need to ensure the fire extinguisher sprockets and the backsplash are cleaned more often."	F 371	<b>Other Resident</b>  All residents would be affected by this deficient practice.  <b>Systemic Changes</b>  Dietary staff have been in-serviced on the proper cleaning regimen for the aforementioned items. Daily cleaning, and PRN as needed cleaning following use of the meat slicer, fire extinguisher sprockets and backsplash located behind the range/grill will be conducted.  <b>Monitoring</b>  CDM will conduct a daily inspection of these items X5 days then weekly X3 months. Monitoring/audits will begin on 3/20/2014. Results of audits will be brought to QA/PI by CDM with further education audits to be determined based on trends identified.	3/21/2014	

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F 371	Continued From page 47  The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."  On 2/10/14 at 5:25 p.m., the ED was informed of the observations. The facility did not provide any additional information.	F 371		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES  If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure a resident's feet could touch the ground when a new wheelchair and cushion were	F 406	<p><b>Specific Resident</b></p> <p>Resident #9 assessed for proper self-propelling ability in WC. Accommodations made for resident to ensure resident's feet were able to touch the ground.</p> <p><b>Other Residents</b></p> <p>Any resident that is able to self propel WC with lower extremities has the potential to be effected. Facility will ensure that any accommodations</p>	

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F 406	<p>Continued From page 48</p> <p>provided. This was true for 1 of 5 (#9) sampled residents with specialized rehabilitation services. This failed practice had the potential for harm if the resident experienced a decline in her gross and fine motor coordination and physical function.</p> <p>Resident #9 was admitted to the facility with multiple diagnoses to include, diabetes mellitus, late effects CVA (cerebrovascular disease), peripheral neuropathy, edema, and venous peripheral insufficiency.</p> <p>The resident's most recent quarterly MDS, dated 1/13/14, coded the following:</p> <ul style="list-style-type: none"> <li>- Severely impaired cognition and</li> <li>- Extensive Assist of one person for most ADLs including locomotion on and off the unit.</li> </ul> <p>The resident's ADL care plan, dated 1/8/14, documented the resident used her, "W/C mode of locomotion, which she self-propels."</p> <p>Note: Inconsistencies were noted in resident's MDS, dated 1/13/14, and ADL care plan, dated 1/8/14. The MDS coded, Extensive assist of one person for locomotion and the ADL care plan documented the resident propelled herself in her wheelchair.</p> <p>The resident's "Nursing-Therapy Referral Form," dated 1/27/14 given to therapy by RN #7 requested an Occupational Therapy Screen be conducted on Resident #9 related to wheelchair positioning. Documented on the form under, "Prior level of function, change documented in chart, and/or comments," was a hand written entry, "? (question if) chair is too big. needs smaller MOHO cushion."</p>	F 406	<p>made to WCs will promote the highest independence level to the resident while still maintaining safety and ensuring medical needs are addressed.</p> <p><b>Systemic Change</b></p> <p>Therapy services must obtain orders to evaluate and treat the resident prior to making any recommendations and/or changes to a residents equipment. Education provided to therapy staff to reflect. Individual training provided to occupational therapist related to WC accommodations and ensuring the highest level of independence remains. In-service to all staff related to proper WC positioning and reporting to management/charge Nurse if unable to complete previous tasks after adjustments to WC completed.</p>	
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F 406	<p>Continued From page 49</p> <p>The Occupational Therapy form, "Rehabilitation Services Multidisciplinary Screening Tool," dated 1/27/14 documented, "O.T. (Occupational Therapy) instructed staff to get pt (patient) a narrower 20" w/c and this was completed by OT and nursing staff."</p> <p>On 2/11/14, the following was observed:</p> <ul style="list-style-type: none"> <li>- 8:30 AM, Resident #9 was sitting in the Hall 3 dining room, in her w/c, without foot pedals on her chair and only the tips of her toes touching the floor.</li> <li>- 11:30 AM, Resident #9 was sitting in her w/c, with a 1 1/2 inch - 2 inch thick cushion on the seat. The resident did not have foot pedals on her chair and her toes were the only part of her foot that touched the floor.</li> <li>- 12:30 PM, the resident was observed in the Hall 3 dining room without foot pedals and her feet were approximately one to one and one half inches off the floor.</li> <li>- 12:55 PM, the resident was taken to her room by CNA #12 and with the assistance of LPN #13 assisted out of her w/c so that she could have her incontinent brief changed. After CNA #12 and LPN #13 assisted the resident back into her w/c only her toes were touching the floor. The surveyor asked the CNA and LPN if the resident was able to use her feet to propel her w/c or if the w/c was suppose to have pedals on it. CNA #12 stated the resident was unable to use her feet to propel herself because her "new" wheelchair with the cushion was too high. The CNA then applied foot pedals to the resident's w/c.</li> </ul> <p>On 2/11/14 at 1:10 PM, LPN #13 told the surveyor therapy had changed Resident #9's w/c cushion and now her feet won't touch the ground so she is unable to propel herself. The LPN stated she</p>	F 406	<p><b>Monitoring</b></p> <p>RSM and/or designee to perform audits to ensure orders are obtained prior to recommendations and/or changes to residents' equipment is attempted. RSM and/or designee to audit that modification to WC maintain the residents' highest level of independence/functional ability while maintaining safety and medical needs. Monitoring to begin 3/20/2014. Audits to be completed weekly X4, every 2 weeks X4 and then monthly X3. Results of audits will be brought to QA/PI by RSM with further education audits to be determined based on trends identified.</p>	3/21/2014

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F 406	<p>Continued From page 50 would have to let therapy know.</p> <p>On 2/12/14 the following was observed: - 10:30 AM and 11:30 AM the resident was sitting in her w/c on Hall 3 with only the tips of her toes touching the ground. - 12:30 PM the resident was was observed in the Hall 3 dining room without foot pedals and her feet were approximately one to one and one half inches off the floor.</p> <p>A written statement provided by CNA #1 on 2/13/14, documented the following,"I remembered last week it being mentioned changing up [Resident #8's name] wheelchair. I have commented a couple of times and today in the dinning [sic] room at breakfast that [Resident's name] should have foot pedals cause she is going to fall out or staff is going to dump her out. [Resident's name] does not sit in the chair properly and she leans to the right and her feet do not touch the floor properly, therefore she cannot propel herself properly."</p> <p>On 2/13/14, at 1:20 PM, OTR/L was interviewed about Resident #9's w/c and wheelchair cushion. He said approximately 3 weeks ago a nurse, (did not remember which nurse), on Hall 3 told him the resident's w/c was not wide enough and she needed a wider chair. The width of the w/c was 18" wide so he went to the w/c closet/room and got a 20 inch w/c for the resident. He said the nurse did not say anything to him about the resident's ability to touch the floor with her feet. He said he was under the impression that Resident #9 used her hands to propel herself.</p> <p>On 2/13/14, at 1:35 PM, the Rehabilitation Director was interviewed related to the screening</p>	F 406			

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F 406	<p>Continued From page 51</p> <p>process. The Director stated when nursing has a OT, PT, and/or SLP therapy concern they fill out a Therapy Referral Form and submit the form to therapy. The therapist then conducts a Therapy Screen and implements an appropriate intervention and/or receives an order from the physician for evaluation and further treatment. The Therapy Screen form is then placed in a book on the Director's desk. The surveyor asked the Rehab Director if she had seen a Therapy Screen Form, from nursing, for January/February 2014, for Resident #8's wheelchair. The Director stated she had not seen a referral form or screening form related to the resident's w/c.</p> <p>On 2/13/14, at approximately 2:15 PM, the Rehab Director provided the surveyor with a typed statement. The statement documented the following, "I spoke with [OT's name] which screened [Resident's name] and fitted her with a new wheelchair after being told by nursing that she was too large for her chair... [Occupational Therapist's name] is pursuing orders at this time as this has been brought to his attention and he thinks a new chair is indicated to promote use of upper and lower extremities for propulsion."</p> <p>Note: Inconsistencies were noted between what was documented on the Nursing-Therapy Referral Form, the Rehabilitation Services Screening Tool, and interviews conducted with the OTR/L, the Rehab Director, and the nursing staff; therefore, it was difficult to ascertain what was being done to promote the resident's ability to propel herself using her legs and feet, related to an improperly fitting w/c.</p> <p>On 2/13/14, at 4:30 PM, the Administrator was notified related to the above observations, no</p>	F 406			

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F 406	Continued From page 52 additional information was provided.  On 2/14/14, at 8:55 AM the Rehab Director was interviewed related to the above identified inconsistencies. The Director stated, "I know there are consistencies with what [OT's name] told you and what he told me. I am not sure why." No further information was provided to resolve this matter.	F 406		
F 441 SS=E	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	<b>Specific Resident</b>  Hall 1 storage closet cleaned and organized to limit possible displacement of items onto the floor. Items found on the floor and were still able to be used for resident care were sanitized and re-stored. Foot cradle was disposed of. Individual education provided to all staff related to hand washing during cares for residents #1 and #8.  <b>Other Residents</b>  Resident using mosaic seat cushions and/or hand pumps for seat cushions may potentially be affected. Any resident within the facility	

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F 441	<p>Continued From page 53</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure resident use items were not stored on the floor in 1 of 4 resident hall storage closets (100 Hall) and that staff performed hand hygiene after assisting residents with toileting and other direct resident contact. This was true for 2 of 13 sample residents (#s 1 and 8) and for any resident who may need a mosaic seat cushion, the use of a hand pump to inflate the seat cushions, or a single foot cradle. Failure to follow standard infection control measures placed residents at risk for infections. Findings include:</p> <p>1. On 2/11/14 at 2:40 p.m., the following items were observed on the floor in the 100 Hall storage closet: * 2 inflatable chair seat size cushions; * 1 hand held air pump; and, * 1 padded item which looked like it would go on a foot.</p> <p>At 2:45 p.m., the DNS accompanied the surveyor to the 100 Hall storage closet. The DNS acknowledged the aforementioned items were on the floor. She said the therapy department used</p>	F 441	<p>requiring direct cares may also be potentially affected.</p> <p><b>Systemic Changes</b></p> <p>Nursing staff will be provided education and training on hand washing while providing cares. Nursing and Therapy staff in serviced on maintaining Hall 100 storage closet orderly with all items off the floor.</p> <p><b>Monitoring</b></p> <p>Hand washing audits to be conducted during direct cares by infection control Nurse or Nurse Manager to monitor proper procedure. Infection control nurse or Nurse Manager will audit proper placement of items in the Hall 1 storage closet. Monitoring to begin 3/20/2014. Audits to be completed weekly X4, every 2 weeks X4 and then monthly X. Results of audits will be brought to QA/PI by DON with further education audits to be</p>	
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F 441	<p>Continued From page 54 the storage closet.</p> <p>A moment later, the DNS accompanied the surveyor to the therapy department where the Occupational Therapist (OT) identified the aforementioned items. The OT said the 2 cushions were mosaic cushions and, "They can still be used;" the padded item was a "foot cradle" missing one of the pads and "We probably should throw it away;" and, the hand pump, "could still be used."</p> <p>No other information was received from the facility which resolved the issue.</p> <p>2. Resident #1 was admitted to the facility 1/29/14 with multiple diagnoses which included septic knee joint at the operative site following right total knee replacement.</p> <p>The resident's 2/5/14 admission MDS assessment coded, in part: * intact cognition, with a BIMS score of 15; * Extensive 2 person assistance for transfers and toileting; and, * functional limitation in range of motion in one lower extremity.</p> <p>a) On 2/11/14 at 8:35 a.m., CNA #14 was observed as she placed a bedpan under Resident #1 while student CNA #17 held the resident's right leg. Afterward, CNA #14 removed her gloves but did not perform any hand hygiene before she placed a pillow under the resident's head and a pillow under the resident's right leg. Then, CNA #14 washed her hands.</p> <p>b) On 2/12/14 at 2:55 p.m., CNA #4 and CNA #5 were observed as they transferred Resident #1</p>	F 441	determined based on trends identified.	3/21/2014

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F 441	<p>Continued From page 55</p> <p>from the wheelchair to the bed using a mechanical lift. CNA #5 removed her gloves afterward but did not perform any hand hygiene before she removed the mechanical lift from the resident's room and headed down the hallway with the lift.</p> <p>At 3:00 p.m., when informed of the observation and asked about hand hygiene, CNA #5 stated, "I did not, but I should have. Thank you." The CNA indicated she would wash her hands then clean the mechanical lift.</p> <p>On 2/13/14 at 4:35 p.m., the Administrator, DNS, and RDCS were informed of the observations. No other information was received from the facility regarding the infection control issues.</p> <p>3. Resident #8 was admitted to the facility with multiple diagnoses to include, Alzheimer's, pain in limb, and Hx of venous thrombosis and embolism.</p> <p>The resident's 11/18/13 Quarterly MDS assessment coded the following: - STM/LTM (Short Term/Long Term) memory impairment - Daily decision making, severely impaired - Extensive 2 person assist for bed mobility</p> <p>On 2/11/14, at 8:45 AM, CNA #12 was observed to take Resident #8 to her room, the CNA then applied clean gloves, attached the resident's hoyer sling to the hoyer lift and assisted the resident into bed. The CNA then with the same gloves proceed to provide incontinent care to the Resident. After the CNA completed cleaning the resident she removed her gloves and positioned</p>	F 441			

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F 441	Continued From page 56 the resident on her right side, adjusted the resident's pillows, and covered her with a blanket. Then CNA #12 washed her hands.  Note: The CNA did not wash her hands prior to providing incontinent care to Resident #8, nor did she wash her hands after before she adjusted the resident's pillows or blanket.  On 2/11/14, at 9:00 AM, CNA #12 was asked about the above observation. The CNA stated, she doesn't wash her hands right after providing incontinent care. She stated she removes her gloves, then she makes sure the resident is safe, adjusts the pillows, blankets, and positioning devices and then washes her hands.  On 2/13/14, at 4:35 PM, the Administrator, DNS, and RDCS were informed of the observation. No other information was received from the facility regarding the infection control issue.	F 441			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	<b>Specific Resident</b>  Oxygen order clarification completed and reflected on TAR with dates and initial when placed on the TAR for resident #12.  Splint care clarified for resident #4 and care plan updated to reflect accuracy of splint regime. TAR audit completed and updated with clarified splint order.		

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F 514	<p>Continued From page 57</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure clinical records were complete and accurately documented. This affected 4 of 12 (#s 3, 4, 7 &amp; 12) sampled residents. This practice created the potential for: staff to provide hand splints for Resident #4 in conflict with the Occupational Therapist's (OT's) current recommendation; Resident #12 to receive O2 administration at liter flows other than ordered by the resident's physician; and, staff to be unaware of Resident #3's podiatrist recommendations. Findings included:</p> <p>1. Resident #12 was admitted to the facility with multiple diagnoses including, chronic airway obstruction.</p> <p>The resident's 12/18/13 admission MDS coded cognitively intact and no oxygen therapy.</p> <p>On 2/5/14 the resident's physician ordered, in part, the following.</p> <ul style="list-style-type: none"> <li>- "Check O2 sats prn for s/s [oxygen saturation levels as needed for signs and symptoms of] respiratory distress.</li> <li>- O2 per standing orders, and</li> <li>- If O2 sats less than 88% [percent] may titrate 1-4 LPM via NC/mask [one to four liters per minute by way of nasal cannula or mask]."</li> <li>- Change O2 tubing, bag, clean filter, change humidifier bottle every 2 weeks and prn.</li> </ul> <p>The resident's care plan contained the 12/23/13 problem, chronic obstructive pulmonary disease. One of the problem approaches was,</p>	F 514	<p>Resident #7's care plan reviewed and updated for accuracy relating to trapeze for bed mobility.</p> <p>Progress note obtained from podiatrist for resident #3 and placed in medical record.</p> <p><b>Other Residents</b></p> <p>Residents residing in the facility that use oxygen, splints , trapeze or see a podiatrist have the potential to be affected and will have accurate documentation of these interventions and have podiatry visits accessible in the medical record.</p> <p><b>Systemic Change</b></p> <p>Therapy and nursing in-serviced that if a new order is written for hand splints the prior order must be discontinued so there is not conflicting orders in the medical record and if a trapeze is placed or removed the order</p>		

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F 514	<p>Continued From page 58</p> <p>"Medication, including nebulizer tx [treatment], per MD order."</p> <p>The resident's 2/14 Treatment Administration Record (TAR) contained the following handwritten entries.</p> <ul style="list-style-type: none"> <li>- "Check O2 Sats prn for s/s resp [respiratory] distress sob [shortness of breath]."</li> <li>- "Titrate 1-4 LPM via nc/mask if sats [are] less than 88%."</li> </ul> <p>The resident's 2/14 TAR was reviewed. Next to the order, Check O2 sats prn for s/s of respiratory distress shortness of breath, were the following handwritten entries:</p> <ul style="list-style-type: none"> <li>-2/5/14, O2 sats 76</li> </ul> <p>Note: The TAR did not provide evidence the resident was administered oxygen for the O2 sats less than 88%.</p> <ul style="list-style-type: none"> <li>--2/6/14, O2 sats 83</li> </ul> <p>Note: The TAR did not provide evidence the resident was administered oxygen for O2 sats less than 88%.</p> <ul style="list-style-type: none"> <li>-2/7/14, O2 sats 90 at 2 L/NC (2 liters per minute via NC)</li> <li>-2/8/14, O2 sats 99</li> </ul> <p>Next to the order, Titrate 1-4 LPM via NC/mask if sats less than 88%, were the following handwritten entries:</p> <ul style="list-style-type: none"> <li>--2/6/14, O2 sats 97 at 5L via mask</li> <li>-2/7/14, O2 sats 90 at 2L via NC</li> <li>-2/8/14, O2 sats 99</li> </ul> <p>The 2/14 TAR did not contain any other handwritten entries for the O2 administration.</p> <p>On 2/13/14 at 9:21 a.m., the surveyor discussed with the DON, the Resident #12's O2 orders and</p>	F 514	<p>and care plan needs written or discontinued appropriately. Licensed staff in-serviced that TAR needs to have initials and date when orders are added on, also in-serviced that oxygen must be administered per MD orders and if the O2 is ordered to maintain a certain saturation the O2 must be adjusted per MD order and documented on TAR. HIM in-serviced on obtaining podiatry progress notes on a timely basis and use of transportation schedule to ensure notes are obtained with the allotted time frame and placed on clinical record.</p> <p><b>Monitoring</b></p> <p>Restorative nurse or designee to audit medical records for hand splints to ensure the current order is accurately transcribed and there are no conflicting orders. Nurse Manager to audit rooms for</p>	

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F 514	<p>Continued From page 59</p> <p>the 2/14 TAR documentation for O2 administration. The DON stated, "Nursing staff should have entered their initials and dates when writing the orders on the TAR. There should also be separate lines designated for sat levels, and liter flow, and the nurse's initials when administering the O2. We will work on the administration of O2 and make sure O2 is administered according to MD orders."</p> <p>2. Resident #4 was admitted to the facility with multiple diagnoses including traumatic brain injury.</p> <p>The resident's 12/5/13 quarterly MDS coded upper extremity and lower extremity impairments.</p> <p>The resident's care plan included a 9/24/13 problem, self care deficit. One of the problem approaches was, "Bilat. [bilateral] hand splints on in pm, off in am."</p> <p>The resident's 2/14 Physician's Orders (recapitulation orders) contained three different orders for the use of hand splints.</p> <ul style="list-style-type: none"> <li>* 8/13/12: bilateral (B) hand splints 6 hours on, 2 hours off to be placed daily on every shift</li> <li>* 6/12/13: Apply (B) hand splints at bedtime - remove every morning</li> <li>* 10/1/13: apply (B) hand splints for up to 8 hrs 4-6x/wk (4-6 times per week)</li> </ul> <p>The resident's 2/4/14 Restorative Assessment documented, in part, "splinting program."</p> <p>On 2/12/14 at 10:30 a.m., the surveyor showed the Occupational Therapist (OT) the three hand splint orders on the resident's recapitulation orders. The OT stated, "My recommendation was</p>	F 514	<p>trapeze and ensure care plans are accurate. Nurse Managers to audit that oxygen is administered and documented per MD order. Medical Records to audit that progress notes are obtained within allotted time after podiatry visits by utilizing transportation schedule.</p> <p>Monitoring to begin 3/20/2014.</p> <p>Audits to be completed weekly X4, every 2 weeks X4 and then monthly X 3. Results of audits will be brought to QA/PI by DON with further education audits to be determined based on trends identified.</p>	3/21/2014	

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F 514	<p>Continued From page 60 the order dated 6/12/13."</p> <p>On 2/13/14 at 10:54 a.m., the surveyor discussed the three different hand splint orders with LN #16. The LN stated, "I did a clarification order to discontinue the 8/13/12 and 10/1/13 orders. We will continue with the OT's 6/12/13 order as we are placing the hand splints on the resident at night and removing the hand splints in the morning."</p> <p>On 2/13/14 at 2:00 p.m., the surveyor observed the hand splints in the resident's room.</p> <p>Resident #4's recapitulation orders contained two hand splint orders that were not relevant to the resident's current needs.</p> <p>On 2/14/14 at 9:15 a.m., the ED and the DON were informed of the concern about three different hand splint orders on the recapitulation orders. The facility did not provide any additional information.</p> <p>3. Resident #7 was admitted to the facility with multiple diagnoses including major depressive affective disorder severe degree.</p> <p>The resident's 2/14 Physician's Orders (recapitulation orders) contained, in part, an order, "5/31/11: Trapeze over head." The order was yellow highlighted and "d/c [discontinue]" was handwritten next to the yellow highlighted order. There were no initials or dates indicating when the trapeze order was discontinued.</p> <p>On 2/12/14 at 12:09 p.m., the Medical Records Director was asked for the original trapeze order and discontinue order for the trapeze. The</p>	F 514			

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F 514	<p>Continued From page 61</p> <p>Director stated, "I found the order for the trapeze on the June 2011 recapitulation orders but I did not find a telephone or verbal order to discontinue the trapeze." LN #16 stated, "The resident's medical doctor did sign the resident's February 2014 recapitulation orders and the order was highlighted in yellow with d/c next to the order."</p> <p>Review of the resident's June 2011 recapitulation orders provided evidence the order, "trapeze over head...for [increased] bed mobility," was handwritten and there were no initials and there was no date of when the handwritten entry was made on the June 2011 recapitulation orders.</p> <p>On 2/13/14 at 1:10 p.m., the resident stated, "I remember having a trapeze over my bed and head. I'd grab ahold of it and use it to move around in bed."</p> <p>On 2/13/14 at 1:13 p.m., LN #16 stated, "The resident quit using the trapeze so we removed it from the room."</p> <p>On 2/14/14 at 9:15 a.m., the ED and the DON were informed of the above concerns with the accuracy of the resident's clinical records. The facility did not provide any additional information.</p> <p>4. Resident #3 was admitted to the facility 2/14/13 with multiple diagnoses which included dementia, depression, progressive debility, and history of stroke.</p> <p>An Incident/Accident Data Entry Questionnaire (I/ADEQ), dated 1/4/14 at 7:25 a.m., included the following documentation, "...bleeding noted to left foot third toe. Nail is loose..." An Incident Follow-up &amp; Recommendation Form, also dated</p>	F 514			

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F 514	<p>Continued From page 62</p> <p>1/4/14, and attached to the I/ADEQ documented, in part, "...Follow up [with] poditrist [sic]: appt [appointment] made [with] poditrist [sic] when available [sic]."</p> <p>Review of the resident's clinical record revealed there were no podiatry visit notes or progress notes.</p> <p>On 2/12/14 at 2:45 p.m., when asked if the resident had been seen by a podiatrist, the DNS stated, "Yes" and said she would call the podiatrist's office to request the note.</p> <p>On 2/13/14 at 2:00 p.m., the DNS provided a 2/11/14 "Follow UP Note" by a podiatrist which documented, "...Sutures intact, nail bed is slightly fibrotic but drainage is minimal...remove sutures today cover with bandaid..." When asked if the podiatrist saw the resident before 2/11/14, the DNA stated, "Yes" and said she would call the podiatrist's office again to request that visit note.</p> <p>On 2/13/14 at 4:30 p.m., the DNS said the resident was seen by the podiatrist on 1/23/14. She stated, however, "We aren't going to get that note though because he [podiatrist] doesn't have office staff right now and he is by himself."</p> <p>No other information was received from the facility regarding the issue.</p>	F 514			
F 518 SS=F	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using</p>	F 518	<p><b>Specific Resident</b></p> <p>All staff within the facility has been in-serviced on what to do in the event of an earthquake.</p>		

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F 518	<p>Continued From page 63 those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of procedures for disasters and in-service records, it was determined the facility failed to ensure staff were trained to respond in the event of an earthquake. This was true for 3 of 3 staff (CNA #s 8 and 19 and LN #20) interviewed regarding emergency procedures. This failure created the potential for more than minimal harm for residents if staff did not know what to do in the event of an earthquake. Findings included:</p> <p>Note: The facility's Specific Procedures for Disasters Other Than Fire: Earthquake procedure documented, in part: "General As initial shaking begins, all staff should: * Position themselves under sturdy furniture, away from windows and swinging doors. As initial shaking stops and a reasonable interval has passed with no further shock, all staff should: * Perform an immediate assessment of injuries and inform the Command Post of their findings. * Perform an immediate assessment of structural damage in the area and inform the Command Post of their findings. * Move residents away from damaged areas. * In anticipation of aftershocks, move residents away from windows and outside walls. Pull all drapes and curtains closed to reduce the potential of flying glass. * Position over-bed tables to shield residents' heads from falling debris." "Nursing * Assess the damage of all involved nursing units and report...to the Command Post.</p>	F 518	<p><b>Other Resident</b></p> <p>All residents have the potential to be affected.</p> <p><b>Systemic Changes</b></p> <p>Emergency preparedness orientation of new employees will include training on earthquakes in accordance to our emergency preparedness manual. Bi-Annual emergency drills will be scheduled for the building on earthquakes for the next year.</p> <p><b>Monitoring</b></p> <p>Maintenance director or designee will audit compliance by interviewing five (5) staff members to determine aptitude on earthquake preparedness. Monitoring to begin 3/20/2014. Audits to be completed weekly X4, every 2 weeks X4 and then monthly X3. Results of audits will be brought to QA/PI by ED with further</p>		

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F 518	<p>Continued From page 64</p> <ul style="list-style-type: none"> <li>* Direct and assist with the evacuation...as necessary.</li> <li>* Initiate and maintain a bed available count.</li> <li>* If you are in a clinical area...your first responsibility is to the residents...</li> <li>* Check for fire or fire hazards...</li> <li>* Make sure all ambulatory residents wear shoes in areas near debris and glass.</li> <li>* Immediately clean up spilled medications, drugs and other potentially harmful materials.</li> <li>* If the water is off, emergency water can be obtained...</li> <li>* Check to see that sewage lines are intact before permitting continued flushing of toilets.</li> <li>* Check closets and storage shelf areas...</li> <li>* Be prepared for additional "aftershocks."..."</li> </ul> <p>a) On 2/12/14 at 4:25 p.m., CNA #8 was interviewed. The CNA said she had worked part time on the evening shift for 11 months. When asked what she would do in the event of an earthquake, the CNA stated, "I don't know if we would take them [residents] outside or not. I'm just not sure." When asked if the facility had provided training about earthquakes, the CNA stated, "I just don't remember but we probably had training when hired."</p> <p>b) On 2/12/14 at 4:45 p.m., CNA #19 was interviewed. The CNA said she had worked full time for 7 months, mostly on the day shift and occasional on evenings. When asked what she would do in the event of an earthquake, the CNA stated, "I really don't know. They've not touched on that. Of course the obvious things." When asked what the obvious things were, the CNA said, "Resident safety." When asked if the facility had provided training about earthquakes, the CNA stated, "I've not had any training on earthquakes."</p>	F 518	<p>education audits to be determined based on trends identified.</p>	3/21/2014	

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

PRINTED: 03/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF IDAHO FALLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</b>		
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F 518	<p>Continued From page 65</p> <p>c) On 2/12/14 at 4:55 p.m., LN #20 was interviewed. The LN said she had worked full time at the facility "for just over a year" and she worked 5 hours 3 times/week on the evening shift and 6:00 p.m. to 6:00 a.m. on Saturdays. When asked what she would do in the event of an earthquake, the LN shrugged her shoulders but did not give any other response. When asked if she had received any training on earthquakes, the LN stated, "No I have not. But I can go find out."</p> <p>On 2/13/14 at about 10:30 a.m., during a tour of the facility's environment with the Administrator, Maintenance Supervisor (MS), and Laundry/Housekeeping Supervisor (L/HS) the MS was asked if staff received emergency preparedness training regarding earthquakes. The MS stated, "I show them where the Emergency book is and go through it and show them what we cover. But I don't train them specifically on earthquakes." When asked to provide evidence the staff had read the procedure regarding earthquake, the Administrator and MS both indicated there was no documented evidence of that. When asked if staff would be expected to go to the Emergency Preparedness manual during or immediately after an earthquake, the MS stated, "I see what you mean" and, "We are in a seismic area." The Administrator stated, "Our staff do receive disaster training." The Administrator was asked to provide evidence the 3 aforementioned staff received training regarding earthquake.</p> <p>On 2/13/14 at 12:00 p.m., the Staff Development Coordinator (SDC) provided a 2 page EMERGENCY PREPAREDNESS ORIENTATION document, an Acknowledgement of Policies</p>	F 518			

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F 518	<p>Continued From page 66</p> <p>document for CNA #8, CNA #19, and LN #20, Global Harmonized System and Hazard Communication Training and Orientation Exams for the same 3 staff, and a 5/5/13 MANDATORY IN-SERVICE SIGN IN SHEET on "Hand In Hand/Disaster Preparedness." The SDC stated, "I place the Emergency Preparedness Orientation document in new hire orientation packets. But, I don't specifically do any training on earthquakes." In addition, a description of the information covered during the 5/8/13 Mandatory In-Service was not provided, and of the 3 aforementioned staff, only LN #20 signed the attendance sheet for the in-service.</p> <p>On 2/17/14 at 4:05 p.m., a 24 page facsimile (fax) from the facility was received at the Bureau of Facility Standards. The fax included a "To whom it may concern" letter which documented in part, "Each employee hired is trained in emergency procedures...As part of this training and the additional training provided, we refer them to look for the Emergency Disaster manual that has in it the procedures to follow...As you can see with the statements from our staff...they were aware of the potential for Earthquakes and had the knowledge and resources within our Emergency Disaster Book in order to respond in the event an earthquake would occur."</p> <p>The fax also included 3 statements by the SDC regarding interviews he conducted with CNA #s 8 and 19 and LN #20 on 2/13/14. The 3 statements documented, in part:</p> <p>* "[CNA #8's name] stated she was shown the location of the disaster manual upon hire but 'couldn't remember where it is.'"</p> <p>* "[CNA #19's name] was asked the location of the disaster manual to which she replied 'the</p>	F 518			

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F 518	Continued From page 67 main nurses station.' This SDC explained to [CNA's name]...location of the disaster manual was in the hall 3 central supply room." * "...spoke to [LN #20's name] regarding location of the disaster manual... [LN's name] stated...it was in 'the main nurses station.' I explained to her that this the location of the MSDS [material safety data sheets] manual. Upon explaining this [LN's name] explained she had confused the MSDS manual with the disaster manual."  The information received via fax did not resolve the issue.	F 518			

Bureau of Facility Standards

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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN; Karen Marshall, MS RD LD; and Amy Barkley, BS RN.</p> <p>Survey Definitions: CPAP = Continuous positive airway pressure</p>	C 000	<p><b>Specific Resident</b></p> <p>Family members were contacted about the discharged resident #15 belongings and they confirmed that the belongings were indeed received.</p> <p><b>Other Resident</b></p> <p>All residents have the potential to be affected that are discharged from the facility. Discharge charts from 02/14/2014 to current have been reviewed for accuracy of discharged belongings received upon discharge and/or upon request.</p> <p><b>Systemic Changes</b></p> <p>Systematic changes in place to assure that personal belongings are received at discharge and/or upon request. The inventory sheet audit will be performed within 3 business days, assuring that the personal inventory sheet has been signed by the responsible party receiving the residents' personal belongings. This audit must be completed prior to any record being "closed." If family or resident are unable to sign the</p>	
C 159	<p><b>02.100.09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES</b></p> <p>09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a personal valuables inventory and disposition of valuables was in the resident's record for 1 of 2 (#15) sampled closed records. Findings include:</p> <p>1. Resident #15 was discharged from the facility on 07/23/13. A review of the closed record failed to contain the facility's "Inventory of Personal Effects" form and the Progress Notes did not document the disposition of belongings upon</p>	C 159		

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

TITLE

(X6) DATE



Executive Director

3/28/14

Bureau of Facility Standards

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C 159	Continued From page 1  discharge.  On 2/13/14 at 11:30 AM, the DNS was notified of the lack of documentation regarding personal valuables. At 12:02 PM, medical records designee confirmed the Resident #15's record did not contain the resident's, "Inventory of Personal Effects," and there was no documentation regarding the disposition of the resident's personal valuables.	C 159	facility will call the responsible party to ensure personal belongings were received.  In-service provided to HIM related to ensuring accuracy of the medical record upon discharge including the inventory sheet. In-service education provided to housekeeping and licensed nursing staff regarding ensuring inventory sheet is signed and accounted for upon discharge or request of belonging and/or verbal confirmation is obtained that belongings were received.	
C 173	02.100,12,d Immediate Notification of Physician of Injury  d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please refer to F 157 as it relates to notification of physician.	C 173	<b>Monitoring</b>  DON/ED or designee will monitor this process weekly X4, every 2 weeks X4 and then monthly X3. Monitoring/audits will begin on 3/20/2014. Results of audits will be brought to QA/PI by HIM with further education audits to be determined based on trends identified.	3/21/2014
C 243	02.106,05 ORIENTATION, TRAINING & DRILLS  05. Orientation, Training and Drills. All employees shall be instructed in basic fire and life safety procedures. This Rule is not met as evidenced by: Refer to F518 as it related to emergency preparedness training regarding earthquakes.	C 243		
C 253	02.106,07,a Prohibited Use of Defective Equipment  a. The use of any defective equipment on the premises of any facility is prohibited.	C 253	C 173 Refer to F 157 C 243 Refer to F 518 C 253 Refer to F 323	3/21/2014 3/21/2014 3/21/2014

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C 253	Continued From page 2  This Rule is not met as evidenced by: Refer to F323 as it related to a defective geriatric chair.	C 253		
C 293	02.107,04,b Therapeutic Diets per Physician Orders  b. Therapeutic diets shall be planned in accordance with the physician's order. To the extent that it is medically possible, it shall be planned from the regular menu and shall meet the patient's/resident's daily need for nutrients. This Rule is not met as evidenced by: Please refer to F367 as it related to following physician's orders for therapeutic diets.	C 293	Refer to F 367	3/21/2014
C 325	02.107,08 FOOD SANITATION  08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to sanitation in the kitchen.	C 325	Refer to F 371	3/21/2014
C 631	02.122,01,a Individual Resident Bed Requirments  a. Each patient/resident shall be provided with his own bed which shall be at least thirty-six (36) inches wide, have a head and a footboard, be substantially constructed, and in good	C 631	Specific Resident  On 2/13/14 resident #9 had a twin sized bed moved into her	

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C 631	<p>Continued From page 3</p> <p>repair. Bedrails shall be provided when needed. Roll-away type beds, cots, folding beds, double beds, or hollywood-type beds shall not be used. Adjustable-height beds are recommended.</p> <p>This Rule is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure 1 of 13 (#9) sampled residents had a bed in her room. Additionally, there was no evidence of informed decision-making to refuse recumbent positioning to relieve pressure to the buttock area. Findings included:</p> <p>Resident #9 was admitted to the facility with multiple diagnoses to include, diabetes mellitus, late effects CVA (cerebrovascular disease), peripheral neuropathy, edema, and venous peripheral insufficiency.</p> <p>During the initial tour on 2/11/14 at approximately 2:00 PM, it was observed that Resident #9 did not have a bed but had a recliner instead in her room.</p> <p>The resident was observed in the recliner, with the back of the recliner against the wall, and or the w/c as follows: - 2/11/14, from 8:30 AM to 10:30 AM, sitting upright in recliner with feet on floor; from 12:15 PM to 1:15 PM, sitting in w/c in the Hall 3 dining room; and at 2:55 PM sitting upright in recliner with feet on the floor. - 2/12/14, 9:30 AM and 11:00 AM sitting upright in recliner with feet on the floor; 12:00 PM and 1:00 PM sitting in w/c; 2:00 PM and 3:15 PM sitting upright in recliner with feet on the floor. On 2/13/14, similar observations were made related to the resident's positioning.</p>	C 631	<p>room due to resident had previous bed removed related to sleeping preference in recliner only. Staff to encourage resident to sleep in and/or spend time in bed.</p> <p><b>Other Residents</b></p> <p>Other residents, who prefer to sleep in their recliners, have the potential to be affected. A house-wide audit was completed to ensure that any other residents who prefer to sleep in their recliner only have had a risk vs. benefits education in regards to sleeping in a recliner only.</p> <p><b>Systemic Change</b></p> <p>In-service provided to licensed nursing staff regarding the need for the facility to provide risk vs benefit education to any resident and their family regarding to sleeping in a recliner only if the resident is refusing and/or choosing to not</p>	

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C 631	<p>Continued From page 4</p> <p>The resident's "Skin 1" care plan, dated 1/8/14, documented, in part:</p> <ul style="list-style-type: none"> <li>- Prefers to sleep in recliner often preferring to keep feet on the floor.</li> <li>- LN to eval[uate] skin weekly</li> <li>- Observe and report any red areas found during adl's (activities of daily living) to LN</li> <li>- Refuses cushion on recliner but allows one to her w/c</li> <li>- Sleeps in recliner per her request</li> <li>- Encourage to reposition every two hours or more frequently. Extensive to limited assist of one to two for bed mobility/ positioning.</li> </ul> <p>Note: It was unclear how the resident was supposed to "Reposition every two hours or more frequently" if all she had was a wheelchair and a recliner that she was not physically able to recline. The back of the recliner was observed against the wall preventing the footrest from being raised.</p> <p>During the survey it was discovered that the resident had developed a pressure ulcer on her buttock. Refer to F314 for full details.</p> <p>On 12/13/14 at approximately 12:45 PM, the DNS was interviewed related to the above observations. The surveyor asked how did staff reposition or assist the resident to off load her weight when the resident was always sitting in the upright position in her w/c and/or recliner. The DNS stated the resident can't be repositioned nor can she offload her weight and she (the DNS) would be addressing the issue today. In addition, the DNS stated the resident's bed was taken out of her room, because she refused to use it.</p> <p>Note: The DNS said the resident's bed was taken out of her room, related to her "refusal" to use it;</p>	C 631	<p>sleep in facility bed provided. Also education provided to use the 24 hour report books to communicate to IDT any resident whom are sleeping in recliners only.</p> <p><b>Monitoring</b></p> <p>The DON and/or Nurse Manager will audit the 24hour report weekly to identify any documentation of residents sleeping in their recliner only. Monitoring to begin 3/21/2014. Audits to be completed weekly X4, every 2 weeks X4 and then monthly X3. Results of audits will be brought to QA/PI by DON</p>	3/21/2014

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C 631	<p>Continued From page 5</p> <p>however, there was no documentation in the resident's record indicating how staff had determined the resident preferred to keep her feet on the floor, or why she preferred to sleep in her recliner. Furthermore, it could not be determined the resident and the resident's legal representative had been educated related to the risk vs. benefits of the resident sitting upright continuously in her chair with her feet on the floor.</p> <p>On 2/13/14 at 6:10 p.m., the resident's room was observed. There was a twin sized bed and the recliner in the resident's room.</p>	C 631		
C 644	<p>02.150,01,a,i Handwashing Techniques</p> <p>a. Methods of maintaining sanitary conditions in the facility such as:</p> <p>i. Handwashing techniques.</p> <p>This Rule is not met as evidenced by: Please refer to F 441 as it relates to handwashing.</p>	C 644	Refer to F 441	3/21/14
C 645	<p>02.150,01,a,ii CARE OF EQUIPMENT</p> <p>ii. Care of equipment.</p> <p>This Rule is not met as evidenced by: Refer F441 as it related to infection control measures.</p>	C 645	Refer to F 441	3/21/14
C 747	<p>02.200,01,e Individualized Resident Care Plan</p> <p>e. Observing and evaluating the condition of each patient/resident and developing a written, individualized patient care plan which shall be based upon an assessment of the needs of</p>	C 747	Refer to F 279	3/21/14

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C 747	Continued From page 6  each patient/resident, and which shall be kept current through review and revision; This Rule is not met as evidenced by: Refer to F279 as it related to individualized resident care plans.	C 747		
C 781	02.200,03,a,iii Written Plan, Goals, and Actions  iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Please refer to F280 as it related to care plan updates	C 781	Refer to F 280	3/21/2014
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F246 as it related to positioning.  Please refer to F309 as it related to the following the care plans.  Please refer to F328 as it related to no orders or care plan for CPAP.	C 784	Refer to F 246  Refer to F 309  Refer to F 328	3/21/2014
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered	C 788		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001400</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/14/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF IDAHO FALLS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</b>
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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) COMPLETE DATE
C 788	Continued From page 7  iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F309 and F328 as it related to following physician's orders. Refer to F328 as it related to oxygen use.	C 788	Refer to F 309  Refer to F 328	3/21/2014
C 789	02.200,03,b,v Prevention of Decubitus  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F 314 as it relates to pressure ulcers.	C 789	Refer to F 314	3/21/2014
C 794	02.200,03,b,x Respect and Kindness  x. Treatment of patients/residents with kindness and respect; This Rule is not met as evidenced by: Please refer to F 241 as it relates to dignity and respect.	C 794	Refer to F 241	3/21/2014
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD  02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following:	C 881	Refer to F 514	3/21/2014

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF IDAHO FALLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2725 EAST 17TH STREET IDAHO FALLS, ID 83406</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 881	Continued From page 8  This Rule is not met as evidenced by: Please refer to F514 as it related to accuracy of clinical records.	C 881		
C 882	02.203,02,a Resident Identification Requirements  a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record.  This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the cause of death signed by the physician was maintained in the resident's closed record. This affected 1 of 2 (#15) closed records reviewed. Findings included:  Resident #15 was admitted to the facility with multiple diagnoses to include, Paralysis Agitans, decubitus heel ulcer, MRSA, debility, malaise, and fatigue.  Review of the resident's closed record did not	C 882	<b>Specific Resident</b>  The physician signed cause of death was located and placed in the residents #15 closed record.  <b>Other Resident</b>  All residents have the potential to be affected who pass away while in the facility. Discharge charts from 02/14/2014 to current reviewed for cause of death to assure proper documentation was present within 30 days of death.  <b>Systemic Changes</b>  Systematic changes in place to assure that reason for discharge, including cause of death will be audited to ensure documentation is present. The discharge audit will be performed by the ED/DON or designee. The audit will be performed within 3	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001400</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/14/2014</b>
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C 882	Continued From page 9 provide evidence the physician signed cause of death.  On 2/13/14 at 11:30 AM, the DNS was notified of the lack of documentation regarding the cause of death in the resident's medical record. At 11:30 PM, the DNS confirmed Resident #15's record did not contain the resident's, cause of death signed by the physician. At 12:02 PM the medical records designee provided a faxed copy, dated 2/13/14, from the physician's office documenting the resident's cause of death. When the medical records designee was asked why the cause of death was not in the medical record, she responded she didn't know, it must have gotten over looked.	C 882	<b>business days and will be completed prior to any record being "closed."</b>  <b>Monitoring</b>  ED/DON or designee will monitor this process weekly X4, every 2 weeks X4 and then monthly. Monitoring/audits will begin on 3/20/2014. Results of audits will be brought to QA/PI by HIM with further education audits to be determined based on trends identified.	
C 950	02.302 SPECIALIZED REHABILITATION SERVICES  302. SPECIALIZED REHABILITATIVE SERVICES. In addition to rehabilitative nursing, the facility provides for or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (i.e., physical therapy, occupational therapy, speech pathology, and audiology) as needed by patients to improve and maintain functioning. This Rule is not met as evidenced by: Please refer to F 406 as it relates to Occupational Therapy.	C 950	<b>Refer to F 406</b>	3/21/2014  3/21/2014