



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 1727**

April 15, 2014

Dallas M. Clinger, Administrator  
Power County Nursing Home  
510 Roosevelt Street, PO Box 420  
American Falls, ID 83211-0420

Provider #: 135066

Dear Mr. Clinger:

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

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

Dallas M. Clinger, Administrator  
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After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 28, 2014**. Failure to submit an acceptable PoC by **April 28, 2014**, may result in the imposition of civil monetary penalties by **May 19, 2014**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does 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 (X5).

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If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

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

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 28, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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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 **April 28, 2014**. If your request for informal dispute resolution is received after **April 28, 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, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "D. Scott, R.N." The signature is written in a cursive style with a large initial "D" and "S".

DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj  
Enclosures

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

PRINTED: 04/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135066</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>POWER COUNTY NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 ROOSEVELT STREET AMERICAN FALLS, ID 83211</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: Sherri Case, BSW, LSW, QIPD, Team Coordinator Susan Gollobit, RN</p> <p>The survey team entered the facility on March 24, 2014 and exited on March 28, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide DON = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NN = Nurses Notes OTA = Open to Air PRN = As Needed RSO = Routine Standing Orders SNF/NFs = Skilled Nursing Facility/Nursing Facilities SNPN = Skin nurse progress note</p>	F 000	<p><i><b>This Plan of Correction is PCHD Skilled Nursing Facility's credible allegation of compliance.</b></i></p> <p><i><b>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</b></i></p>	
F 167 SS=E	<p><b>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</b></p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p>	F 167	<p><b>F 167 483.10(g)(1) RIGHT TO SURVEY RESULTS</b></p> <p><u>Residents with the potential to be affected:</u> All residents and their family and friends have the potential to be affected.</p> <p><u>Corrective Actions:</u></p>	<b>12MAY14</b>

RECEIVED  
MAY 14 2014  
FACILITY STANDARDS

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

TITLE

(X6) DATE



**ADMINISTRATOR**

**12 MAY 2014**

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 167	<p>Continued From page 1</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure the results of the Annual survey were readily accessible to residents. This deficient practice was true for any resident or their representative who may want to review the survey results, including 8 of 8 sampled residents (#1 - 8). Findings included:</p> <p>On 3/26/14 at 12:15 pm, the State Survey Results binder was located in a plastic pocket on the right side of the door exiting the Long Term Care facility. The clear plastic pocket was above the door handle high on the wall, and out of reach of wheelchair residents. The binder contained the results from the 1/2/12 re-licensure survey. The 2013 survey was not in the binder.</p> <p>On 3/26/14 at 1:20 pm, the DON was asked where 2013 re-licensure survey results were, and she stated, "I know I just checked this. I wonder if staff took it out and did not put it back in there. We will make a copy of it and put it back in there. " The DON was if wheelchair residents could reach it and she stated, "No probably not. We can move it down."</p> <p>On 3/27/14 at 5:00 pm, the Administrator and the DON were informed of the findings. No further information was provided.</p>	F 167	<p>The most recent survey of the facility conducted by Federal or State surveyors and any plan of correction will continue to be posted by the door exiting the Long Term Care facility. The clear plastic pocket has been lowered to make it more accessible to wheelchair residents.</p> <p><u>Measures to Prevent Recurrence:</u> The Administrator or designee will conduct checks to assure that a copy of the most recent survey is posted.</p> <p><u>Monitoring/Assurance:</u> The Administrator or designee will monitor to check that the Survey and Plan of Correction is posted. This will begin the week of 4/14/14 and be done weekly for seven weeks, then monthly for four months. Any discrepancies will be discussed in the Quality Assurance Committee.</p>		

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F 225 F 225 SS=D	Continued From page 2 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225 F 225	<b>F225 483.13(c)(1)(ii)-(iii),(c)(2)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b>  <u>Residents with the potential to be affected:</u> All residents have the potential to be affected.  <u>Corrective Actions:</u> The Administrator will be notified by immediately by cell phone of all alleged violations of resident abuse, neglect, injuries of unknown source, resident-to-resident abuse and resident-to-staff abuse. 'Immediately' means as soon as reasonably possible, and no later than the end of the shift in which the incident was discovered. Additionally, the staff member who discovered the alleged violations will report the alleged violation on the 'Resident Abuse or Neglect form' and on a Quality Management Memo (QMM) form. The Resident Abuse and Neglect form will be faxed to the Administrator and the Assistant Administrator, prior to the end of the shift in which the incident was discovered. The Administrator and the Assistant Administrator have 24-7 access via secure mobile technology to view the faxed form. All alleged violations will be investigated by the administrator or his designee. All QMMs for injuries of unknown origins will include an Addendum with statements by the LN and CNAs on duty. The MDS Assistant will check the schedule and determine what other nursing staff worked for the previous 48 hours. The MDS Assistant will call these staff members and let them know they have 24 hours to come in and fill out their statement. If they cannot come in within the	<b>12MAY14</b>

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F 225	Continued From page 3  This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and review of the facility's abuse protocol it was determined the facility failed to ensure all incidents of unknown injury were investigated. This was true for 1 of 9 (#2) sample residents. Additionally the facility failed to ensure all investigations were completed within 5 working days of the incident in accordance with Resident Abuse Reporting SNF/NFs Informational Letter 2005-1. This was true for 1 of 9 (#7) sample residents. Failure to investigate injuries of unknown origin and/or ensure timely completion of investigations placed these residents at risk for abuse/neglect.  1. The facility's Abuse Investigation Protocol stated under the Policy section, "All reports of resident abuse, neglect, injuries of unknown source, resident-to-resident abuse and resident-to staff abuse are -promptly and thoroughly investigated by facility management."  Resident #2's Nursing Notes documented on 3/12/14 at 4:00 p.m., "Cont [continues] to be combative with cares Bruising found upper 2nd and 3rd finger and 2nd and 3rd finger also bruised resident unable to say how and when bruising occurred-bruises found this a.m...."  On 3/27/14 at 2:45 p.m. the DON stated the unknown injury had been investigated; however, the facility failed to provide the investigation.  2. The Bureau of Facility Standards Resident Abuse Reporting SNF/NFs Informational Letter	F 225	24 hour window, the MDS Assistant will have them give their statement over the phone and they will sign the Addendum as soon as possible. These QMMs will continue through the review process and will be signed by the Administrator within five business days. After completion, these QMMs will be filed in the office of the DON.  <u>Measures to Prevent Recurrence:</u> The staff members will follow the above procedures for timely and complete investigation of abuse or injuries of unknown origin. During the 4/03/14 and the 4/09/14 CNA and LN mandatory meetings this system was discussed by the DON and all staff members were informed of the changes for notification and investigations to ensure they are completed timely. All staff members were also informed about the Addendum to the QMM and that they would be contacted to record their statements for the investigation within 24 hours.  <u>Monitoring/Assurance:</u> The MDS Assistant will complete an audit to ensure that all QMM's with injury of unknown origin have the addendum investigation completed within the 5 working days as per the regulation. This audit will monitor the date of the QMM for injury of unknown origin; the addendum statements and dates; when the DON or staff RN signed and wrote their statement; when the QA manager receives and signs the audit; and when the Administrator signs and dates the investigation. Any QMM and investigation for unknown injury that goes beyond the 5 working days will be reviewed for		

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F 225	Continued From page 4 2005-1 includes guidance that a facility's administrator must sign the investigation within five working days of the allegation/incident. This signature indicates the administrator had reviewed the investigation, approved it as complete and had ensured appropriate measures had been taken.  Resident #7's medical record included an Event Report (ER) dated 8/2/13 which documented "2 new bruises on right shin found during skin checks..."  The ER "Addendum for QMM (Quality Management Memo) Injuries of Unknown Origin" included an area for statements from staff who worked 48 hours prior to the discovery of an unknown injury. A statement dated 8-20 (no year) documented "can't remember it's being (sic) a while I didn't work 8/2." A statement dated 8-21 (no year) "Don't remember too far back." The Administrator signed the form on 9/16/13.  On 3/27/14 at 3:45 p.m. the DON was informed of the above concerns. The DON stated the incident for Resident #2 had been investigated, but documentation of the investigation was not provided. The DON also stated the facility was working on the timeliness of the investigations.	F 225	reason and will be discussed with the staff involved. This audit will begin 4/23/2013 and will be done 2 times a week for 3 weeks, then 1 time a week for 3 weeks, then 1 time a month for 8 months. Deficiencies in this practice will be reported to the District QA Committee for review to determine if further actions are necessary. All monitoring will be documented and retained.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	<b>F 241 483.15(a) DIGNITYAND RESPECT</b>  <u>Residents with the potential to be affected:</u> All independent residents that use the central restroom have the potential to be affected by the first example in the citation. All residents with a hearing device have the potential to be affected by the second example in the citation.	12MAY14

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F 241	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interviews, it was determined the facility failed to maintain residents' dignity by ensuring privacy while toileting and availability of adaptive equipment/devices. This was true for 3 of 9 sample residents (#s 2, 5 &amp; 7). This practice created the potential to negatively affect the resident's self-worth and self-esteem. Findings included:</p> <p>1. On 3/25/14 at 5:42 p.m. Resident #5 was observed to independently go into the hallway bathroom. The resident did not shut the hallway door to the bathroom but did pull the privacy curtain. The privacy curtain was not pulled completely over and the resident could be seen with her pants down to her ankles sitting on the toilet. Two CNA's were observed in the hallway bathroom talking with each other near the toilet in use by the resident. CNA #2 was informed by the surveyor the resident could be seen from the hall. CNA pulled the privacy curtain so the resident could not be seen.</p> <p>2. On 3/27/14 at 10:00 a.m. CNA #6 and #8 were observed to remove Resident #7's hearing aide. After removing the hearing aide CNA #8 asked the resident to put his hands on the handle of the Sit-to-Stand transfer device. The resident did not respond. The CNA then shouted into the resident's ear to put his hands on the handles of the Sit-to-Stand. The resident responded appropriately when he could hear CNA #8's request.</p> <p>On 3/27/14 at 4:45 p.m. the Administrator and DON were informed the Resident's hearing aide</p>	F 241	<p>All residents have the potential to be affected by the third example in the citation.</p> <p><u>Corrective Actions:</u></p> <p>The Housekeeping staff unfolded the privacy curtain and rehung it, creating a much wider barrier for resident privacy in the restroom. An in-service on 4/18/14 was also provided to all Nursing Home staff regarding increased attention to ensuring that the curtain is completely pulled or the door closed for all residents with toileting.</p> <p>Staff members have been instructed on the Caretracker system on 4/22/14 to make sure that before giving care instructions they should pay close attention to ensure that the residents have their hearing devices in place and not to remove them until cares have been completed. Nursing Home staff will check that resident hearing devices remain in good working order. If any resident is still not able to understand instructions, staff will offer a dry erase board for staff to write instructions for residents to read. If a task is simple, staff will also use body language to communicate instructions.</p> <p>Dietary staff will not send sippy cups for drinks or meals unless it is specifically stated in the care plan and has been assessed by the IDT staff members as necessary.</p> <p><u>Measures to Prevent Recurrence:</u></p> <p>The curtain has been fixed so that it will completely cover the opening to the restroom stall. The nursing staff members have also reviewed in-service material on 4/18/14 regarding dignity and respect along with specific instructions on monitoring the bathroom area to ensure better resident privacy.</p>		

The care plans have been revised for all residents that use a hearing device for communicating to include instruction that their hearing device is to be kept in place until all cares are completed. All staff members were notified on 4/22/14 on the Caretracker system to utilize a dry-erase board or body language for simple instructions to assist residents with additional problems hearing.

Dietary staff members were instructed on 3/26/14 and 3/27/14 not to use sippy cups without having the IDT team assess the situation and add it specifically to a resident's care plan. The CNAs will also make sure that Resident #2 uses a straw at meals.

Monitoring/Assurance:

An audit will be completed by the RSD to ensure that any resident that is independent with their toileting and uses the restroom that the privacy curtain is closed completely. The RSD will do a visual walk through and document any findings. These audits will begin 4/21/14 and will be done 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then 1 time a week for 4 weeks. Deficiencies in this practice will be reported to the DON and the QA Committee for review to determine what further actions are necessary. All monitoring will be documented and retained.

An audit will be completed by the RSD to ensure that all residents that wear a hearing device have the device turned on and it is in good working condition when they are up for activities and cares. The audit will begin on 4/21/14 and will be done 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then 1 time a week for 4 weeks. Deficiencies in this practice will be

reported to the DON and the QA Committee for review to determine what further actions are necessary. All monitoring will be documented and retained.

An audit will be completed by the RSD to ensure that no residents have a sippy cup on their meal tray unless it has been approved by the IDT and revised in the care plan. The RSD will check one meal per day and document any findings. The audit will begin 4/21/14 and will be done 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then 1 time a week for 4 weeks. Deficiencies in this practice will be reported to the DON, Dietary manager, and the QA Committee for review to determine what further actions are necessary. All monitoring will be documented and retained.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135066</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>POWER COUNTY NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 ROOSEVELT STREET AMERICAN FALLS, ID 83211</b>		
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F 241	Continued From page 6 was removed prior to the CNA asking him to use the Sit-to-Stand. The facility provided no further information.  3. Resident #2's nutrition Care Plan, dated 9/2013, included an intervention to "put a straw in all of my liquids."  On 3/25/14 at 12:10 p.m. and at 6:05 p.m. (meal times) the resident was observed at the dining table with a "sippy cup" (frequently used by toddlers). Staff did not offer the resident a straw or another way to independently drink fluids without spilling them.  On 3/27/14 at 2:45 p.m. the DON was informed the resident was observed with sippy cups and a drinking straw was not provided for the resident. The DON stated she would check on the concern; however, the facility provided no further information.	F 241			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;	F 272	<b>F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b>  <u>Residents with the potential to be affected:</u> All residents have the potential to be affected.  <u>Corrective Actions:</u> Resident #3 was admitted to the facility and per admission protocol the Initial Side Rail Usage Assessment form was completed by the LN that inadvertently marked that she was at risk for getting her limbs caught in the rails and she was not at risk. This was not corrected until her more recent quarterly side rail usage assessment on 2/20/14. It documents that she is not at risk for safety issues with the side rails being up. The	<b>12MAY14</b>	

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F 272	<p>Continued From page 7</p> <p>Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure side rails used for 1 of 5 (#3) sampled residents reviewed for side rails were assessed for safety. This placed the resident at risk for limb entrapment in the side rails. Findings included:  Resident #3 was admitted to the facility on 11/11/13 with multiple diagnoses including diabetes, insomnia/sleep disturbance and progressive dementia.  During an observation on 3/24/14 at 3:55 p.m.</p>	F 272	<p>initial and quarterly assessment covers many safety and care questions for resident side rail usage. Per inspector recommendation to the DON, the following question was also added to the initial and quarterly side rail assessment forms by the MDS Assistant, if the resident qualifies: "They have been assessed and are safe to be used with this resident". These updated forms will be used for all future resident side rail assessments.</p> <p><u>Measures to Prevent Recurrence:</u> All future admissions and quarterly side rail usage assessments will now contain the specific wording addressing if the side rails are safe to use with a particular resident. Any answers on either the admission or quarterly assessments that indicate a potential safety hazard for the resident will be discussed with the IDT and if further assessments are needed to determine safety for the resident they will be referred to the Physical Therapy department for an evaluation and recommendation for use.</p> <p><u>Monitoring/Assurance:</u> The MDS Assistant completed an audit on 4/23/14 of all current resident charts to check for all initial and recent quarterly side rail usage assessments. Beginning 4/23/14, all residents will continue to be assessed using the new assessment form and any questions related to resident safety will be further discussed by the IDT and follow up assessments will be done sooner if needed. An audit will be conducted monthly for six months by the MDS Assistant beginning 5/12/14 to check for completion of the new quarterly side rail usage assessment form in the resident charts.</p>		

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F 272	Continued From page 8 and numerous observations throughout the survey from 3/24/14-3/27/14, Resident #3 was observed lying on her bed with 1/4 side rails in the upright position.  The resident's ADL Care Plan, dated 2/2014, identified the resident preferred to have her 1/4 side rails in the upright position.  The resident's medical record did not include documentation that the side rails had been assessed as safe for the resident to use.  On 3/27/14 at 3:30 p.m. the DON stated the side rail assessment did not include that the side rails were assessed to be safe for the resident.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure: * A resident's pain was addressed in a timely manner. This placed Resident #4 at risk of suffering with unnecessary pain. * Care Plan interventions for socially inappropriate behaviors were implemented. This	F 309	<b>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  <u>Residents with the potential to be affected:</u> All residents in the facility have the potential to be affected by this practice. All care plans have been reviewed and changes made if needed. They are reviewed with every MDS and changes made if necessary, the staff are notified via messages on the Caretracker system of any changes and are expected to review that care plan.  <u>Corrective Actions:</u> Resident #2 diagnosis included Lewy Body Dementia, severe cognitive impairment and hallucinations. The care plan documented if the	<b>12MAY14</b>

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F 309	<p>Continued From page 9</p> <p>placed Resident #2 at risk for unmanaged behaviors.</p> <p>*The development of individualized care plans to meet the needs of residents with dementia who received psychopharmacological medication. This placed Resident's #2 and #5 at risk for receiving a medication which were not clinically indicated. These practices affected 3 of 5 sample residents (#s 2, 4 &amp; 5). Findings included:</p> <p>1. Resident #2 was admitted to the facility on 8/20/13 with diagnoses which included Lewy Body Dementia.</p> <p>The resident's 3/13/14 quarterly MDS assessment documented severe cognitive impairment and hallucinations.</p> <p>Resident #2's Care Plan, dated 9/2013, documented if the resident became angry and yelled, staff were to make sure the resident was safe, leave her alone for a few minutes, reapproach or have another staff member approach her. A revision to the Care Plan, dated 1/28/14, included to hand her a stuffed animal to hold if she resident attempted to grab at people during transfers, positioning changes and cares.</p> <p>*On 3/25/14 at 11:47 a.m. the resident was observed asleep in a recliner in the common area. At 11:55 a.m. CNA #2 and CNA #6 approached the resident. Resident #2 woke up and the two CNA's told her they were going to help her to lunch. The CNA's did not offer the resident a stuffed animal to hold while they transferred her from the recliner to her wheelchair. The resident stated she was not hungry and said "get out of my house-leave me alone." The resident was upset and yelling. The</p>	F 309	<p>resident becomes angry and yelled, staff was to make sure she was safe, leave her alone for a few minutes, re-approach or have another staff member approach her. A revision to the care plan on 1/28/14 included handing her a stuffed animal to hold as she attempted to grab at people during transfers, positioning changes and cares. The stuffed animal was tried for a period of time and she would try to hit staff with it, therefore they stopped using it. They did not remove it from the care plan, it has since been removed. All staff members were in-serviced on 4/03/14 and 4/09/14 on leaving her alone and safe for a few minutes then re-approaching or have other staff members approach her. The resident has had visual hallucinations that include conversations with someone who is not there. Her care plan was revised on 4/11/14 to include interventions for these hallucinations. Hallucinations were also added as an option in the Caretracker system for staff documentation.</p> <p>Resident #5 with a diagnosis of dementia and depression has an order for Risperdal 0.25mg at bed time for paranoia and agitation. The care plan identified problems of accusing others of taking her things, making up stories and hoarding. The BCDR for resident #2 and #5 on the care tracker identifies wandering, verbal abuse, physical abuse, socially inappropriate behavior and resistance to cares. The staff members have been in-serviced on adding a narrative to explain the behaviors on both residents #5 and #2.</p> <p>Resident #4 was admitted on 1/17/14 with gout, generalized osteoarthritis and pain. Her admission orders included Fentanyl patch 50mcg/hr. change every 72 hours. Norco</p>	

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F 309	<p>Continued From page 10</p> <p>CNAs continued to transfer the resident. The resident was not left alone for a few minutes or re-approached by different staff. The resident was taken to the dining room table and refused water or food when offered to her. CNA #6 approached the resident at the dining table and the resident again yelled, "get out of my house."</p> <p>Resident #2's 3/1/14 Physician Orders (recapitulation) included an order for Risperdal (antipsychotic) 0.25 mg twice a day for agitated dementia and visual hallucinations. The Physician order documented a start date of 8/30/13.</p> <p>Throughout the survey from 3/25/-3/27/14, Resident #2 was observed to be looking up from where she was sitting (recliner/wheelchair) talking to an "unseen" individual. The resident appeared to be having a conversation with someone, would ask questions, wait for an answer and then respond. Staff did not acknowledge or respond to the resident when observed to have these conversations.</p> <p>The resident's Care Plan identified the resident would attempt to grab at staff, verbally threaten staff, and use foul language. The care plan did not identify hallucinations or behaviors which were harmful to the resident.</p> <p>The resident's "Behavior Chart Detail Report" (BCDR) from 12/25/13 through 3/25/14 was reviewed. The form identified the following behaviors: wandering, verbal abuse, physical abuse, socially inappropriate, and resistance to care. The resident's care plan or the BCDR did not identify what socially inappropriate behaviors were.</p>	F 309	<p>7.5/500mg bid. The doctor usually orders the Tylenol on the routine standing orders, however on her admission he did not. The residents' pain appeared to be controlled according to nurses' notes. One episode on 2/11/14 during her shower she complained of pain and they were unable to find her Fentanyl patch, it was replaced and her pain was monitored and she was comfortable. She had an episode on 3/16/14 that she wasn't feeling right, sleepy, non-specific, but confused as to what was going on. The doctor was notified of the change and decreased her Fentanyl patch to 25mcg/hr on 3/17/14. The doctor was notified on 3/23/14 with complaints from the resident of leg cramps, restless legs. The doctor ordered valium 5mg po every HS for leg cramps and restless legs. The charge nurse did question him on the valium order and he said to give it and monitor her. The doctor was called on 3/26/14 and gave the order to follow the routine standing order for Tylenol 650mg every four hours as needed. Urine was sent for C/S on 3/24/14 and was negative for infection. The valium was discontinued on 4/3/14 as she had become sleepy, periods of confusion. Alternatives to pain medication was addressed in her care plan, warm blankets, back rubs, position change. Warm blankets and position change were used a lot to reduce her pain. It also states to check the orders for the RSO for prn Tylenol. That order was given by the doctor on 3/26/14. As of 4/21/14 she is able to ambulate with her walker with 2-assist, and is also able to feed herself.</p> <p><u>Measures to Prevent Recurrence:</u> All staff members have been in-serviced on the need to let the IDT Committee know when changes need to be made on the care plans if there are changes in the resident so the care plan</p>		

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F 309	<p>Continued From page 11</p> <p>On 3/27/14 at approximately 2:45 p.m. the DON was asked if there was a program to address the hallucinations for which the Risperdal was prescribed. The DON stated the only behaviors documented were the ones on the BCDR. When asked about the interventions for hallucinations, the DON stated she had witnessed the resident when she appeared to be hallucinating and talking with her mother. The DON agreed that the care plan did not include interventions for the hallucinations and the behaviors had not been documented/tracked.</p> <p>2. Resident #5 was admitted to the facility on 2/17/05 with diagnoses which included dementia and depression.</p> <p>Resident #5's most recent quarterly MDS assessment, dated 11/21/13, and annual MDS assessment dated 1/7/14 documented: * Cognitively intact, and * Physical or verbal behavioral symptoms directed toward others - not exhibited.</p> <p>The resident's 3/12/14 Physician Orders included an order for Risperdal 0.25 mg at bedtime for paranoia and agitation.</p> <p>The resident's 1/2014 Care Plan identified problems of accusing others of taking her items, making up stories, and hoarding. The interventions were for staff to not point out that the resident was misinformed and noted that it was difficult to redirect the resident. The plan also stated that the DON was to assist the resident to clean her room for the hoarding behavior.</p> <p>The resident's BCDR from 12/25/13 through 3/25/14 was reviewed. The form identified the</p>	F 309	<p>can be reviewed and updated. A nurse and an aide are to come to the IDT meeting and address any changes that need to be made. The standup meeting is scheduled weekly to review all the residents; this will include making changes on the care plans if needed. When changes in care plans are made the IDT will continue to send out messaging in the Caretracker system to update the staff of the changes to be made.</p> <p><u>Monitoring/Assurance:</u> A QA audit will be completed by the DON or the staff RN to ensure that care plans are addressing specific behaviors for each resident and they are being charted correctly on the Caretracker. A narrative has been added to address behavior areas on the Caretracker. All residents have a weekly pain assessment and the QA audit will also address pain and monitor whether they have a PRN medication ordered. The audits will begin 4/28/14 and will be done 2 times a week for 2 weeks, 1 time a week for 8 weeks, and then every other week for 6 weeks. Deficiencies in any of these practice(s) will be reported to the QA Committee for review to determine if further action is needed. All monitoring will be documented and retained.</p>		

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F 309	<p>Continued From page 12</p> <p>following behaviors which were the same behaviors as identified above for Resident #2: wandering, verbal abuse, physical abuse, socially inappropriate, and resistance to care. The socially inappropriate behaviors were not identified on the BCDR form or the care plan.</p> <p>The BCDRs documented on 1/10/14 a behavior of insisting on getting more hygiene wipes and on 1/19/14 getting upset when asked to wash her hands after she touched her incontinence brief.</p> <p>On 3/27/14 at approximately 3:30 p.m. the DON was asked how the paranoia was displayed by Resident #2. The DON stated the behavior of accusing staff of taking her things could be a form of paranoia. When asked about documentation for the behaviors, the DON stated the only behaviors documented were the ones on the BCDR. The DON agreed that the behaviors were not specific for this resident. When told the care plan identified what staff were "not" to do, but did not include interventions for staff to implement when the behavior was displayed, the DON agreed. Additionally the behaviors displayed were not harmful to the resident or others. The behaviors displayed were not an acceptable reason for the use of the antipsychotic.</p> <p>Refer to F329 as it relates to the use of antipsychotic medication without adequate indication of use.</p> <p>The Administrator and DON were informed of the above concerns on 3/27/14 at 4:45 p.m. The facility provided no further information to address the concerns regarding care plans and behavior monitoring not being individualized for each resident.</p>	F 309		

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F 309	Continued From page 13  3. Resident #4 was admitted to the facility on 1/17/14 with diagnoses that included, gout generalized osteoarthritis, and pain.  The resident's Admission MDS dated 1/24/14 documented: * BIMS score: 14, Cognition intact. *A. Received scheduled pain medication regime: Yes. *B. Received PRN [as needed] Pain medication or was offered and declined: No. *C. Received non-medication interventions for pain: Yes. *Have you had pain or hurting in the last 5 days: Yes. *How much of the time have you experienced pain or hurting over the last 5 days: Occasionally. *Numeric rating scale- Rate your worst pain over the last 5 days on a zero to 10 scale, with zero being no pain and ten as the worst pain you can imagine.: 6.  The resident's Narrative Care plan dated January 2014, documented, *Page 13 and 14: "I have long standing knee and back pain. My physician has ordered routine pain medications for both of these. My dx [diagnosis] of gout could also cause me to have pain if it flares up. In addition to the scheduled pain medication you can also try non-pharmaceutical methods of pain relief such as warm blankets, back rubs, or position changes. If I complain of pain you should also check my physician RSO [routine standing orders] and see if he marked anything on that for me to take. The LN will do weekly pain assessments on me checking for the effectiveness of pain relief."	F 309			

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F 309	<p>Continued From page 14</p> <p>*Page 21: "3/24/14 I have been having restless legs and my physician was contacted. He ordered Valium 5 mg [milligrams] po [by mouth] q [every] HS [hour of sleep] for this [and] also leg cramps. Monitor me for sedation, lack of coordination. This med could also [increase] my risk of falls. If I complain of pain check my RSO for pm pain meds [and] offer them. My Fentanyl patch was recently decreased."</p> <p>The resident RSO dated 3/24/14, documented for pain; *Fentanyl Patch 50 mcg/ hr [micrograms per hour]. One patch q 72 hours for knee pain. * Norco 7.5/325 one po [orally] BID for back pain. NOTE: There were no PRN medications for pain on the RSO orders.</p> <p>The resident's telephone orders documented: **3/17/14 Lets [decrease] her fentanyl back to 25 mcg per hour." **3/23/14 Give 1 mg [milligram] Ativan po now, start Valium 5 mg po QHS [every hour sleep].</p> <p>On 3/25/14 at 4:40 pm, the resident was observed in bed. She stated she was having pain in her right leg. The resident was asked if she had asked for pain medication, and stated she was told, "Your pain medicine is after dinner." The resident was rolling side to side and moaning, "Oh, oh. I have cramps all the time. I have to keep moving."</p> <p>On 3/25/14 at 5:05 pm, LN #3 was asked if the resident had pain medication, the LN stated, "She doesn't have a PRN. She has Hydrocodone at 8 am and 8 pm. Her Fentanyl patch just got lowered to 25 from 50. The 16th was her last dose of 50. We asked for a PRN and he [the</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>physician] wrote back and said no prn's." The LN was asked how long ago that had happened, and replied, "I am not sure." The LN was asked why the physician had not ordered a PRN, and she stated, "I don't know a lot of times we just throw up our hands and don't ask questions."</p> <p>On 3/25/14 at 5:25 pm, CNA #1 was observed getting the resident up from bed. When the surveyor asked the resident if she was still having pain, and she stated, "Yes, I do." The CNA was asked if the resident had pain often, and she stated, "Not very much. I think it is because she had a shower today and it gets her cold." The resident ambulated to the bathroom with CNA #1. The CNA asked the resident how her leg was, and the resident stated, "It's working ok."</p> <p>On 3/25/14 at 5:47 pm, the resident was sitting in the lounge chair in the TV room. The resident was sitting upright and the lounge chair foot rest was down. The resident's legs were in a dependent position with feet on the floor. The resident was rubbing her lower right leg, continuously. The right shin was red from the knee to the top of the sock at the ankle. The surveyor asked the resident if her leg still hurt, and the resident replied, "Yes, it does." The resident was asked if she had Ted Hose that she wore on her legs, and the resident stated, "Yes, I took them off when I had my bath. They don't do much good." A resident sitting next to Resident #4 asked her if it helped when she rubbed it. The resident replied, "Yes, it helps." CNA #9 asked the resident if her leg hurt, and the resident stated, "Yes, it hurts at night."</p> <p>On 3/25/14 at 5:53 pm, LN #3 was asked if the resident's lower legs were always red, "Yes, they</p>	F 309			

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NAME OF PROVIDER OR SUPPLIER  <b>POWER COUNTY NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 ROOSEVELT STREET AMERICAN FALLS, ID 83211</b>		
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F 309	<p>Continued From page 16 are always red like that." The surveyor stated the resident is in pain and that is sad, the LN #3 stated, "Yes, it is."</p> <p>On 3/25/14 at 6:47 pm, the resident ambulated from the dining room table to the lounge chair in the TV room. The resident was sitting back in the chair with the foot rest up and a pillow under her feet. Both of the resident's shins were red. The resident was asked how her legs were, and stated, "They don't hurt right now but they are going to be pretty soon, I'll betch ya."</p> <p>On 3/26/14 at 9:03 am, the resident was seated in the lounge chair in the TV room. The resident was asked how her legs were, and replied, "Ok, today."</p> <p>On 3/26/14 at 2:20 pm, the DON was asked why the resident did not have a PRN pain medication, and she stated, "It's [Resident's MD] and usually he marks the PRN Tylenol." The DON checked the chart and verified there was not an order for PRN pain medication, and she stated, "She needs one and we will fax him and see if we can get it. I was concerned the Valium might snow her but she was more alert yesterday." The DON was asked, why the MD had said no, and she replied, "He gets really frustrated when the nurses call him with the same questions."</p> <p>On 3/26/14 at 3:52 pm, the DON provided the order for PRN Tylenol. The DON was asked if he agreed to it and she stated, "Yes, he said I didn't mark it on the RSO and I told him no. So he was ok with it."</p> <p>On 3/27/14 at 5:00 pm, the Administrator and the DON were informed of the findings. No further</p>	F 309			

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F 309	Continued From page 17 information was provided.	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility failed to ensure 3 of 3 (#1, 6, 7) residents reviewed for pressure ulcers, did not have reoccurrence of pressure ulcers and preventive measures were implemented. Resident #6 was harmed when preventive measures were not implemented and the resident had a reoccurrence of 6 Stage 2 pressure ulcers to her coccyx. Resident #1 was harmed when preventive measures were not in place and she suffered the reoccurrence of a Stage 2 pressure ulcer. Resident #7 was harmed when a reoccurring Stage 2 pressure ulcer developed under his catheter tubing and a stage 2 pressure ulcer developed due to his incontinence brief. Additionally the resident's pressure relieving devices were not implemented. Findings included:  1. Resident #6 was admitted to the facility on 7/20/07 with diagnoses that included Parkinson's,	F 314	<b>F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b>  <u>Residents with the potential to be affected:</u> All residents in the facility have the potential to be affected by this practice. Any resident with skin impairments will be repositioned every two hours. All staffs have been instructed how to float heels regardless of how they are laying in the bed or in the recliner. The charge nurse(s) will monitor and observe position changes along with those assigned the QA. Fluids will be offered and assistance to all residents especially those that are unable to reach their own.  <u>Corrective Actions:</u> Resident #6 has had a chronic area on her coccyx that gets macerated; it improves for a brief time then develops again. She is incontinent of bowel and bladder and is non-ambulatory. The doctor and PA have agreed to allow at least two weeks on a new treatment to monitor for improvement rather than changing treatments weekly. At this time we have been using zinc barrier cream and open to air since 4/3/14 and it has shown a lot of improvement. The split on 4/10/14 was 1.5cm and red scar 6cm x 11cm. The measurements on 4/19/14 were split 0.5cm with edges together. Her care plans include interventions to be turned with a turning sheet and side lying only, she is changed with peri-care done and position change every two hours. The nurses are to monitor to	<b>12MAY14</b>	

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F 314	<p>Continued From page 18 Parkinson's dementia, and osteoporosis.</p> <p>The resident's Annual MDS dated 9/24/13, and Quarterly MDS dated 12/17/13, recorded: *Cognitive Skills for daily decision making- 3, Severely impaired- never/ rarely made decisions. *Rejection of cares: 0, behavior did not occur. *Bed mobility- 3-3, extensive assistance, 2 person physical assist. *Transfer- 3-3, extensive assistance, 2 person physical assist. *Functional Limitation ROM (Range of motion)- Upper extremity: 2, impairment on both sides. Lower extremity: 2, impairment on both sides. *Urinary incontinence- 2, frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding.) *Risk of pressure ulcers- Yes. *Unhealed pressure ulcers at Stage 1 or higher- No. *Moisture associated skin damage- Marked as present.</p> <p>The resident's Quarterly MDS dated 3/18/14, was the same with the following exceptions: *Transfer- 4-3, total dependence, 2 person physical assist. *Urinary incontinence- 3, always incontinent (no episodes of continent voiding). *Unhealed pressure ulcers at Stage 1 or higher- Yes. *Number of Stage 1 pressure ulcers: 1 *Were pressure ulcers present on the prior assessment: Yes. *Moisture associated skin damage- Not marked this assessment. NOTE: The resident had a decline in transfers, urinary continence, had a stage 1 pressure ulcer, with none in the 2 previous assessments.</p>	F 314	<p>ensure that it is done timely and correctly, with heels floated. The rash on her feet seemed to get worse when we used the heel protectors, as if from an allergy. We will float her heels and leave the heel protectors off to see if the rash improves. She has a pressure relieving pad in her wheelchair and an air mattress on her bed. All staff members have been shown how to float heels regardless of how she is lying in bed. These interventions have been included in her care plan.</p> <p>Resident #1 is wheel chair bound with recurring break down on her buttock. She has been healed completely and then it reoccurs. She has had several treatments on her buttocks and as of 4/20/14 the area is healed and has remained healed through 5/12/14. The staff has been instructed to change her position every 2 hours to prevent break down. Her care plan includes that her heels are to be floated as staff members have been shown how to float them correctly. She is not to be in the wheelchair for 2-3 hours or in any one position without position changes. Restorative is working with her on sit-to-stands, ROM and the pulleys. In the past, she has not always received enough daily fluids and we now have a snack cart that is taken around at 10:00am and 3:00pm. One staff member is assigned to it and all staffs were given instructions to make sure all residents, especially those that are unable to reach and hold their own cup are given fluids. Resident #1's fluid intake and refusals are being documented with the snack cart beginning 4/10/14.</p> <p>Resident #7 has a catheter and did have a blister from the catheter tube against his leg. In Jan 2014 he also had a blister on his lower right abdomen, most likely from his attend. The skin issues have both been resolved. The staff</p>		

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F 314	<p>Continued From page 19</p> <p>Moisture associated skin damage was not identified on the 3/18/14 assessment and was on the prior 2 assessments.</p> <p>The resident's Braden scale for predicting pressure sore risk dated, 9/21/13, 12/13/13, and 3/13/14, recorded the resident at "High Risk" for development of pressure sores.</p> <p>The resident's Narrative Care plan dated September 2013, recorded:</p> <p>*Page 6: "I am incontinent of both bowel and bladder. I require your assistance with every aspect of my toileting. I do wear disposable briefs to help maintain my dignity. Assist me to sit on the commode first thing in the morning, just before bed, before and after meals and PRN. Even if I am already incontinent when you check me assist me with sitting on the commode to see if I can void more."</p> <p>*Page 9, 10, 11: "Since I am incontinent and also non-ambulatory I am at greater risk for skin breakdown I am not able to reposition myself and also have no way of actually letting you know that I need to have my position changed. For over a year I have had a chronic area on my coccyx that gets macerated. Numerous treatments and interventions have been done and it will improve for a brief time but then develops again. The LN is following my physician orders for treatment to the macerated area and it is checked daily. During the day you need to change my position every 2-3 hours and at night I am able to go 3 hours without needing to be repositioned. Float my heels or use heel protectors on me when I am in bed or the recliner. Make sure that I have a pressure relieving pad in my wheelchair and that the air mattress on my bed is working."</p>	F 314	<p>members have been instructed to monitor the placement of the catheter against his skin to avoid pressure. They have also been instructed to monitor the Attends against his skin to avoid pressure. These monitors as well as toileting time are included in the care plan. The resident has heel protectors and the staff members have been instructed to place them when he is in the recliner also and his heels are to be floated, he does scratch himself and staff members are to observe him to see that he is not scratching. He has Sarna lotion for dry skin and it has worked well for him, especially if he is itching. These monitors have also been added to his care plan.</p> <p><u>Measures to Prevent Recurrence:</u> The charge nurse will actively participate in the position change of all residents that require assistance with changing their positions. They will be aware of who has had a position change and monitor that it is being done. A snack cart was started daily at 10:00am and 3:00pm to ensure that all residents are getting enough fluids. A staff member is assigned to the cart and is responsible to see that residents are given fluids. The diabetic residents and those on special diets and snacks are to continue to receive their required snack from the dietary department. Floating heels and heel protectors (if ordered) are to be placed while up in recliner or wheel chair. Three staff members and a Physical Therapy Assistant from our facility also attended a regional wound care conference on April 11-12 to receive additional training on wound and pressure sore prevention and treatment.</p> <p><u>Monitoring/Assurance:</u> An audit will be completed by the DON to monitor any change in the skin condition of all</p>	

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F 314	Continued From page 20  The resident's Physician Assistant [PA] progress note, PA orders, the wound or pressure sore identification and progress note [Skin Nurse PU progress note - SNPN] and the nurse's notes [NN] recorded:  *PA orders: 12/3/13-"D/C [discontinue] Clotrimazole please."  *PA orders: 12/10/13- "D/C Lotrisone. Start CA Alginate to buttocks QD [with] dressing. Eucerin to skin PRN but QD at minimum."  *PA note: 12/10/13 "Skin Fragile [with] Stage 1 coccyx." "Assessment & Plan 1) Skin Care-Fragile dishydrotic skin [with] overlay of immobility due to subtle breakdown of coccyx will start Calcium Alginate QD- due to long term Lotrisone/Clotrimazole use may be weeks to resolution due to friability, Eucerin to skin [at] least QD."  *SNPN: 12/14/13 "Coccyx" Size: "L[length] 1.5 cm [centimeter], W[width] [less than] 0.25 cm, D[depth] 0. Started out as a split." Stage: "Stage 1 per PA- DX [diagnosis]." Wound Bed: "Granulation 95%." Periound: "Intact."  *PA note: 12/17/13 Assessment and Plan: "1) Decubitus- Doing well [with] Silver Algonite however dressing not on when patient seen this morning. Will continue until resolution."  *SNPN: 12/21/13 "Coccyx" Size: L. 1.5 cm, W. together." Stage: "Stage 1 per PA. Looks like split to me." Wound Bed: "Granulation 95%." Periound: "Macerated. This area is frequently macerated in appearance. R/T [related to]	F 314	residents; to monitor all residents that need assistance for a position change; to monitor the floating of heels and orders for the use of heel protectors; to monitor for brief and catheter pressures causing skin issues; and to monitor fluid intake on the residents that are unable to reach their own glass. These audits will begin 4/28/14 and will be done 3 times a week for 4 weeks, 2 times a week for 4 weeks, and then 1 time a week for 6 weeks. Deficiencies in this practice will be reported to the QA Committee for review to determine if further actions are needed. All monitoring will be documented and retained.		

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F 314	<p>Continued From page 21 increase moisture." Change in Plan &amp; comments: "Continue as per PA order."</p> <p>*SNPN: 12/28/13 Size: "L 1.5 cm, W. 1.5 cm" Stage: "Stage 1." Wound Bed: "Granulation 25%." Periwound: "Macerated." response to treatment: "Continue as per MD order" NOTE: The orders were written by the PA. The resident had not been seen by the MD. Refer to F 387.</p> <p>*PA orders: 12/28/13 "Eucerin to affected areas (Buttocks legs - Arms."</p> <p>*PA note: 12/31/13 CC [Chief complaint]: "Decubitus evolving to Stage 2-3 [with] Calcium Alginate unavailable [at] this time. Pt. [patient] has significant immobility and very sensitive skin [with] breakdown of coccyx area and long term topical steroid use [illegible]. What was thought as dermatophysis- this was d/c'd and Eucerin started as no fungus seen and I support the steroid use precipitated skin breakdown. Initial Stage 1 now 2-3 while waiting Ca Alginate and continued incontinence. Has been side lying only."</p> <p>*SNPN: 1/4/13[sic -1/4/14]: Size: L 1.5, W 2, D NA [not applicable]." Stage: "Stage 1" Wound Bed: "Granulation 50%" Periwound: "Intact. Macerated." Response to treatment: "Continue TX [treatment] per PA order." Change in plan [and] Comments: "filling in some." The Skin nurse documented a picture of the resident's coccyx, with an open wound. NOTE: The PA, on 12/31/13, 3 days earlier, staged the pressure ulcer as a Stage 2-3. The Skin nurse documented the wound as a Stage 1, with granulation tissue, and included a picture of the coccyx which documented an open wound.</p>	F 314		

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F 314	<p>Continued From page 22</p> <p>The wound had increased in size from 12/21/13 to 1/4/14; on 12/21/13 the width was "together," and on 1/4/14 was 2 cm. The PA documented on 12/17/13 the wound was doing better with Ca Alginate but the treatment was not in place when he saw the resident.</p> <p>*PA progress note: 1/14/14 Assessment /Plan/ Labs: "Decubitus 1) Healing nicely- Ag Alginate in use- Depth [decreased] No secondary infection seen." Plan -"Continue to resolution."</p> <p>*SNPN: 1/18/14 Size: "L 2 cm, W 6 cm, D 0." Stage: "Stage 1," Wound Bed: "Granulation 10%." Periwound: "macerated." Response to treatment: "Increasing in size." Change in plan [and] comments: "MD will be notified regarding need for new T. [treatment]." The Skin nurse documented 2 pictures of the resident's coccyx, with an open wound.</p> <p>*NN: 1/18/14 "[PA name] called [phone number]. Stated buttocks looks more macerated and peeling. [PA name] said keep same Ca+ tx and he will re-eval[uate] on Tuesday Jan. 21, 2014." NOTE: The wound had increased in size from 1/4/13[14] to 1/18/14 from L 1.5 cm to L. 2 cm and width 2 cm to 6 cm. There was no documentation that the Skin nurse saw the resident between those dates, which was 2 weeks. The Skin nurse documented the MD would be notified; however, there was documentation that the PA, not the MD, was contacted.</p> <p>*NN: 1/19/14 10:52 am, "Coccyx area is improving--drying overnight OTA [open to air].</p> <p>*NN: 1/20/14 03:00 am, Repositioned Side to</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>Side q 3 H [every 3 hours]. coccyx clean / dry/ OTA [open to air]."</p> <p>NOTE: The resident's coccyx was OTA and turned every 3 hours. PA ordered treatment was not in place.</p> <p>*PA progress note: 1/21/14 CC: "review wound care. decubitus Stage II - III coccyx. Still [with] slow healing. Much of this due to body habitus [and] maceration of incontinence.- only side lying now Ag Alginate in use." Assessment/ Plan/ labs: "Decubitus A) will try Mepilex AG as Ag Alginate [with] no success. B) Side lying only."</p> <p>NOTE: On 1/18/14 the Skin nurse documented the MD would be notified regarding need for new treatment to the wound. There was no documentation that the MD was notified or responded. The PA addressed the wound 3 days later.</p> <p>*PA order: 1/21/14 "1) Stop Ag Alginate. Start Mepilex Ag to coccyx decubitus daily [and] PRN. 2) Vit C 1000 mg [milligram] p.o. [by mouth] BID [twice daily]. 3) Side lying only please or prone if tolerated."</p> <p>*NN: 1/22/14 3:00 am, "Rt. [resident] repositioned side to side q 3 h. Coccyx kept clean and dry."</p> <p>*NN: 1/22/14 5:00 am, "Coccyx OTA."</p> <p>*NN: 1/22/14 11:00 pm, "Resident is resting, peri care complete, Eucerin applied to skin sore to inner crease of buttock, is looking smaller [and] less red."</p> <p>*NN: 1/24/14 11:00 pm, "Resident is resting, peri care complete, Eucerin applied to skin wound to buttock, is looking less less red [and] resolving."</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER  <b>POWER COUNTY NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 ROOSEVELT STREET AMERICAN FALLS, ID 83211</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 314	Continued From page 24  *SNPN: 1/25/14 Size: "L 2 cm, W 6 cm, D [with] 1 cm split [with] edges together." Stage: "Stage I looking better than last week." Wound bed: "Granulation 100%" Periwound: "Macerated slight." The Skin nurse documented a picture of the wound, and recorded: "PA 'cleaned' it up and changed the TX on 1/21/14." NOTE: NN documented the resident was being turned every 3 hours, the wound was being left OTA, and was improving. The Skin nurse documented no change in size of the wound from 1/18/14 to 1/25/14.  *SNPN: 2/1/14 Size: "L 3/4 cm, W -, D -, split only" Stage: "Stage II" Change in plan & comments: "Mepilex to wound, keep dry."  *PA progress note: 2/4/14 Assessment/ Plan/ Labs: Decubitus A) Healing [with] Mepilex AG, B) Maceration gone. C) Sidelying."  *SNPN: 2/8/14 Size: 2.5 [and] 0.5 cm, W "0.75 [and] 0.25 cm, D 0 now is separated into 2 sores." Stage: "Stage II, Partial thickness" Response to treatment: "Mepilex Ag is working" Change in plan & comments: "No."  *PA progress note: 2/18/14 CC "Decubitus has increased in size [and] depth. Stage III." Assessment/ Plan/ Labs: Decubitus of coccyx A) Stop Mepilex Ag. B) Start Flexigel QD. C) Limit Eucerin to buttocks fold. D) Debridement next week."  *PA orders: 2/18/14 "D/C Mepilex AG. D/C Eucerin to buttocks creases. Start Flexigel (Hydrogel) to decubitus change QD [and]PRN"	F 314			

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F 314	<p>Continued From page 25</p> <p>*SNPN: 2/22/14 Size: "Area L 7 cm, W 8 cm, D -, 3 sores [with] varying sizes." Stage: over total area, 1 sore separated = 3 sores." Wound bed: "Granulation 100%" Periwound: "Intact" Change in plan &amp; comments.: "Continue as per PA orders."</p> <p>*PA order: 2/25/14 "May use Calmoseptine to areas around Flexigel PRN."</p> <p>*SNPN: 3/1/14 Size: "L 3 cm, W 3 cm, D 0, [no] split noted" Stage: "Stage I." Change in plan &amp; comments: "Flexigel Drsg. continues."</p> <p>*SNPN: 3/8/14 Size: "L NA, W NA, D NA, no open areas or redness noted." Stage: "Stage I" Response to treatment: "Resolved right now." Change in plan &amp; comments. "No [change in] Preventative measures."</p> <p>*NN: 3/13/14 1:26 am, "Buttock and coccyx area look clean, skin intact, pink. Flexigel to buttock area."</p> <p>*NN: 3/13/14 2:30 pm, "Peri care given no open areas. White callus like skin in buttock crease new order given to use Mepilex to coccyx prn and Calmoseptine oint[ment] to buttocks prn-flexigel no longer available."</p> <p>*NN: 3/14/14 10:15 am, "Bottom looks great cleaned [and] applied Flexigel."</p> <p>*NN: 3/15/14 10:00 am, "Area on coccyx cleand [and] left open to air flexigel not available."</p> <p>*NN documented by Skin nurse: 3/15/14 6:30 am, "Late entry: No open area noted near coccyx. Will not resolve at this time because the area is so</p>	F 314			

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F 314	Continued From page 26 fragile it [is] prone to breakdown."  *SNPN: 3/15/14 Stage: "Stage I" Response to treatment: "No no open areas noted." 6:30 am, "Late entry: No open area noted near coccyx. Will not resolve at this time because the area is so fragile it prone to breakdown."  *SNPN: 3/22/14 Response to treatment: "No open areas but remains fragile [and] dark pink."  *NN: 3/22/14 2:09 pm, "Calmoseptine [and] drsg. to bottom looks ok."  *NN: 3/22/14 11:00 pm, "Resident is resting, peri care complete, calmoseptine applied to skin area of buttock, there does appear to be a split at the most inner crease of buttock just upward from rectum."  *NN: 3/23/14 1:44 pm, "Buttock area cleaned, circular areas caution to open up." TX done per order.  *NN: 3/23/14 7:00 pm, "Buttock is macerated [and] peeling. Pericare / Buttocks clean [and] OTA."  *NN: 3/23/14 11:00 pm, "Buttocks OTA."  *NN: 3/24/14 2:00 am, Repositioned to [left] side. Buttock OTA. Some improvement from Maceration noted."  *NN: 3/24/14 10:53 am, Rt. skin looks macerated some of the white damp has sloughed off. redress [with] Mepitel[sic]."  *NN: 3/25/14 1:27 pm, New order for Hydrophillic	F 314		

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F 314	<p>Continued From page 27</p> <p>dressing most like Flexigel DC Mepilex. Use on coccyx."</p> <p>*PA progress note: 3/25/14 "Decubitus that comes [and] goes- augmented by incontinence - will start Hydrophyllic similar to Flexigel as it is no longer [illegible]."</p> <p>*PA order 3/25/14 "Please D/C Mepilex to coccyx - use Hydrophyllic dressing most similar to Flexigel daily and PRN."</p> <p>On 3/24/14 at 4:10 pm, CNA #1 and CNA #2 were observed to change the resident's brief. The resident had an open reddened area to the right buttocks into the crease of the rectum. The area of skin around the wound was wet and appeared macerated. CNA #2 stated, "Usually it has a dressing on it. It comes and goes. It is strange, it's like scarred tissue."</p> <p>On 3/25/14 from 9:33 am until 11:45 am, the resident was lying on her right side with a flattened pillow behind her left back. Bilateral feet were on the bed with socks on her feet.</p> <p>On 3/25/14 from 2:25 pm until 4:10 pm, the resident was on her left side with a flattened pillow behind her back and bilateral feet were on the bed, with socks on.</p> <p>On 3/25/14 at 4:10 pm, the DON and LN #3 were observed to check the resident's coccyx. The resident's incontinence brief was in place, but not hooked. The DON stated, "We get her completely healed then it opens up and she keeps breaking down. It looked good the other day." LN #3 stated, "I just think you need to be aware of it. The flexigel is good." The DON stated, "We can't</p>	F 314			

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F 314	<p>Continued From page 28</p> <p>get the flexigel but we can get the other one. He ordered one that is very similar to the flexigel." The DON stated, "She is soaked. There is no dressing on it right now; we have Calmoseptine we have been putting on it." The resident had soaked through the extra pad that was placed inside the brief, the brief and the cloth pad on the bed. The open wound was on the right buttock into the crease of the rectum. The DON asked the LN, "When did we run out of the flexigel." The LN stated "When I told him and he ordered the other one." The DON asked, "When did this one open up." The LN answered, "It wasn't there last Sunday." The surveyor told the DON the surveyor had observed the open area the night before and the DON stated, "I am sure it was." The area was cleaned with wipes and a new brief applied. The LN was asked, by the surveyor, about dressing the open wound and she stated, "Just leaving it to the air." The LN stated, "I am going to look at her feet too." The heels were observed to be in direct contact with the bed. The DON stated to the LN, "Have them come and get her heels off the bed." When the surveyor asked about the air bed the resident was on, the DON stated, "It's an Air Pro mattress overlay. It's continuous. It deflates one line and the next line has air in it." The mattress was observed by the surveyor to have air flow pockets that rotated with air. The resident was positioned on the left side when the DON and LN#3 had completed the observation.</p> <p>On 3/25/14 at 4:30 pm, 2 CNA's were observed to enter the resident's room. When they exited the room the resident was positioned on the right side. The resident's feet had a pillow between the lower legs. The right foot laid laterally to the side, on the bed. The left foot was on top of the pillow with the heel on the bed. Socks were in place.</p>	F 314			

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F 314	<p>Continued From page 29</p> <p>On 3/25/14 at 5:55 pm, the resident was wheeled to the dining room in her wheelchair.</p> <p>On 3/26/14 at 9:25 am, 9:52 am, 10:05 am, 11:45 am and 11:59 am, the resident was in bed on her left side, with a pillow between the lower legs. The resident's bilateral feet had socks on and the heels were directly on the bed.</p> <p>On 3/26/14 at 11:59 am, CNA #2 and CNA #4 got the resident up for lunch. When the surveyor asked if the resident was wet and if there was a dressing on the resident's coccyx wound, CNA #4 stated, "Yes, she is wet." CNA #2 stated, "The new dressing will be in tomorrow, there is nothing on there now."</p> <p>On 3/26/14 at 1:15 pm, the resident was awake in bed, lying on her left side, with a pillow between the lower legs. The right foot was on top of the pillow and the left foot was under the pillow. Both heels were resting directly on the bed, with socks on.</p> <p>On 3/26/14 2:00 pm, the surveyor asked the DON for the documentation of the open area that was observed on 3/25/14. The DON stated, "[LN name] would have done it yesterday, maybe in the nurse notes." Documentation was not found. When asked if she would have expected documentation of the new open area, the DON stated, "Yes I would have." When asked what she would call the wound, the DON stated, "Probably a Stage II or III."</p> <p>On 3/26/14 at 2:10 pm, when asked what the current pressure sore treatment, LN #5 stated, "We are using Calmoseptine ointment; suppose</p>	F 314		
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F 314	<p>Continued From page 30</p> <p>to put it on every 1 to 1 1/2 hour. I am supposed to check it for being wet." When asked when the Hydrophillic dressing that was ordered on 3/25/14, would be in, the LN stated, "I am not sure when the new ordered treatment will be in, will have to ask Central Supply." The LN called Central Supply staff and stated, "It will be in tomorrow morning."</p> <p>On 3/26/14 at 2:19 pm, LN #5 and CNA #2 were observed to check the resident. The LN stated, "I just need to check her." The resident was on the left side, with a pillow between her legs. The right foot was off the pillow and directly on the bed, the left was directly under the pillow on the bed. LN #5 was asked if the heels were floated. She stated, "No, that is not floated." LN #5 and CNA #2 were asked if the resident had heel boots and both stated, "No, she doesn't have any."</p> <p>The surveyor asked LN #5 to describe the resident's wound. LN #5 stated, "I don't know." When asked how many open areas were on the resident's coccyx, LN #5 counted and said, "I would say 6. It did not look like this last week when I was here." When was asked about the flexigel and when it was last used, she stated, "Yes, [it did work] but I was told we could no longer get the flexigel. What I remember, it was last week when we last used it. It looks really bad. It is peeling." LN #5 applied the Calmoseptine. The LN#5 and CNA#2 were asked if there was any special training that had been provided for turning residents and floating their heels. CNA #2 stated, "I think we had an inservice about turning them and floating heels, like when they are on their back you put the pillow under their legs. But like with her on her side, it's hard to do that."</p>	F 314		

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F 314	<p>Continued From page 31</p> <p>On 3/27/14 at 9:55 am, the DON was informed of the concerns with the resident being soaked through to the pad on the bed, the resident's turning schedule, the inconsistency of the application of ordered treatments and heels not being floated. The DON stated, "I know I have them change her every 1 1/2 to 2 hours, because she is so wet. I can see that is not being done." The DON was asked if the facility had heel protectors for the resident, and she stated, "Yes we do and it is not just at night. They all know how to float heels, it's not just putting a pillow under them."</p> <p>2. Resident #1 was admitted to the facility on 8/17/07 with diagnoses that included osteoarthritis and general weakness.</p> <p>The resident's Quarterly MDS's dated, 10/22/13 and 1/21/14, documented:            *BIMS score on 10/22/13- 8, cognition moderately impaired. On 1/21/14- 4, cognition severely impaired.            *Both assessments- Rejection of cares: No.            *Both assessments- Transfer: 3-3, extensive assistance, 2 person assist.            *Both assessments- Bed mobility: 3-3, extensive assistance, 2 person assist.            *Both assessments- Functional limitation in ROM: Upper extremity- 2, impairment on both sides. Lower extremity- 2, impairment on both sides.            *Both assessments- Risk of pressure ulcers: Yes.            *Unhealed pressure sores on 10/22/13- No. On 1/21/14- Yes.            *Current number of unhealed pressure ulcers at each stage: Number of stage 2 pressure ulcers: 1. Date of oldest Stage 2 pressure ulcer: 12/21/13.</p>	F 314			

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F 314	<p>Continued From page 32</p> <p>The resident's Braden scale for predicting pressure sore risk dated 10/18/13 and 1/17/14 documented a score of 16, at mild risk.</p> <p>The resident's Narrative care plan dated July 2013, documented: *Page 17, 18, 19: "I am at risk for developing pressure sores as well as other skin problems. I require your assist with making significant position changes. I am wheelchair bound and also have incontinence of bowel. I have a hx [history] of skin breakdown on my coccyx, and feet. Make sure that the air mattress on my bed is working every day. Use heel protectors or float my heels when I am in bed if I agree. My physician has ordered ointments/creams that can be used for skin issues. Reposition me every 2-3 hours around the clock. [NOTE: Changed August 2013 to "during the day."] (10/16/13) I am able to go 8[hours] at noc.[night] [without] being disturbed for position [changes]. If any pressure areas develop cut back on the time [between] checks. At night when you empty my foley check me for bowel incont.[ence]." "1/8/14 Critic Acid [and] xeroform to coccyx," "1/28/14 I do have a sore on my buttock but goal is unchanged."</p> <p>The resident's temporary care plan dated 1/28/14, documented: **"I have an open area on my right buttock. Physician gave order on 1/25/14 for critic acid [and] xeroform BID [twice daily] Have me lay on my sides in bed. The night shift has been keeping my buttock open to air at noc.[night]. I am also not drinking fluids like I should so you need to offer me fluids [and] encourage me to drink them. While I have this open area you will need to reposition me more often. The skin nurses check the area [every] week [and] record the size [and]</p>	F 314		

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F 314	<p>Continued From page 33 other info on my open area." NOTE: The care plan did not give a specific time frame for turning and repositioning the resident at night. The narrative care plan documented, "8 hours".</p> <p>PA progress notes, SNPNs, NN and PA orders, documented:</p> <p>*NN: 9/13/13, "Rt[right] buttocks has two open[which open is crossed out] scaly areas [one] on each side - Stage II. Laid [down] btwn [between] meals." *NN: 9/22/13, "Buttock open [with] no [change.]Cm [cream to open areas [after] cleaning. Repositioning per DON. Keeping off buttock area. OTA." *NN: 10/17/13, "skin issues to buttocks are resolved, no scaly area, or redness noted. Moisture barrier applied to buttock for protection," *NN: 11/18/13, "No new skin issues."</p> <p>*SNPN: 12/21/13 Wound site: "Ischium" Size: "L 0.75 cm, W 2 cm" Stage: "Stage II" Wound bed: "Granulation 5%." Periwound: "Intact. Scaly at edges but intact around that." Change in plan &amp; comments: "Monitor [and] use moisture barrier cream or [illegible]."</p> <p>*SNPN: 12/28/14 Size: "L 2 cm, W 2 cm, D NA" Stage: "Stage I" Wound bed: "Granulation 100%" Periwound: "Intact"</p> <p>*SNPN: 1/18/14 Size: "L 1.5 cm W 1.5 cm D 0" Stager: "Stage II" Response to treatment: "Appears to be slowly healing." Change in Plan &amp; comments: "Bag balm TX continues."</p> <p>*SNPN: 1/25/14 Size "L 2 cm W 2 cm D shallow"</p>	F 314			

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F 314	<p>Continued From page 34</p> <p>Stage: "Stage II" Wound Bed: "Slough 100%" Response to treatment: "TX [changed] 1/25/14" Change in plan &amp; comments: "Xeroform drsg [and] critic acid oint[ment]."</p> <p>*PA order: 1/25/14 "Criticaide [and] Xeroform on sore on [right] buttock until healed (BID) per telephone order from [PA's name]."</p> <p>*PA note: 1/28/14 CC: "Evaluation of [right] buttock decubitus. She has an intermittent breakdown on [right] buttock [no] specific antecedent event. By hx this may have been an old area of breakdown [and] is fragile VS [versus] an old sebaceous cyst that periodically [illegible]. Regardless my evaluation is timed only after notification of breakdown and seeing today." Assessment/Plan /Labs: "Decubitus A) Healing [with] good granulation tissue seen. B) Continue [with] decubitus care (decrease of friction) [and] protection. C) Side lying only. D) May add Vit. C [and] medicated pad other than xeroform in future depending on resolution." NOTE: This was the first documented evidence that the PA had seen the wound, that was first documented by the skin nurse on 12/21/13. The PA documented the area of breakdown as intermittent, and the old area of breakdown as fragile.</p> <p>*SNPN: 2/1/14 Size: "L 2 cm W 1 cm" Stage: "Stage II" Wound Bed: "Slough 100 %."</p> <p>*PA note: 2/4/14 CC: "[Follow up] [left] buttock decubitus. Had granulation tissue on last exam of [left] buttock decubitus.- Initial re[check]." Assessment/Plan/Lab: "Decubitus A) Healing well. B) Continue Mepilex [with] Ag VS xeroform [illegible]. C) Side lying."</p>	F 314			

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F 314	<p>Continued From page 35</p> <p>NOTE: The PA refers to the left buttock rather than the right buttock which is reflected in all other documentation.</p> <p>*SNPN: 3/22/14 size: "L 0.75 W 0.50" Stage "Stage II" Wound Bed: "Granulation 90%" Periound: "Intact" Response to treatment: "Closing up."</p> <p>On 3/24/14 at 4:00 pm, the resident was lying in bed on her left side. She had socks on and both feet were resting directly on the bed. A pillow was between the resident's lower legs.</p> <p>On 3/25/14 at 9:25 am, 9:32 am, 9:45 am, and 9:55 am, the resident was up in her wheelchair in the dining room, participating in a seated exercise activity. At 10:12 am, 10:39 am, 10:55 am, 11:25 am, and 11:39 am, the resident was sitting in a lounge chair in the TV room.</p> <p>On 3/25/14 at 11:52 am, the resident was transferred to her wheelchair and positioned at the dining room table. The resident was observed at the dining room table until 12:21 pm.</p> <p>NOTE: The resident was in a seated position on her buttocks for approximately 3 hours.</p> <p>On 3/25/14 at 1:28 pm, 2:25 pm, 2:35 pm, 3:05 pm, 3:40 pm, 4:00 pm, and 4:35 pm, the resident was in bed. The resident was lying on her back with the head of her bed slightly elevated. A pillow was positioned under her lower legs with both of her heels directly on the pillow. She had socks on her feet.</p> <p>On 3/25/14 at 4:35 pm, the resident's position remained unchanged and the resident's family</p>	F 314		

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F 314	<p>Continued From page 36 was in to visit.</p> <p>On 3/25/14 5:30 pm, and 5:55 pm, the resident's visitors were gone. The resident remained in the same position in the bed.</p> <p>NOTE: The resident was observed by the surveyor to be in the same position from 1:28 pm until 5:55 pm, which was approximately 4 hours and 25 minutes. Her heels were not floated and she was lying on her back.</p> <p>On 3/25/14 at 6:05 pm, the resident was assisted up from bed and wheeled to the dining room in her wheelchair.</p> <p>On 3/26/14 from 8:04 am until 10:00 am, the resident was observed in her wheelchair in the dining room.</p> <p>On 3/26/14 at 10:00 AM the resident was wheeled to her room and assisted to bed by CNA#4 and CNA #6. CNA #4 told the resident, "Let's get you off your bottom, roll that way," pointing to the right. CNA #4 placed a pillow behind the resident's back and between the resident's lower legs. The right foot was directly on the bed and the left foot was on top of the pillow with the foot on the pillow.</p> <p>On 3/26/14 at 11:46 am, the resident was observed being wheeled from the shower room by CNA #2. The surveyor asked CNA #2 if the resident had a shower, and she stated, "No, we also potty them in the shower room." When asked how the resident's bottom looked, the CNA stated, "It has a bandage on it, so I didn't see it."</p> <p>On 3/26/14 at 1:08 pm, the resident was in bed in</p>	F 314			

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F 314	<p>Continued From page 37</p> <p>her room, positioned on her back. She had a pillow between her lower legs with her heels rested directly on the bed. LN #5 was in the room and when the surveyor asked if the resident's heels were floated, she stated, "Nope they are not." The LN left the room to get help to reposition the resident.</p> <p>On 3/26/14 at 2:17 pm, the resident was lying on her back with a pillow behind her lower legs with both heels resting directly on the bed.</p> <p>On 3/26/14 at 2:50 pm, LN #5 and the surveyor went in to observe the resident's position. The resident was in the same position. When asked about floating the heels with a pillow, the LN stated, "It doesn't work very good with her." The LN agreed the resident's feet were directly on the bed, and stated, "Yeh, these won't work, they just smash down." The resident's buttocks were observed with the assistance of CNA #7 and LN #5. The right buttock had a small dark scabbed area approximately 2 cm x 1 cm. The right and left buttocks were red and the xeroform dressing was falling off. The LN #5 stated, "It doesn't stay on very good. Her bottom is very red. I wonder why it does that?" The resident was oozing stool. The LN cleaned the resident of the stool, and put the dressing back in place, and stated, "It doesn't stay, see it doesn't stay in place." The LN pulled up the brief and asked CNA #7, "Is her bottom always that red?" The CNA replied, "Yup, when she is in her wheelchair and we toilet her it is red." The surveyor asked if it was that red when she was positioned off of her buttocks, the CNA replied, "Nope." The resident was positioned on her right side with heels floated on 2 pillows.</p> <p>On 3/26/14 at 3:59 pm, the resident was on her</p>	F 314			

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F 314	<p>Continued From page 38 right side and heels were floated on pillows.</p> <p>On 3/27/14 at 9:55 am the DON was told about the concerns of the resident not being repositioned. When asked if there were heels boots for the resident, she stated, "I don't know. I will have to check."</p> <p>On 3/27/14 at 5:00 pm the administrator and DON were informed of the findings. No further information was provided.</p> <p>3. Resident #7 was admitted to the facility on 2/28/07 with diagnoses which included severe leg weakness, presbycusis (hearing loss), lumbar myelopathy, and urinary retention.</p> <p>The resident's current care plan (CP), dated 2/14, included in the "ADL's will be met daily" section the resident was incontinent of stool, had a catheter, was in a wheelchair and at risk for pressure sores and other skin issues. The CP documented the resident would scratch until he bled and the sit to stand mechanical lift was to be padded as it rubbed his leg. The CP interventions were:</p> <p>*Check under the catheter strap when getting dressed in the morning and undressed at night. *When resting in the recliner or in bed use heel protectors or float heels. *Skin assessment head to toe every 12 hours.</p> <p>The resident's Nursing Notes (NN) and Alteration in Skin Report (ASR) documented the following:</p> <p>*1/1/14 NN at 3:00 p.m. -"Blisters found right thigh poss (possibly) from resident scratching."</p>	F 314		

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F 314	<p>Continued From page 39</p> <p>ASR - The Problem was identified as blisters on the right thigh. The Cause was documented as, "Scratching or the F/C (foley catheter) tubing against his skin."</p> <p>*1/2/14 NN at 3:30 p.m. - "Poss blisters now look like scratches sm (small) open areas." NN at 11:00 p.m. - "Does have sm[all] red possible scratch markings to his right lateral upper thigh, no open skin sore noted..."</p> <p>*1/3/14 NN at 9:00 a.m. - "Fax reply re (regarding) blisters found yesterday. No new orders." NN at 11:00 p.m. - "...no changes in broken blister to his right upper thigh, no signs of infection."</p> <p>*1/4/14 NN (time not documented) - "Blisters noted right hip/up thigh area - dry and clean - have popped." NN at 11:00 p.m. - "...no change in skin wounds to right upper thigh..."</p> <p>ASR - The Problem was identified as blisters on the "right thigh area." The Cause was documented as, "Scratching or the F/C [foley catheter] tubing against his skin."</p> <p>*1/5/14 NN at 1:36 p.m. - "Right thigh blisters closed, no weeping or s/s [signs/symptoms] of infection."</p> <p>*1/6/14 NN at 4:06 a.m. - "Right thigh scabbed over and closed." NN at 10:50 a.m. - "Right scabs intact ..."</p>	F 314			

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F 314	<p>Continued From page 40</p> <p>NN at 11:00 p.m. - Left hip blisters dry and continue to resolve."</p> <p>NOTE: Documented as left hip blisters when previously documented as right hip/thigh blisters.</p> <p>*1/7/14 NN at 1:45 p.m. - "...Left hip blister dry and resolving..."</p> <p>*1/8/14 NN at 2:30 p.m. - "Right thigh blisters have dried and scabbed over..."</p> <p>*1/9/14 NN at 3:45 p.m. - "Right thigh blisters dry and resolving."</p> <p>*1/10/14 NN at 10:02 a.m. - " Saw sm blisters on left thigh dry (have burst) and intact." NOTE: The blisters were documented on the right thigh on most of the previous documentation. NN at 11:00 p.m. - "...blisters are scabbed over on right upper thigh..."</p> <p>*1/11/14 NN at 9:00 a.m. - "New blister found on skin cheek lower right abdomen 1 cm x 1.5 cm ....I think it's from the attend [incontinence brief] ..." NN at 10:44 p.m. - "...intact to right abdomen no s/s of infection</p> <p>ASR - The Problem identified blisters on the right thigh and a blister on the lower abdomen. The Cause documented, "Scatched or the F/C tubing against his skin. Attend rubbing."</p> <p>*1/12/14</p>	F 314			

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F 314	<p>Continued From page 41</p> <p>NN at 2:18 p.m. - Documented a bandage on the right lower abdomen. The right upper thigh lesions were closed, scabbed and resolving.</p> <p>NN at 11:03 p.m. - Documented the lesions on the right thighs were closed with scabs and the right abdomen bandage was intact, clean without drainage.</p> <p>*1/13/14 NN at 9:50 a.m. - Documented the bandage was in place on the abdomen and scabs still present on the right thigh. "Received faxed reply from MD (physician) re (regarding) new blister, no new orders."</p> <p>*1/14/14 NN at 3:30 a.m. - Documented no symptoms of infection to abdomen blisters and the "left thigh blisters continue to resolve....Resident repositioned side to side."</p> <p>*1/15/14 NN at 3:00 a.m. and 4:00 p.m. document the blisters are resolving.</p> <p>*1/16/14 NN at 1:41 p.m. - Documented the "Blistered area 95% resolved."</p> <p>*1/18/14 ASR - Documented blisters to the right thigh caused by scratching of the F/C tubing against his skin and resolved.</p> <p>*2/8/14 NN at 10:00 a.m.- "Blister found on right upper thigh outer apx [approximately] 2 cm by 1 cm intact..."</p>	F 314			

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F 314	<p>Continued From page 42</p> <p>NOTE: The ASR for 2/8/14 did not document the blister documented in the NN on 2/8/14 .</p> <p>*2/9/14- 2/13/14 NN document skin issues (blister) to the right thigh with no signs of infection. On 2/13/14 at 11:00 p.m. the notes documented the blister was cleaned and no longer fluid filled.</p> <p>*2/14/14 NN at 4:20 a..m. document the blister on the right thigh is resolved.</p> <p>* 2/15/14 ASR documented a blister to the right hip with a cause of "clothes rubbing." The ASR for 3/22/14 had no further documentation for the blister to the right hip documented on the 2/15/14 ASR . NN for 2/15/14 did not document the blister to the right hip.</p> <p>On 3/26/14 at 11:50 a.m. Resident #7 was observed eating the mid-day meal. At 1:05 p.m. CNA #6 and CNA #4 transferred the resident from his wheelchair to the recliner in the common area. The catheter tubing was observed to be under his pants and appeared to be on the resident's right thigh. The CNA's did not float the resident's heels or put heel protectors on the resident. The resident remained sitting in the recliner until 3:20 p.m. when CNA #2 used a Sit to Stand lift to have the resident stand (less than 2 minutes). The resident was then placed back in the recliner. The resident was not taken to the toilet or the skin checked for pressure under the catheter strap.</p> <p>On 3/27/14 at 8:17 a.m. the resident was observed in his wheelchair at the dining room table. At 9:00 a.m. the resident was observed in</p>	F 314			

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F 314	Continued From page 43 his wheelchair sitting in front of the television in the common area. At 9:28 a.m. the resident was taken to the exercise activity. The resident participated minimally in the activity, occasionally lifting one foot. At 9:50 a.m. the resident was returned in his wheelchair to sit in front of the television. At 10:00 a.m. CNA #6 and #8 transferred the resident into the recliner.  When interviewed on 3/27/14 at 3:45 p.m. the DON stated Resident #7 should be toileted before and after meals. The DON stated the placement of the tubing should be checked (to prevent pressure) when the resident was repositioned. Additionally the DON stated scratching did not cause blisters. The DON stated the incontinent brief and the catheter tubing could have caused pressure to the resident's skin. The DON stated the CNA's should have ensured the resident's heels were floated on pillows or he wore heel protectors when he was in the recliner. The DON was asked for any of the resident's skin assessments as stated would be done in the CP.  On 3/28/14 at 10:00 a.m. the facility provided the weekly ASRs; however, the 12 hour assessments were not provided. The ASR assessments did not document the size, drainage or amount of drainage and the stage of the pressure ulcer.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	<b>F315 483.25(d) NO CATHETER, PREVENT UTI RESTORE BLADDER</b>  <u>Residents with the potential to be affected:</u> All residents with a catheter have the potential to be affected. Resident #3 was admitted to the facility with a supra-pubic catheter in place and a history of neurogenic bladder.	12MAY14	

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F 315	<p>Continued From page 44</p> <p>who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident with an indwelling catheter received the appropriate care. This was true for 1 of 5 (#3) sample residents and resulted in a resident experiencing pain due to the catheter being the wrong size and not inserted correctly. The findings include:</p> <p>Resident #3 was admitted to the facility on 11/11/13 with multiple diagnoses including diabetes, insomnia/sleep disturbance, progressive dementia and neurogenic bladder.</p> <p>The resident's Admission MDS assessment dated 11/19/13 and Significant Change MDS assessment dated 2/19/14 both documented the resident received a scheduled pain medication and had an indwelling catheter.</p> <p>The Physicians Orders (PO) (recapitulation) dated 1/17/14 and 2/12/14, documented the use of a 18 French catheter which was to be changed every 3-4 weeks. Both POs included an as needed order for Hydrocodone/APAP 5/325 mg every 4 hours for pain lumbago/neck with a start date of 11/11/13.</p> <p>The resident's Nursing Notes from 1/18/ - 3/23/14 documented the following:</p>	F 315	<p>She has had leakage around the s/p site from the time of admission. She did have a Tylenol order for 650mg Q6 hours while awake for pain on 11/12/13. She also had an order for hydrocodone/APAP 5/325 mg Q4 hours prn pain ordered on the same date.</p> <p>She was treated for a UTI following a c/s on 12/3/13 for a total of 14 days. She had a CT scan of the pelvis and abdomen on 1/29/14. She has had a number of urine samples sent to the lab. On 12/19/13 the c/s was negative for infection. On 01/24/14 the urine was negative for infection. She has had many work-ups concerning her urinary system starting in December 2012, including biopsy of 5 areas of the bladder, all were negative for malignancy. A Fentanyl 12mcg/hr patch was started on 2/1/14. She was seen by an urologist on 2/24/14, for a cystoscopy and the report states that the catheter was in the bladder but the balloon was not in the bladder. From her previous reports from 2012, a CT-scan, and repeat consults and tests there is a duplicated left collecting system with dilated ureters extending in to the bladder. She has complained of bladder pain, right hip pain and back pain. She has an appointment with the Urologist on 4/23/14 to re-evaluate her. She was seen by her primary doctor her in the facility on 4/3/14. The primary doctor will visit with the Urologist following her appointment for pain interventions and any changes that need to be made regarding her pain or catheter care. Warm blankets and position changes will also continue to be used to help relieve her pain. She ambulates with a walker to meals and activities. Her pain had been addressed from the time of admission and several changes had been made for pain control. UTI's have been addressed and treated, the last catheter inserted before her appointment with the</p>	

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F 315	Continued From page 45 1/18/14 at 12:50 p.m. - The resident complained of bladder pain. The resident's husband stated the resident indicated she was getting a bladder infection.  1/20/14 at 12:37 p.m. - The resident was receiving an antibiotic ear drop . The note documented "c/o (complained) pain early morning, scheduled pain med given and results good." The NN did not identify whether the pain was ear pain or bladder pain.  1/21/14 at 2:45 p.m. - "Foley care completed ....no c/o pain  1/22/14 at 9:15 a.m. - "given hydro/APAP 5/325..." The pain medication was for pain of 7 on a 1 to 10 scale at the SP (supra pubic) site.  1/24/14 at 1:30 p.m. - The resident's husband reported "My wife feels like she has another bladder infection...checked site of SP no s x (symptoms) of it being pulled out."  1/24/14 at 3:30 p.m.- "Sent mesg (message) to Dr. (Physician name) and also fax." The note documented the resident's urine had blood in it.  1/25/14 at 9:29 p.m.- The note documented "pinkish amber urine."  1/26/14 at 3:03 p.m. - "...tea colored urine. Rt. (resident) complained [of] bladder pain...requested Hydro-APAP5/325 for pain relief."  1/27/14 at 3:00 a.m. - "Pink amber" urine. At 9:30 a.m. the lab report results documented "no	F 315	Urologist was 1/31/14 and was replaced in his office on 2/24/14.  <u>Corrective Actions:</u> The primary doctor will be notified after the results of the UA, for any residents with a catheter that shows signs or symptoms of a UTI. Residents with a catheter will have them changed monthly and prn as doctor ordered. Any pain is addressed and monitored for response to alternate pain relief methods and medication relief and a pain assessment is completed weekly on all residents. The doctor will be notified for any resident with unrelieved pain control and will be asked to evaluate the resident for pain control.  <u>Measures to Prevent Recurrence:</u> An RN will monitor all residents with a urinary catheter to ensure that any resident admitted without a catheter will not have a catheter inserted without an evaluation from the doctor and a valid reason for the catheter. Any signs or symptoms of a UTI will be addressed in a timely manner and treated if indicated. Pain control will be evaluated for effectiveness and treatment will be adjusted by the doctor to maintain the pain in a tolerable state for the resident. The Charge Nurse will continue to complete a weekly pain assessment for all residents. All pain will be assessed by staff members in a timely manner and the resident's physician contacted for specific concerns. On admission all residents have a seven day bowel and bladder assessment for incontinence patterns. If there are any episodes of incontinence the assessment will continue for a total of 14 days. No resident will have a catheter placed without a proper diagnosis		

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F 315	<p>Continued From page 46</p> <p>growth." The note documents the resident was a "little gray...message to MD re-(regarding) issues and general discomfort."At 2:30 p.m. the urologist requested a copy of the resident's most recent urine analysis, culture and sensitivity report. On 12/31/13 the catheter was changed and 4 cc's of fluid were removed from the balloon to leave 5 cc's.</p> <p>1/28/14 at 3:00 a.m. "Pinkish yellow urine with tissue/sediment -no complaints of discomfort."</p> <p>1/29/14 at 3:00 a.m. - "Awake with 9/10 bladder pain [9 out of 10 pain scale-bladder pain]. Urine red orange per 1st dose Pyridium (urinary tract analgesic)...Hydrocodone/APAP 5/325" was given for pain. At 7:00 a.m. the resident "complaint continued abdominal pain." Given hydro-apap for 7 out of 10 abdominal pain, however the resident reported there was no relief from bladder spasms from the Pyridium. The physician and family were notified and the family requested a different urologist. At 8:54 the physician assistant (PA) called back and ordered a CT scan of the abdomen and pelvis. At 9:55 a.m. the PA requested a current creatine level. The laboratory reported the contrast CT could not be done for 2 days due to the resident taking the medication Metformin. The PA ordered a non contrast CT. At 1:25 p.m. the resident received another Hydrocodone/APAP for pain and to help with pain during the CT. The resident received Tylenol 650 mg at 8:00 p.m.</p> <p>1/30/14 at 3:30 a.m.-The resident complained of level 7 pain on a scale of 1-10 and received Hydrocodone/APAP 5/325. At 7:30 a.m. the resident received a Hydrocodone/APAP 5/325 for pain of 7 out of 10. At 4:52 p.m. the PA called and</p>	F 315	<p>to follow the guidelines set for placement of catheters.</p> <p><u>Monitoring/Assurance:</u> An RN will complete an audit for all resident's with catheters on the correct placement of their catheter, beginning 4/28/14, for 1 time a week for 8 weeks, then every other week for 8 weeks, and then monthly for 2 months. Deficiencies in any practice will be reported to the QA Committee for review to determine if further action is needed. All monitoring will be documented and retained.</p>	

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F 315	<p>Continued From page 47</p> <p>stated "No identifiable cause of pain evident."</p> <p>2/1/14 at 10:30 a.m.- The PA called and the resident reported unrelieved pain. The PA ordered the resident receive a Hydrocodone/APAP 5/325 mg for pain. At 12:34 p.m. the PA called in a new order for a Fentanyl patch 12 mcg. At 3:14 p.m. the resident reported less pain since the pain patch was applied.</p> <p>1/31/14 (late entry) at 11:00 p.m. A new 14 FF foley catheter was placed.</p> <p>2/3/14 at 3:00 a.m. -The resident was awake and complained of 8 out of possible 10 pain. The resident received a Hydrocodone/APAP 5/325 mg. At 10:30 a.m. the resident complained of bladder pain and requested pain medication. It was not time for the medications so a warm blanket was placed on the resident. At 8:00 p.m. the resident received a Hydrocodone/APAP 5/325 mg for 8 out of 10 hip pain</p> <p>2/4/14 at 1:30 a.m.-Resident awake with 8 out of 10 hip pain and received a Hydrocodone/APAP 5/325 mg. The resident received another Hydrocodone/APAP 5/325 mg at 8:00 p.m. for 8 out of 10 hip pain.</p> <p>2/5/14 at 1:00 a.m. - The resident was awake and received a Hydrocodone/APAP 5/325 mg for 8 out of 10 hip pain. At 2:00 a.m. warm blankets were placed on the right hip for pain. At 7:45 a.m. the resident received a Hydrocodone/APAP 5/325 mg for 7 out of possible 10 pain. The note documents the resident continues "on Fentanyl patch." At 11:00 p.m. the notes documented the resident "did receive a PRN (as needed) pain med earlier for complaints -bladder pain."</p>	F 315		

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F 315	<p>Continued From page 48</p> <p>2/6/14 at 8:00 a.m. -The resident received a Hydrocodone/APAP 5/325 mg for 7 out of 10 pain. At 2:45 p.m. the resident received another Hydrocodone/APAP 5/325 mg for pain of 7 out of 10.</p> <p>2/7/14 at 11:00 p.m. -Resident requested and received pain medication. (pain medication not specified)</p> <p>2/8/14 at 10:30 a.m.- "Some blood noted at cath site."</p> <p>2/9/14 at 12:15 a.m. - The resident complained of pain and received pain medication. (pain medication not specified.)</p> <p>2/10/14 at 2:57 a.m. - Resident complained of "all over pain" and received pain medication. At 10:17 a.m. the resident stated-- "generally doesn't feel very well..." The nurse documented the pain patch was changed.</p> <p>2/11/14 at 4:00 a.m. - No complaints of pain. The catheter was documented intact with some red blood drainage.</p> <p>2/14/14 at 2:00 p.m. - Resident complained of 8 out of 10 pain level in the bladder and received pain medication. (pain medication not specified)</p> <p>2/16/14 at 2:23 p.m.- The resident complained of "all over pain" and received pain medication Hydrocodone/APAP 5/325 mg at noon "Now complains pain again from cath site."</p> <p>2/17/14 at 11:00 p.m.- The resident received Hydrocodone/APAP 5/325 mg for complaints of 8</p>	F 315			

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F 315	<p>Continued From page 49</p> <p>out of 10 right abdomen/hip pain.</p> <p>2/18/14 at 3:46 p.m. - The resident complained of bladder urgency "10 cc syringe to empty cath balloon, re-inflated with 5 cc. Resident states it is painful when deflating PRN pain pill given 50 minutes prior (pain medication not specified) ...Resident complains x2 (2) more." At 8:00 p.m. streaks of blood noted in amber urine.</p> <p>2/19/14 at 11:30 a.m. - "...pink tinged urine" The resident received Hydrocodone/APAP 5/325 mg pain medication at 2:15 p.m. for a pain level of 9 out of 10.</p> <p>2/24/14 at 2:14 p.m.- The resident and family member returned from the urologist. The family member reported the urologist stated the "Catheter placement was the problem it is not getting put in deep enough-it is being inflated before it is all the way to the bladder- This is the cause of her pain. He replaced the catheter with a 16 Fr. states to only use a 16 Fr. and that it should move back and forth easily when balloon is inflated."</p> <p>Note: The resident's recapitulation PO dated 3/12/14 documented to only use a 16 French catheter with a start date of 2/24/14.</p> <p>On 3/27/14 at 1:40 p.m. the DON was asked why the resident was in pain for more than a month due to the improper placement of the catheter. The DON stated the nurses were checking with the physician daily regarding the resident having pain. When asked if the physician assessed the resident for the pain the DON stated the Physician Assistant was the one who responded to the nurses when they reported the resident's</p>	F 315			

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F 315	Continued From page 50 pain. When asked why it took so long to address the resident's pain the DON stated the urologist identified the resident needed a different size catheter and the resident had a very small bladder.	F 315			
F 323 SS=D	<b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  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 for 1(#9) random resident and any other resident who used the resident men's bathroom, were safe from hazards that would cause falls or injury. The deficient practice had the potential to cause more than minimal harm for Resident #9 when he used the toilet, from one closet door that was off the hinge and the miscellaneous items that were overflowing from the closet. Findings included:  On 3/24/14 at approximately 1:45 pm, during the initial tour of the facility, the surveyor and the DON observed the resident men's bathroom, across the hall from resident room #6. The right slat door to the storage closet at the far end of the bathroom was open, the left slat door was off the hinges, and leaning against the wall inside the closet. Overflowing outside of the closet, and	F 323	<b>F323 483.25(h) FREE OF ACCIDENT HAZARDS</b>  <u>Residents with the potential to be affected:</u> All residents and their family and friends have the potential to be affected.  <u>Corrective Actions:</u> The closet door was rehung before the surveyors left the facility and the items being stored in that closet were transferred to storage. The handrail was also repaired prior to the surveyors' exit from the facility.  <u>Measures to Prevent Recurrence:</u> The Administrator or designee will conduct checks to assure that the doors are properly attached and that the storage items that are needed are properly stored. The Administrator or designee will also conduct checks to make sure the handrails are firmly attached and that they are in good repair.  <u>Monitoring/Assurance:</u>	<b>12MAY14</b>	

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F 323	<p>Continued From page 51</p> <p>stacked onto the floor, a folded up walker, a bed foot cradle, and blankets.</p> <p>On 3/24/14 at 3:56 pm, the surveyor observed the overflow items observed earlier in the day had been removed from the resident men's bathroom. There was tall shelving inside the closet, and on the left side between the shelving and wall, was a long metal object which protruded into the open closet space. The shelving contained boxes with resident names on it, and two clear containers containing craft paint. The left door was off the hinges and placed inside the closet against the left wall. The right closet door was open.</p> <p>On 3/25/14 at 9:37 am, the surveyor observed Resident #9 ambulating with his walker from the men's bathroom where the left closet door off the hinges and stored inside the closet against the left wall, and the right door was open. The metal object observed earlier was positioned between the wall and shelving, and no longer protruded into the closet space.</p> <p>On 3/25/14 at 11:20 am, 2:29 pm, and 5:59 pm, the closet in the men's bathroom was observed by the surveyor, and was unchanged from the previous observation.</p> <p>On 3/26/14 at 9:30 am, the closet in the men's bathroom was observed by the surveyor which remained unchanged from the surveyor's previous observations.</p> <p>On 3/27/14 at 9:10 am, during the environmental tour, the Maintenance employee was asked about the closet door and overflowing items. He stated, "It is an on going battle. They store stuff in there. They keep piling it up and the door breaks</p>	F 323	The Administrator or designee will monitor to check that the doors are properly attached and that the handrails are also properly attached and in good repair. This will begin the week of 4/14/14 and be done weekly for seven weeks, then monthly for four months. Any discrepancies will be discussed in the QA Committee.	

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F 323	Continued From page 52 off the hinge." The Maintenance employee was asked who he was referring to and he answered, "Nursing home staff." The metal object between the wall and the shelving was shown to the Maintenance employee, regarding the concern of it falling into the closet space, he stated "Yes it is a concern. We have had trouble with the women's bathroom too. We cleaned them out on Monday." When asked if it was after the surveyor had seen the situation, he stated "Yes."  On 3/27/14 at 1:50 pm, the Maintenance employee told the surveyor, "I have fixed the hand rail and put the door back on." The closet in the men's bathroom was observed by the surveyor with the Maintenance employee present. The Maintenance employee, when asked to explain the function of the metal apparatus that remained between the wall and the shelving, answered, "It is a piece of the trapeze bar. Yes, that could be a concern." When asked how maintenance staff were notified that something needed repairs, he replied, "We have a work order system." The maintenance man was asked if had received an order to repair the closet door and remove the stored items from the floor, to which he replied, "No we hadn't."  On 3/27/14 at 5:00 pm, the Administrator and DON were informed of the findings. No further information was provided.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION  The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327	<b>F 327 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</b>  <u>Residents with the potential to be affected:</u>	<b>12MAY14</b>

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F 327	<p>Continued From page 53</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 implement measures to ensure 1 of 5 (#1) sampled residents received adequate fluids. The deficient practice had the potential for harm when the resident was identified to be at risk of decreased fluid intake and the facility did not implement measures to ensure she was given fluids. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 8/17/07 with diagnoses that included osteoarthritis, general weakness.</p> <p>The resident's Quarterly MDS dated, 10/22/13 and 1/21/14, documented: *BIMS score on 10/22/13- 8, cognition moderately impaired. On 1/21/14- 4, cognition severely impaired. *Rejection of cares: Both assessments = No. *Eating: 10/22/13 assessment = 0-1, Independent, set up only. 1/21/14 assessment = 1-2, Supervision, 1 person assist. *Functional limitation in ROM: Both assessments- = Upper extremity- 2, impairment on both sides. Lower extremity- 2, impairment on both sides. [NOTE: The 1/21/14 MDS Assessment documented the resident experienced a decline in eating from the 10/22/13 MDS Assessment.]</p> <p>The resident's Narrative care plan dated July 2013, documented in part: *Page 1: "I do have some confusion at times and make statements that don't make sense. Even my daughter [name] has noticed a decline in my</p>	F 327	<p>Resident #1 is dependent on others to consume her recommended daily fluids at this time. All residents unable to get fluids on their own or who may not recognize thirst have the potential to be affected.</p> <p><u>Corrective Actions:</u> We have changed the seating in the dining room during meals so that one staff member is always seated at the table where resident #1 eats. All other residents that require prompting during meals will also be seated at a table with a staff member for cuing and assistance. A CNA will now offer all eligible residents food and beverages twice daily at 10am and 3pm from a snack cart provided by the dietary department.</p> <p><u>Measures to Prevent Recurrence:</u> The dining room seating has been arranged so that those residents who need prompting or cuing with eating or drinking have a staff member sitting at the table with them. A CNA will offer all eligible residents food and beverage twice daily from a snack cart provided by the dietary department. In the 4/03/14 and 4/09/14 mandatory staff (CNA and LN) meetings, the DON reminded staff to follow the care plans for hydration recommendations, offer fluids more often and keep them within reach for residents as well as information about the snack cart. The MDS Assistant placed flyers at the nurse's station and in the dining room to remind staff to pour a glass of water for the residents while they wait for meals. The MDS Assistant also provided a sheet listing residents and their minimum fluid requirements to all CNA's to place in their report book as a reminder.</p>		

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F 327	<p>Continued From page 54</p> <p>cognitive status. My BIMS score does fluctuate thru out the year but only by a few points."</p> <p>*Page 5: "I am able to feed myself but do need set up help at meals. 1/21/14, If I am tired I tend to sleep thru the meal. Allow me rest periods in recliner or bed before meals. 1/21/14, During IDT [Interdisciplinary team] it was discussed that [resident's name] is needing more prompts at meals, at times. We are going to hold off moving her to a helper table [and] see if allowing her to rest before meals allows her to more alert at meal time."</p> <p>*Page 6: "My fluid intake is less than what I require based on my body size. Since I am not able to get water on my own you will need to make sure that I have a mug of water where I can reach it when I am in my bed. You will need to refresh this at least once every 12 hour shift and PRN [as needed]. Offer me water when I am waiting for meals. Encourage me to drink a full glass of water with each med pass."</p> <p>The resident's Nutrition Progress Note dated 12/27/13, documented in part: **"Fluid intake 1231 cc average / day. Please encourage fluids [with] all meals and cares."</p> <p>The resident's IDT/Care Plan Meeting notes dated 1/21/14, documented in part: **"RCNA [Restorative certified nurse aide] reports that she is tired today. Also reports that she is sleeping thru meals. Will discuss moving her to a D.R [dining room] table where she may get more help [with] meals."</p> <p>The resident's Nutrition Assessment dated 1/22/14, documented: *WT [weight][pound]: "190.5" *Total Fluids: "2164 cc [cubic centimeter] / 2580</p>	F 327	<p><u>Monitoring/Assurance:</u></p> <p>The MDS Assistant will monitor the amount of fluids that are sent from the kitchen for meals on specific residents and the quantity of fluid consumed by the resident. The MDS Assistant will monitor snack cart intake. The MDS Assistant will monitor for placement of water mugs in resident rooms to be within reach for the resident. These audits will begin on 4/22/14 and they will be done 3 times a week for 8 weeks, then 2 times a week for 6 weeks, then 1 time a week for 4 weeks. Deficiencies in this practice will be reported to the DON, as well as the QA Committee for review to determine if further actions are necessary. All monitoring will be documented and retained.</p>		

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F 327	<p>Continued From page 55 cc (25/30 cc/kg [kilogram])" *Fluid restriction: "NA"[ not applicable]. *Oral/Nutrition intake/fluids: "1459 cc." *Total points: "13" [greater than] 8 points- High Risk *Overall Risk Category: "[Increase] Risk" The resident's Nutrition Progress note dated 1/22/14, documented: "Reviewed Rt[resident] Wt. 1-5-14 190.5 [pounds] meals, 70% fluids 1459 cc. Will continue to monitor." [NOTE: The resident was identified to require 2164cc / 2580 cc of fluid a day, and the amount documented by the CDM [Certified Dietary Manager] which the resident received was 1459 cc.]</p> <p>The resident's temporary care plan dated 1/28/14, documented: *"I have an open area on my right buttock. Physician gave order on 1/25/14 for critic acid [and] xeroform BID [twice daily] Have me lay on my sides in bed. The night shift has been keeping my buttock open to air at noc.[night]. I am also not drinking fluids like I should so you need to offer me fluids [and] encourage me to drink them. While I have this open area you will need to reposition me more often. The skin nurses check the area [every] week [and] record the size [and] other info on my open area."</p> <p>The resident's Fluid Intake Detail Report documented: *3/24/14: Breakfast- "360" Lunch- "300" Dinner-"120" Extra-"790" Total-1470. *3/25/14: Breakfast-"280" Lunch- "360" Dinner-"0" Extra "605" Total-1245. *3/26/14: Breakfast- "0" Lunch- "360" Extra-"120" The record was not completed for 3/26/14 due to</p>	F 327		

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F 327	<p>Continued From page 56 the time of day it was compiled.</p> <p>On 3/24/14 at 4:00 pm, the resident was observed in bed asleep. A water container was on the three drawer stand on the left side, at the head of the bed. The container was full.</p> <p>On 3/25/14 from 9:32 am until 10:12 am, the surveyor observed the resident in an exercise activity.</p> <p>On 3/25/14 at 10:12 am, the surveyor observed the resident be transferred to a lounge chair in the TV room. The resident was provided a cup of popcorn to eat. No fluids were offered.</p> <p>On 3/25/14 at 10:39 am, the surveyor observed the resident awake and eating the popcorn. No fluids were provided.</p> <p>On 3/25/14 at 11:25 am, and 11:39 am, the surveyor observed the resident asleep in the lounge chair.</p> <p>On 3/25/14 at 11:41 am, the surveyor observed CNA #8 wake the resident and state, "[Resident's name] we are going to get you up for lunch." The CNA washed the resident's face and oxygen tubing and walked away. No fluids offered.</p> <p>On 3/25/14 at 11:52 am, the surveyor observed CNA #2 and #6 assist the resident from the lounge chair to the dining room table. CNA #2 handed the resident a magazine, and placed a glass of water on the resident's place mat. The resident, who moved the cup to the right side of the mat, was not encouraged to drink the water, and did not drink it herself.</p>	F 327			

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F 327	<p>Continued From page 57</p> <p>On 3/25/14 at 12:05 pm, the surveyor observed the the resident receive her lunch tray. On the tray was a small can of diet soda. The drink was poured into a cup until it was 1/2 full. The resident was not encouraged to drink from the cup, which remained at the side of the mat. At 12:15 pm, the resident had not eaten or drunk from either of the two fluid containers. At 12:16 pm, CNA #8 walked up to the resident and stated, "[Resident's name] you need to eat." The CNA did not encourage fluids before she walked back to the assisted dining table. At 12:21 pm, CNA #8 returned to the table and assisted Resident #1's tablemate. CNA #8 did not encourage Resident #1 to eat or drink at this time.</p> <p>On 3/25/14 at 1:28 pm, and 2:25 pm, the surveyor observed the resident in bed. The resident's water container, which was full of water, was on the three drawer stand out of reach of the resident.</p> <p>On 3/25/14 at 2:35 pm, the surveyor observed CNA #1 distribute water in the resident's hallway. The CNA offered the resident fresh water with a straw; the resident took a sip of the water and stated, "That's cold." The CNA placed the water container on the three drawer stand, with an empty plastic container in front of the container and out of the reach of the resident. The CNA was asked if the old water cup she had emptied was full, and the CNA stated, "Yes."</p> <p>On 3/25/14 at 3:05 pm, 3:40 pm, 4:00 pm, 4:35 pm, 5:00 pm, 5:30 pm, and 5:55 pm, the resident's water cup remained on the three drawer stand to the left of the head of the bed, and out of reach of the resident and was full.</p>	F 327			

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F 327	<p>Continued From page 58</p> <p>On 3/25/14 at 6:05 pm, the surveyor observed the resident as she was wheeled to the dining room table, and an empty red cup was placed on the resident's table mat by staff. At 6:07 pm, the resident was served her dinner tray. The red cup was removed from the mat in front of the resident. The resident was provided one small can of pineapple juice, which was poured into a clear cup by staff. The resident dozed off, and was not cued to eat or drink. At 6:20 pm, CNA #9 approached the resident, touched her back and stated, "Do you want to eat." The resident did not respond and CNA#9 stated, "I'll be back to you in a minute." At 6:27 pm, CNA #9 re-approached the resident, touched her shoulder and stated, "You want some water," and took the empty cup to another table to fill it from a pitcher. When the CNA brought the water back to the table and offered it to the resident. The resident shook her head from side to side, and the CNA stated "OK, I'll be back," and walked away. At 6:33 pm, CNA #9 returned to the resident's table. Standing beside the resident, the CNA offered the resident, food, juice and water. The resident did not respond and the CNA stated, "I am not going to try anymore," and walked away from the table. The fluids were not offered with a straw or handed to the resident to drink. At 6:51 pm, LN#10 walked up to the resident, and asked CNA #9 from across the room, "She hasn't eaten," and CNA#9 stated, "No, she hasn't." LN#10 took the resident from the table to the nurse station without offering or encouraging the resident to drink fluids.</p> <p>On 3/26/14 from 8:04 am until 9:27 am, the surveyor observed the resident at the dining room table with her breakfast tray. The resident had a cup of milk which staff poured into her cold</p>	F 327			

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F 327	<p>Continued From page 59</p> <p>cereal, one cup of water and a cup of hot chocolate. At 8:49 am, CNA #4 cued the resident to eat. At 9:06 am, CNA #4 cued the resident to eat. At 9:15 am, CNA #2 asked the resident, "You want some eggs," at which point the resident picked up her water glass for the first time during the meal. CNA #2 stated, "You go ahead and drink," and the resident took a sip and continued to chew the bacon already in her mouth. CNA #2 encouraged the resident to drink one more time during the observation before Resident #1's tray was taken from the table at 9:27 am, and the water and hot chocolate was placed on the resident's table mat. During the meal LN# 5 and CNA #6 passed by the resident, and did not cue the resident to drink or eat.</p> <p>[NOTE: During the meal observation of 1 hour and 23 minutes the resident had been cued to drink once and had drunk independently one time. The drink the resident took, and when the CNA cued her to drink, occurred approximately 1 hour and 10 minutes after she received her breakfast tray.]</p> <p>On 3/26/14 at 9:35 am, the surveyor observed the resident seated at the dining room table with the water and hot chocolate in front of her. The DON stated to the resident, "Good morning, [Resident's name.]" The DON did not cue the resident to drink fluids.</p> <p>On 3/26/14 at 9:55 am, the surveyor observed the resident as she remained at the dining room table with the full cup of hot chocolate, and full cup of water. The full cups of fluid were removed and the resident was taken to her room by CNA #4. No fluids were offered to the resident before leaving the table or during cares when assisted to bed.</p>	F 327			

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F 327	<p>Continued From page 60</p> <p>On 3/26/14 at 11:46 am, the surveyor observed that the resident's water container in her room was full and on the three drawer stand out of the reach of the resident.</p> <p>On 3/26/14 at 1:08 pm, the surveyor observed CNA #4 in the resident's room assisting with cares for the resident. The resident's water container was on the three drawer stand and was full. The CNA was asked if the resident was able to reach her water cup, and if she was able to drink on her own. The CNA stated, "No, she doesn't drink on her own. We have to come in and give it to her, even at meals." The CNA left the room without offering fluid to the resident.</p> <p>On 3/26/14 at 2:50 pm, the surveyor observed LN # 5 and CNA #7 providing cares for the resident. The resident's water container remained on the three drawer stand beside the bed, and was full. Fluids were not offered during cares.</p> <p>On 3/26/14 at 3:05 pm, the surveyor observed CNA #7 changing the resident's water container. She emptied the full container in the sink and provided fresh water. The CNA was asked if the container she had emptied was full, and she stated, "Yes, that's pretty much considered full." The CNA placed the fresh water container on the three drawer stand beside the bed and left the paper on the tip of the straw sticking out of the container. The CNA did not offer fluids to the resident.</p> <p>On 3/26/14 at 3:59 pm the surveyor observed that the container remained on the three drawer stand with the paper on the straw. It was full, and out of reach of the resident.</p>	F 327		

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F 327	<p>Continued From page 61</p> <p>On 3/27/14 at 8:20 am, the surveyor observed the resident in her wheelchair at the dining room table. The fluid provided for her was one cup of juice on her breakfast tray.</p> <p>On 3/27/14 at 9:55, the DON was interviewed concerning the resident's fluid intake. The surveyor asked the DON whether she observed meal times for the resident. She stated, "Yes, I go in at different times. [RN's name] is always out there at lunch time watching their food. The three days she is here, it's either breakfast or lunch. I know [resident's name] intake is very low. If you hand her a cup and a straw, I know she will drink. I have given her a straw and she drinks. We have talked about moving her. I can tell she is not eating as well, but if I hold a cup up she will drink. Recently she has deteriorated, somewhat, not as bubbly as she was. She does need a lot of cueing." The DON who was asked if the staff was aware the resident needed more help, stated, "We have talked about it in the staff meetings," and, acknowledged the resident's need for cueing.</p> <p>On 3/27/14 at 2:20 pm, the DM [Dietary Manager] was asked to name which fluids the resident likes and what is provided for the resident. The DM stated, "She doesn't normally drink milk, it's just for her cereal. I understand she does drink buttermilk when she has it. She was suppose to get it three times a week and [DON] and I have talked and will give it to her all three meals." When asked about assistance at meals, the DM stated, "I believe she does need to be at a restorative table for cueing and assist[ance]."</p> <p>On 3/27/14 at 5:00 pm, the Administrator and</p>	F 327			

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F 327	Continued From page 62	F 327			
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff in interview it was determined the facility failed to ensure 1 of 4 (#1) sampled resident were provided oxygen therapy according the resident's orders. The deficient practice had the potential to cause more than minimal harm when Resident #1's oxygen flow was higher than the Physician Assistant ordered. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 8/17/07, with diagnoses that included, SOB [Shortness of breath], anxiety, and general weakness.</p> <p>The resident's RSO dated 3/25/14, documented in part: *Oxygen at 1-3 liters, titrate to keep sats [blood oxygen saturation levels] &gt;[greater than] 90% at</p>	F 328	<p><b>F328 483.25(k) TREATMENT CARE FOR SPECIAL NEEDS</b></p> <p><u>Residents with the potential to be affected:</u> All residents using oxygen have the potential to be affected.</p> <p><u>Corrective Actions:</u> The DON talked with the CNA in question regarding her actions and that turning down the flow rate was not in her scope of practice and oxygen rates need to be adjusted by the LN. In the 4/03/14 and 4/09/14 mandatory staff (CNA and LN) meetings the DON discussed with all staff that it is not in the CNA scope of practice to adjust oxygen flow rates. Resident #1 has her oxygen saturation level checked every 12 hour shift and PRN by the LN. These results are recorded on her TAR. The LN also records the oxygen saturations on the facility Check Sheet for Alarms and Oxygen form. This form has been revised to include a space for the LN to record the liter flow rate at the time of the oxygen saturation check.</p> <p><u>Measures to Prevent Recurrence:</u> In the 4/03/14 and 4/09/14 mandatory staff meetings the DON discussed that it is not in the CNA scope of practice to adjust oxygen flow rates. This is a duty of the LN and CNA's were informed to get a LN anytime a concentrator needs to have the flow rate adjusted or a wall oxygen unit needed to be turned on. The LN's will complete the Check Sheet for Alarms and</p>	<b>12MAY14</b>	

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F 328	<p>Continued From page 63 all times.</p> <p>The resident's Narrative Care Plan dated July 2013, included: *Page 14 and 15: "I need to have my oxygen on and you need to check that either my concentrator or the tank is working if I am out of my room. Change my oxygen tubing per facility protocol and record it on the tx[treatment] sheet. Check my oxygen levels every 12 hour shift and PRN [as need]. My physician wants my sats to stay above 90% at all times."</p> <p>On 3/25/14 at 9:25 am, the surveyor observed the resident seated in her wheelchair at the dining room table. The resident's concentrator was next to her and was set at 5L[liter]/ min[minute]. The oxygen was being administered by N/C[nasal cannula].</p> <p>On 3/25/14 at 11:52 am, the surveyor observed the resident seated in her wheelchair at the dining room table. The resident's concentrator was next to her and was set at 5L/min. The oxygen was being administered by N/C.</p> <p>On 3/25/14 at 6:10 pm, the surveyor observed the resident seated in her wheelchair at the dining room table. The resident's concentrator was next to her and was set at 5L/min. The oxygen was being administered by N/C.</p> <p>On 3/26/14 at 8:53 am, the surveyor observed the resident in her wheelchair seated at the dining room table. The resident's oxygen concentrator was set at 2L/min and being administered by N/C.</p> <p>On 3/26/14 at 8:55 am, CNA #4 was asked if she had turned the concentrator down and why it had</p>	F 328	<p>Oxygen form including the liter rate of oxygen that the resident is on. The LN will also verify and check the prescribed liter flow rates every time they record a resident's oxygen saturation level.</p> <p><u>Monitoring/Assurance:</u> An audit will be completed by the MDS Assistant reviewing the Check Sheet for Alarms and Oxygen form and visual checks on concentrators and wall oxygen units to make sure liter flow rates are within the physician prescribed range for each resident. These audits will begin 4/22/14 and they will be done 4 times a week for 6 weeks, then 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then 1 time a week for 4 weeks. Deficiencies in this practice will be reported to the DON, as well as the QA Officer for review to determine if further actions are necessary. All monitoring will be documented and retained.</p>		

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F 328	Continued From page 64 been on 5L/[min]. CNA#4 stated, "I don't know why, but I saw it was on 5[L/min] and I know she is on 2-3 L[ <u>min</u> ], so I turned it down."  On 3/26/14 at 9:50 am, the surveyor asked the DON why the oxygen was on 5 L[ <u>min</u> ], and she stated, "I know CNA's are not suppose to titrate oxygen. I talked to the CNA and she told me she did it. I told her she should have gotten the nurse."  On 3/27/14 at 5:00 pm, the administrator and DON were informed of the findings. No further information was provided.	F 328		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	<b>F329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  <u>Residents with the potential to be affected:</u> All residents have the potential to be affected by this practice. The doctors were given a reminder of the diagnoses that are appropriate for the use of antipsychotic drug therapy and the importance to receive a gradual dose reduction and behavioral interventions, unless clinically contraindicated. They have been notified that they need to write the proper documentation to address why it is not advisable to do a dose reduction.  <u>Corrective Actions:</u> Resident #2 was admitted on 8/20/13. One diagnosis was Lewy Body dementia. The quarterly MDS documented severe cognitive impairment and hallucinations. The recap doctor	12MAY14

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F 329	Continued From page 65  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility did not ensure residents were free from unnecessary medications. This was true for 2 of 2 residents (#s 2 and 5) sampled for psychopharmacological medication. The deficient practice had the potential to cause declines if residents experienced negative effects from receiving a medication for which there was no clear clinical indication. Findings included:  1. Resident #2 was admitted to the facility on 8/20/13 with diagnoses which included Lewy Body Dementia.  The resident's 3/13/14 quarterly MDS assessment documented severe cognitive impairment and hallucinations.  The resident's 3/12/14 Recapitulation Physician Orders contained an order for Risperdal (antipsychotic) 0.25 mg twice a day for agitated dementia and visual hallucinations with a start date of 8/30/13.  * A 11/15/13 "Physician Action Report" (PAR) for the resident documented in the recommendation section "Need reduction on her Risperdal or note why not" and was signed by the pharmacist. The physician comments documented "No reduction in Risperdal due to her agitated dementia."  *The resident's Care Plan identified the resident	F 329	orders contained an order for Risperdal 0.25mg BID for visual hallucinations and agitated dementia. On 11/15/13 from pharmacy review it was recommended that we need a reduction on her Risperdal or note why not. The doctor responded no reduction due to her agitated dementia. Care tracker charting for the Behavior Chart Detail Report identified the following behaviors: wandering, verbal abuse, physical abuse, socially inappropriate and resistance to care. The staff have been reminded and directed to add a narrative to describe her behaviors or select from one of the specific behaviors that have been added. She has an order for Citalopram 20mg daily started 8/30/14; the diagnosis has been clarified by the physician for the MARS.  Resident #5 has an order for Risperdal 0.25mg at bed time for paranoia and agitation. Caretracker charting identified the following behaviors, wandering, verbal abuse, physical abuse, socially inappropriate behaviors as most of these options did not fully describe her behaviors, others have since been added to the system as options to select. The staff members were again reminded to add a narrative to describe her behaviors. The resident also has an order for Sertraline 25mg for depression. The care plan has been updated to address the resident's depression, interventions for the depression, and how the depression is displayed (tearfulness, isolation, or other symptoms of depression.)  <u>Measures to Prevent Recurrence:</u> Any resident with a medication ordered for depression, dementia, psychosis or related medication will be monitored by the DON for proper diagnosis, to see that gradual dose		

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F 329	<p>Continued From page 66</p> <p>would attempt to grab at staff, verbally threaten staff, and use foul language. The care plan did not identify hallucinations or behaviors which were harmful to the resident.</p> <p>The resident's "Behavior Chart Detail Report" (BCDR) from 12/25/13 through 3/25/14 identified the following behaviors: wandering, verbal abuse, physical abuse, socially inappropriate, and resistance to care. The resident's care plan or the BCDR did not identify what socially inappropriate behaviors were.</p> <p>On 3/27/14 at approximately 2:45 p.m. the DON was asked for clinical rationale for the use of the Risperdal. The DON stated the only behaviors documented were the ones on the BCDR.</p> <p>*Resident #2's 3/12/14 Recapitulation Physician Orders included an order for Citalopram 20 mg every day for dementia with a start date of 8/30/14.</p> <p>Nursing 2013 Drug Handbook( NDH), 33rd Edition, page 324, under Indications and Dosage for use of the medication Citalopram documented it is to be administered for depression, premenstrual disorders and obsessive-compulsive disorders. The NDH did not document the antidepressant was indicated for the treatment of dementia.</p> <p>On 3/27/14 at 2:45 p.m. the DON was asked if the physician statement included rationale the medication should not be reduced. The DON stated the physician had not provided rationale for its continued use.</p>	F 329	<p>reductions are ordered or the proper documentation is in the chart to keep the resident on the current medication.</p> <p><u>Monitoring/Assurance:</u> An audit will be completed by the DON beginning 4/28/14 and will be done 2 times a week for 4 weeks, 1 time a week for 6 weeks, and then every other week for 6 weeks. The audit will review for any resident that has an order for depression medication, antipsychotic medications, dementia, psychosis or related medications for proper diagnosis, to monitor that gradual dose reductions are ordered or the proper documentation is in the chart. The MDS Assistant will also audit the Physician Action Reports to ensure physician response beginning with the 4/9/14 Pharmacy Review and this will be done monthly for 6 months. Deficiencies in any of these practice(s) will be reported to the QA Committee for review to determine if further action is needed. All monitoring will be documented and retained.</p>		

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F 329	<p>Continued From page 67</p> <p>2. Resident #5 was admitted to the facility on 2/17/05 with diagnoses which included dementia and depression.</p> <p>Resident #5's most recent quarterly MDS assessment, dated 11/21/13, and annual MDS assessment dated 1/7/14 documented: * Cognitively intact, and * Physical or verbal behavioral symptoms directed toward others - not exhibited.</p> <p>The resident's 3/12/14 Physician Orders included an order for Sertraline 25 mg for depression with a start date of 1/28/10. The resident also received Risperdal 0.25 mg at bedtime for paranoia and agitation with a start date of 10/28/11 antidepressant</p> <p>The resident's 1/2014 Care Plan identified problems of accusing others of taking her items, making up stories, and hoarding. The Care Plan did not address the resident's depression, interventions for the depression or how the depression was displayed (tearfulness, isolation etc.).</p> <p>The resident's BCDR from 12/25/13 through 3/25/14 the form identified behaviors of wandering, verbal abuse, physical abuse, socially inappropriate, and resistance to care. The socially inappropriate behaviors were not identified on the BCDR form or the care plan.</p> <p>The BCDRs documented on 1/10/14 a behavior of insisting on getting more hygiene wipes and on 1/19/14 getting upset when asked to wash her hands after she touched her incontinence brief. There were no other behaviors documented for the resident.</p>	F 329			

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F 329	Continued From page 68  The resident's medical record had 3 PARs signed by the pharmacist. The dates on the PARS were 11/13/13, 1/7/14 and 2/12/14. Each PAR had a handwritten "monitor" in the "Detailed Description of Irregularity and Recommendations" section. The section did not identify the medication or what was to be monitored. The Physician Comments section was blank and was signed by the physician on 11/15/13, 1/6/14 and 2/15/14.  On 3/27/14 at approximately 3:30 p.m. the DON was asked for clinical indication for the continued use of the antidepressant. The DON stated the facility had not documented the signs or symptoms of depression. When asked if 2 behaviors in months justified the use of the antipsychotic the DON stated they did not.  On 3/27/14 at 5:00 pm, the Administrator and the DON were informed of the lack of rationale for the continued use of the medications, care plans with interventions to address behaviors and depression and the monitoring of behaviors and symptoms of depression. No further information was provided.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to ensure that 2 of 3	F 332	<b>F332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</b>  <u>Residents with the potential to be affected:</u> All residents in the facility have the potential to be affected by this practice. Following the QA audit, any nurse with 3 or more errors will be required to take a medication review class. This will ensure that they are paying attention when they are giving medication and are held accountable.  <u>Corrective Actions:</u> In-service was presented by the DON to all LNs on 3/19/14 and then re-inserviced on 5/08/14 concerning the importance of giving all	12MAY14

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F 332	<p>Continued From page 69</p> <p>(#4, and 10) residents were free of medication errors. The deficient practice had the potential for more than minimal harm, when Resident #4 and Resident #10 were given a medication at the wrong time and Resident #4 was administered a medication without a physician's order. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 1/17/14, with diagnoses that included, gastroparesis, gout, generalized osteoarthritis, and pain.</p> <p>The Resident's RSO [routine standing order] dated 3/24/14, documented: **"Metoclopramide 5 mg[milligrams] one po [by mouth] BID [twice a day] ac [before breakfast] Gastro Paresis."</p> <p>On 3/26/14 at 8:29 am, the surveyor observed LN #5 administer: *Polyethylene Glycol [Miralax] 3350-17 grams, in a cup of water. *Metoclopramide[Reglan] 5 mg, 1 tablet po. This was given after the resident had eaten breakfast.</p> <p>On 3/26/14, the Medication Reconciliation review was completed by the surveyor and an order for the "Miralax" was not found, although the resident was ordered to receive Reglan given before meals.</p> <p>On 3/26/14 at 3:55 pm, LN #5 was asked about giving the Reglan after breakfast. She stated, "Yes I did, and it should have been given at 7 am."</p> <p>On 3/27/14 at 2:05 pm, LN #5 was asked to produce a physician order for Miralax. The LN</p>	F 332	<p>medication at the time specified. Resident #4 and #10 were given their medications Reglan after breakfast, not before breakfast as ordered. The nurse was aware of the error at the time it was given and has been monitored by the DON periodically since then and the medications have been given correctly. Resident #5 was given Miralax as it was written on the Mars but there was no order in the chart to cover the Miralax. The licensed staff members were in-serviced on 3/19/14 and then re-inserviced on 5/08/14 on the importance of not writing medications on the MARS without a doctor's order. The staff has also been required to review the routine standing orders on the residents to become familiar with what medications are on the RSO.</p> <p><u>Measures to Prevent Recurrence:</u> All nurses have been in-serviced on 3/19/14 and re-inserviced on 5/08/14 on the medication pass, timeliness and to have an order for any medication given. The routine standing orders were reviewed and they understand that each doctor will mark on the orders what he wants for each resident on the RSO.</p> <p><u>Monitoring/Assurance:</u> The DON will do an audit on the medication pass, especially medication ordered before meals to ensure they are given at the correct time. The MARS will be reviewed to monitor any medication added to ensure there is an order or it is on the RSO. This audit will begin 4/28/14 and will be done 4 times a week for 4 weeks, then 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then 1 time a week for 2 weeks. Deficiencies in any of these practice(s) will be reported to the QA Committee for review to</p>		

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F 332	Continued From page 70 went to the chart to find it and stated, "I can't find it here either. I don't see it." The LN was asked to produce the MAR [Medication Administration Record] for the resident. The MAR contained directions for giving the medication, and the LN verified, "Yes, I did give Miralax."  2. Resident #10 was admitted to the facility on 8/12/10, with diagnoses that included Gastroesophageal reflux disease [GERD].  The resident's RSO dated 3/25/14, documented: *Reglan 5 mg po AC BID GERD.  On 3/26/14 at 8:45 am, the surveyor observed LN #5 administer the resident's medications. The resident had eaten breakfast and was sitting in the TV room.  On 3/26/14 at 3:55 pm, LN #5 was asked about giving Resident #10 the Reglan after breakfast. She stated, "Yes, I did and it should have been given at 7 am."  On 3/27/14 at 5:00 pm, the Administrator and the DON were informed of the findings. No further information was provided.	F 332	determine if further action is needed. All monitoring will be documented and retained.		
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 record review, observation and staff interview the facility failed to ensure therapeutic	F 367	<b>F367 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN</b>  <u>Residents with the potential to be affected:</u> All residents on a prescribed therapeutic diet have the potential to be affected.  <u>Corrective Actions:</u> Resident #1 did not receive the prescribed mechanical soft diet. Each dietary staff member was in-serviced either on 3/26/14 or on 3/27/14, individually, that whole bacon is not to be provided for Resident #1. Resident #1 and all other residents on a mechanical soft diet must have their foods processed or chopped accordingly to prevent choking. The notation of	12MAY14	

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F 367	<p>Continued From page 71</p> <p>diets were received by the residents. This was true for 2 of 7 (#s 1 and 6) sampled residents who, because of the deficient practice were at risk for choking and adverse clinical conditions. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 7/20/07 with diagnoses that included Parkinson's, Parkinson's dementia, and osteoporosis.</p> <p>On 3/27/14 at approximately 11:30 a.m. Cook # was observed as he prepared the mid-day meal tray for resident #6. Cook #1 placed mechanical soft meat on the resident's tray and then placed the tray on the cart to take to the dining room for the resident. The surveyor had observed the meal card for the resident identified the resident was to receive "extra protein" asked if the resident received the extra protein. The cook responded the resident did not get the extra protein with meals but as snacks throughout the day.</p> <p>The Dietary Manager was present and stated the resident should get extra protein with her meals. The resident's tray was pulled from the cart and additional protein was placed on the tray with her meal.</p> <p>The Administrator and the DON were informed of the above concern on 3/27/14 at 5:00 p.m. The facility provided no further information.</p> <p>2. Resident #1 was admitted to the facility on 8/17/07, with diagnoses that included weakness, and anxiety.</p> <p>The resident's Speech Therapy notes dated 11/23/09, documented in part: **"Dysphagia Assessment: Rt.[resident] referred</p>	F 367	<p>the mechanical soft diet was added to Resident #1's meal card to remind dietary and nursing staff. All resident meal cards were reviewed by the Dietary Manager to ensure all residents with therapeutic diets had doctor orders, notations on the meal cards, and are being implemented.</p> <p><u>Measures to Prevent Recurrence:</u> The Dietary Manager will continue to update resident meal cards with any changes in resident therapeutic diets. Dietary staff members were in-serviced either on 3/26/14 or on 3/27/14 by the Dietary Manager to watch resident meal cards for those that require mechanical soft diets and be more conscious of chopping or processing any food that may be difficult to eat to avoid choking. A copy of the dietary-related plans of correction will be posted for all staff.</p> <p><u>Monitoring/Assurance:</u> The RSD will monitor to check for compliance with residents that need a therapeutic diet that the information is included on the resident meal cards and will monitor that residents on a therapeutic diet received the correct food and beverage requirements and they are prepared correctly. These audits will begin on 4/28/14 and they will be done 3 times a week for 8 weeks, then 2 times a week for 6 weeks, and then 1 time a week for 4 weeks. Deficiencies in this practice will be reported to the Dietary Manager, as well as the QA Committee for review to determine if further actions are necessary. All monitoring will be documented and retained.</p>		

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F 367	<p>Continued From page 72</p> <p>SLP [Licensed Speech Pathologist] d/t [due to] new onset coughing / choking during meals. SLP did trial feeding during evening meal. SLP recommends mech. [mechanical] soft diet consistency [with] nectar thick liquids."</p> <p>The resident's RSO [routine standing orders] dated 3/25/14, documented in part: *Diet: 1800 ADA, [American Diabetic Association] Mechanical soft.</p> <p>On 3/26/14 at 8:12 am, the resident was observed by the surveyor to be seated in her wheelchair at the dining room table, and served breakfast. The resident's breakfast tray contained a cup of hot chocolate, a glass of milk, a bowl of cold cereal, an egg, a piece of toast and a slice of bacon. At 8:49 am, CNA #4 stated to the resident, "Your breakfast is in front of you, go ahead and try your bacon." The resident took a bite of toast. At 9:07 am, CNA #4 stated to the resident, "[Resident's name] eat your food." The resident picked up her bacon and took a bite of it. The resident was observed to chew the bacon until 9:15 am, at which time the resident had closed her eyes. At 9:18 am, CNA #2 stated to the resident, "[Resident's name] stay awake and eat." The resident did not respond and CNA #2 stated, "Are you done eating your breakfast. You got bacon there too." The resident picked up the bacon, half of which was gone, and closed her eyes again. At 9:27 am, the resident's tray was removed and the resident had the remaining bacon and toast in her hand. [NOTE: The resident was cued by the 2 different CNA's to eat her bacon.]</p> <p>On 3/26/14 at 9:35 am, the DON was asked by the surveyor if she considered bacon to be on a</p>	F 367			

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F 367	Continued From page 73 Mechanical soft diet, and she stated, "No I would not." The DON stated to the resident, "Good morning, [Resident's name]." The bacon and toast were observed by the surveyor to be in the resident's hand and the DON did remove them from the resident.  On 3/27/14 at 2:20 pm, the DM [Dietary Manager] was asked by the surveyor whether bacon was part of a Mechanical soft diet, and she stated, "It's not normally sent for a Mechanical soft diet."  On 3/27/14 at 5:00 pm, the Administrator and the DON were informed of the findings. No further information was provided.	F 367			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS  The facility must provide special eating equipment and utensils for residents who need them.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility failed to ensure 1 of 7 (#1) sampled residents was provided special equipment needed for meals. The deficient practice had the potential to cause harm when resident #1 was identified to need a partition plate at meals, and this was not consistently provided. Findings included:  1. Resident #1 was admitted to the facility on 8/17/07, with diagnoses that included weakness, and anxiety.  The resident's Nutrition Assessment dated,	F 369	<b>F369 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS</b>  <u>Residents with the potential to be affected:</u> All residents requiring adaptive devices for eating have the potential to be affected.  <u>Corrective Actions:</u> The Dietary Manager will review all resident care plans for those requiring assistive devices while eating and add that information to each resident's meal cards to serve as a reminder for all dietary and nursing staff. Each dietary staff member was in-serviced either on 3/26/14 or 3/27/14, individually, that a partition plate is to be provided for Resident #1 for all meals. This information was added to Resident #1's meal card to remind dietary and nursing staff.	12MAY14	

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F 369	<p>Continued From page 74 4/23/13, 7/22/13, 10/23/13, and 1/22/14, documented in part: *Adaptive Devices: "Partition Plate."</p> <p>The resident's Nutrition Progress Note dated 1/22/14, documented in part: *"provide partition plate for independence [at] feeding."</p> <p>On 3/26/14 at 8:12 am, the surveyor observed the resident seated in her wheelchair at the dining room table, as she was served breakfast. The resident's breakfast tray contained a cup of hot chocolate, a glass of milk, a bowl of cold cereal, an egg, a piece of toast and a slice of bacon. The egg, toast and bacon were provided to the resident on a regular, non-partitioned plate.</p> <p>On 3/26/14 at 12:12 pm, the surveyor observed the resident eating lunch. The resident was provided, one can of diet soda, a croissant sandwich on a regular plate, a small bowl with cucumber salad, a bowl of soup and a bowl with jello in it. [NOTE: The resident's breakfast and lunch meal, on 3/26/14 were both provided on regular, non-partitioned plates.]</p> <p>On 3/27/14 at 2:20 pm, the surveyor asked the CDM about the use of the partition plate for the resident at the noon meal. She stated "She wouldn't have one with a sandwich and the salad is put in a bowl and she can pick it up to eat it." The CDM, when told of the breakfast observation of the egg, bacon and toast on a regular plate, stated, "I am surprised." The CDM was asked how her staff knew to put the resident's food on a partition plate. She stated, "I am pretty sure it is written on the card." The CDM obtained the</p>	F 369	<p>Meals that include soup and sandwiches do not require a partitioned plate as well as any salad that may be served.</p> <p><u>Measures to Prevent Recurrence:</u> The Dietary Manager will continue to update resident meal cards with any changes in resident eating assistive device requirements. The Dietary Manager in-serviced all dietary staff either on 3/26/14 or on 3/27/14 individually to watch the resident meal cards and follow any instructions for assistive devices required to better assist residents with independent feeding. A copy of the dietary related plans of correction will be posted for all staff.</p> <p><u>Monitoring/Assurance:</u> The RSD will monitor to check for compliance with residents that need assistive devices while eating and that the information is included on the resident meal cards. These audits will begin on 4/28/14 and they will be done 3 times a week for 8 weeks, then 2 times a week for 6 weeks, then 1 time a week for 4 weeks. Deficiencies in this practice will be reported to the Dietary Manager, as well as the QA Committee for review to determine if further actions are necessary. All monitoring will be documented and retained.</p>	

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F 369	Continued From page 75 resident's meal card and stated, "It's not on there. The lady who used to do this retired and the new lady did not get that on there."	F 369		
F 387 SS=D	On 3/27/14 at 5:00 pm, the Administrator and DON were informed of the findings. No further information was provided.  483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT  The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.  A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility failed to ensure 3 of 3 (#1, 3, 6,) residents reviewed for timely Physician visits, and all other residents with the same primary physician, received timely physician visits. Resident #1 had not been seen by an MD [Medical Doctor] since September of 2013 and had a reoccurring pressure sore which the PA [Physician Assistant] treated. Resident #6 had not been seen by an MD since the Physician group took over in October 2013 and had a reoccurring pressure sore, which the PA treated with multiple changes in treatments. Resident #3 suffered pain for more than 30 days from a urinary catheter being incorrectly inserted which was treated by the PA. Findings included:	F 387	<b>F 387 483.40(c)(1)-(2) FREQUENCY &amp; TIMELINESS OF PHYSICIAN VISIT</b>  <u>Residents with the potential to be affected:</u> All residents have the potential to be affected.  <u>Corrective Actions:</u> The Administrator has spoken with all resident physicians by 4/3/14 with reminders about the regulations concerning frequency and timeliness of physician in-person visits every 60 days for current residents and every 30 days for new residents for the first 90 days after admission. Additionally, residents #1, 3, 6 were each visited in-person by their physician for follow-up and documentation on 4/3/14. The physician also visited all his other patients for examination, orders, and documentation while at the facility on 4/3/14.  <u>Measures to Prevent Recurrence:</u> The DON will conduct checks of patient records to verify frequency and timeliness of physician in-person visits. The	<b>12MAY14</b>

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F 387	<p>Continued From page 76</p> <p>1. Resident #6 was admitted to the facility with diagnoses that included Parkinson's, Parkinson's dementia, osteoporosis, and Ogilvies syndrome.</p> <p>The resident's Adult Progress note completed by a PA and dated 10/23/13, documented: *CC[Chief complaint]: "Initial assessment of 76 [year old] [female], routine. Pt has been in facility 5 years." *Assessment and plan: "76 [year old] [female] appears stable [with] multiple comobities. Continue current medications. Pt. completely dependent on staff for all needs/cares/feeding. Requested reweigh [illegible] to weight gain. No [change.] Will follow." Note: The PA had documented the initial assessment in October when the care of this resident was transferred to the Physician group the PA worked with, and the resident had pressure ulcers that the PA's were treating which the physician had not been involved in the care of. Refer to the citation F 314 for Pressure ulcers.</p> <p>The resident's Facility Physician notes documented the resident was visited by a PA on: 10/23/13, 11/14/13, 12/3/13, 12/10/13, 12/17/13, 12/28/13, 12/31/13, 1/14/14, 1/21/14, 2/4/14, 2/18/14, 2/25/14, 3/10/14, and 3/25/14.</p> <p>The resident's Physician telephone orders were signed by the PA, and dated 11/6/13, 11/19/13, 12/10/13 two different orders, 3/13/14, 3/19/14 and 3/25/14.</p> <p>The resident's RSO monthly orders dated 10/23/13, 11/19/13, 12/3/13 1/8/14, 2/18/14, and 3/25/14, were all signed by the PA.</p>	F 387	<p>Administrator will follow-up with the physicians, prior to visit due dates, to ensure that residents are seen in-person according to the regulation due dates.</p> <p><u>Monitoring/Assurance:</u> The DON will monitor to check for physician compliance with frequency and timeliness of all resident visits every month and report this to the Administrator. This will begin the week of 3/28/14 and will be done monthly for one year. The DON will monitor new admissions for compliance with current regulations for signing new admission orders of residents to the facility. This monitoring will begin the week of 5/1/14 and will be done monthly for one year.</p>		

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F 387	<p>Continued From page 77</p> <p>2. Resident #1 was admitted to the facility with diagnoses that included Diabetes Mellitus 2, hypertension, spinal stenosis, neurogenic bladder, depression, osteoarthritis and general weakness.</p> <p>The medical record indicated the resident had not been seen by an MD since 9/16/13.</p> <p>NOTE: The resident was being treated for a pressure ulcer and the MD had not been involved in the treatment for it. Refer to the citation F 314 for Pressure ulcers.</p> <p>The resident's Facility Physician notes documented dates the resident was visited by an MD as 6/26/13 and 9/16/13.</p> <p>The resident's Facility Physician notes documented dates the resident was visited by a PA as: 12/17/14, 1/28/14, and 2/4/14.</p> <p>The resident's RSO monthly orders dated: 1/19/13, 12/13/13, 1/8/14, 2/18/14, 3/25/14, and were signed by only the PA.</p> <p>On 3/26/14 at 10:15 am, the DON was asked by the surveyor, concerning the PA signing the monthly orders and visits to the facility. The DON stated, "He [PA] has been coming in once a week and writing new orders. I have seen [MD's name] once. He came in on 10/23/13 to take over the care of the residents. The PA does all the pharmacy reviews too." When asked about orders needed during the month whether the MD was involved with those, the DON stated, "[MD name] does not want us faxing him. So we have a tablet that we write him concerns. He says he can do orders from it. If we have a need we just contact [PA's name.] We do not approach the</p>	F 387		

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F 387	<p>Continued From page 78</p> <p>doctor because he does not know the patients."</p> <p>On 3/26/14 at 3:35 pm, LN #5 was asked by the surveyor whose signature was on the RSO's and the Physician Progress note, and she stated, "It's [PA name] and he is a PA." LN #5 was asked if he was in the Physician group that was responsible for Resident #1, and #6, LN #5 stated, "Yes he is." When LN #5 was asked if she had had seen [MD name] very often, LN #5 gestured "no" by shaking her head, and stated, "I have seen him once since he took over care of the resident's when [MD name] left in October."</p> <p>The resident's Physician telephone orders were signed by the PA, and dated: 11/6/13, 12/13/13 and 1/25/14.</p> <p>3. Resident #3 was admitted to the facility on 11/11/13 with multiple diagnoses including diabetes, insomnia/sleep disturbance and neurogenic bladder.</p> <p>The resident's Admissions MDS Assessment dated 11/19/13 and Significant Change MDS Assessment dated 2/19/14 documented the</p>	F 387			

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F 387	<p>Continued From page 79</p> <p>resident received a scheduled pain medication and had an indwelling catheter.</p> <p>Record review completed by the surveyor during the week of 3/24/14 through 3/27/14 disclosed the resident had not been visited by a MD since she was admitted to the facility on 11/11/13.</p> <p>Note: Refer to F 315 for an incorrect catheter insertion that caused the resident pain for more than 30 days.</p> <p>The resident's Facility Physician notes documented the resident was visited by a PA on: 11/19/13, 11/26/13, 12/3/13, 12/31/13, 1/20/14, 1/21/14, 1/29/14 and 3/4/14.</p> <p>The resident's recapitulation monthly orders dated 1/7/14, 2/12/14 and 3/12/14, were all signed by the PA.</p> <p>Additionally the resident's Admission Orders were signed by the Nurse Practitioner.</p> <p>The Administrator and the DON were informed of the above concern on 3/27/14 at 5:00 p.m. The facility provided no further information.</p>	F 387			
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>	F 431	<p><b>F431 483.60(b)(d)(e) DRUG RECORDS LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <p><u>Residents with the potential to be affected:</u> All residents in the facility that has or may have an order for a narcotic can be affected by this practice. The MDS assistant, the staff RN and the DON will continue to review all new orders and make sure that a sign-in sheet has been started for any and all narcotic orders.</p>	12MAY14	

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F 431	<p>Continued From page 80</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure, 4 of 8 sampled residents (#1, 4, 5, and 6), 1 random resident (#11) and all other residents in the facility who were prescribed scheduled narcotics, were provided safe storage and tracking of narcotics medications. The deficient practice had the potential for more than minimal harm should resident's narcotics not be available when the resident was to be administered pain medication, or pain medication would be given when not</p>	F 431	<p><u>Corrective Actions:</u> All residents in the facility who are prescribed scheduled narcotic medication will have a sign out sheet for each medication and will be signed by the nurse that will be giving that medication. Each of those medications is locked in the medication cart in the narcotics drawer. They will be counted at change of shifts to ensure that they are accounted for.</p> <p><u>Measures to Prevent Recurrence:</u> The MDS assistant will review all new orders and record them in her files, the staff RN and the DON will monitor all new orders also and any orders for narcotics will be monitored to ensure that a tracking sheet is issued to document each medication on a narcotic that is ordered to be given, not a prn.</p> <p><u>Monitoring/Assurance:</u> An audit will be completed by an RN beginning 4/28/14 on the narcotics sheets 1 time a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time per month for 3 months, and then quarterly for 6 months. Deficiencies in this practice will be reported to the QA Committee for review to determine if further actions are needed. All monitoring will be documented and retained.</p>		

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F 431	<p>Continued From page 81</p> <p>ordered. The facility did not have a tracking system in place to account for scheduled narcotics. The facility stored narcotics with regular medication and not in a separate locked compartment. Findings included:</p> <p>On 3/27/14 at 8:30 am, LN #5 was observed to administer Hydrocodone 5/325 mg to Resident #1. The LN obtained the narcotic from the resident slot in the regular medication drawer, along with the other non-narcotic medications to administer. The LN was asked where the narcotics were usually stored, and she replied, "It is kept in with her regular medications." The LN was asked, if the staff counted the narcotics, and the LN stated, "No we only count the PRN's"[as needed]. The LN was asked by the surveyor to clarify the situation, regarding storage of scheduled narcotics in with the resident's regular medication drawer and not counted. The LN answered, "Yes, that's right and maybe we should count them."</p> <p>On 3/27/14 at 9:45 am, the DON was asked about the storage and counting of the facility's narcotics. The DON stated, "Yes, all narcotics are in with their cards." The DON was asked what narcotics this would include, and she stated, "It would included all Valium, narcotic pain medications, Ambien, not Fentanyl patches they are all locked up. There is one lock that opens the cart for the scheduled 'gives.' [Narcotics] If it is a PRN it is locked up, the gives are in the cart." The DON was asked how the facility tracked narcotics and the DON stated, "If one nurse notices it's popped out they will tell me. We never had a problem with a narcotic or a sleeper; usually its the Senna. It's always been done that way." The DON was asked how the facility got</p>	F 431			

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F 431	<p>Continued From page 82</p> <p>their medications, and stated, "[Pharmacy name] downtown. When they bring the routine medications, they are in bins in the hospital pharmacy. I go through the MARs [medication administration record] and check the bins, if there are any problems I make a list and tell the pharmacy. Then at the end of the month the charge nurse upstairs brings the bins downstairs to the charge nurse in the LTC [Long Term Care]. The LTC charge nurse checks them again and puts them in the slots in the drawer. Those are the routine medications. If the Hydrocodone is scheduled it's in the bins. The fentanyl and PRN's, I don't have anything to do with those." The DON verified the facility did not have a narcotic tracking system once the narcotics were brought to the facility.</p> <p>On 3/17/14 at 3:00 pm, the [Pharmacy name] that provides medication to the facility was called by the surveyor and [name of pharmacist] was asked the tracking system that was in place when the narcotics were brought to the facility, "I am pretty sure we have to track the meds we take there. So we bring the meds to them and we have like a MAR and the person counts the cards with them and they sign that they are received. They keep a copy and we keep a copy here." The pharmacist was asked if they were aware the facility did not track scheduled narcotics and the pharmacist stated, "It would be up to their policy." The pharmacist was asked about the storage of resident narcotics for administration and stated, "The general rule for narcotics is they are kept in a cabinet separate from the regular medications."</p> <p>On 3/27/14 at 5:00 pm, the Administrator and the DON were informed of the findings. No further information was provided.</p>	F 431		

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F 441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p><b>F441 483.65</b> <b>INFECTION CONTROL, PREVENT</b></p> <p><u>Residents with the potential to be affected:</u> All residents with catheters have the potential to be affected. All residents have the potential to be affected by antibiotic tracking.</p> <p><u>Corrective Actions:</u> The DON reviewed all physician orders for residents currently on antibiotics to check for accuracy and completeness. A new facility Antibiotic-Infection noted sheet is to be used for all residents effective 4/28/14. The nursing staff will be required to complete this initial sheet and notify the RN when a resident is placed on a new antibiotic. The RN will then complete a personal resident Antibiotic-Infection Monitoring sheet and verify physician orders for completeness and accuracy. All forms will be kept in the infection control binder and the RN will monitor ongoing for patterns. All residents with catheters have been provided with cloth bag covers and all staff in-serviced of proper handling of catheter bags. A new infection control policy on 'Antibiotic Use' was also written for implementation with staff.</p> <p><u>Measures to Prevent Recurrence:</u> The RN will use the Resident Antibiotic-Infection Monitoring forms to track all resident antibiotic usage, orders, and infection control patterns. An in-service reminder on 4/18/14 was done for all nursing staff on infection control measures and antibiotic tracking using the new facility form. The in-service also covered infection control best practices and catheter care.</p>	<b>12MAY14</b>	

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F 441	<p>Continued From page 84</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview it was determined the facility failed to ensure that:</p> <p>*There were policies and procedures for antibiotic usage, and</p> <p>*Nursing staff managed catheter tubing in a manner to prevent potential infections.</p> <p>This had the potential to affect all residents in the facility including 7 of 7 (#s 1-7) sampled residents. There was a potential for harm when the facility did not have policies implemented or a system to track the usage of antibiotics, which potentially could contribute to drug-resistant organisms. Staff failing to manage catheter tubing in a manner to prevent potential infections, could contribute to the development of urinary tract infections. Findings include:</p> <p>1. A Physician Telephone order for Resident #4 documented: **1/13/14, Erythromycin ointment 0.5%, 1/2 inch ribbon in each eye, TID [three times a day] PRN [as needed] for eye redness [and] infection. Dx[diagnosis]: infection. [NOTE: This order was for administering an eye antibiotic without a diagnosis for the infection. The order also was for as needed, leaving the nursing staff to decide when the resident had an eye infection and needed the antibiotic, and for how many days it would be given.]</p> <p>On 3/27/14 at 11:00 am the Infection Control [IC] nurse was asked about the facility's policy on tracking antibiotics. The IC Nurse provided the tracking system the facility had for tracking resident's that had antibiotics ordered. The IC</p>	F 441	<p><u>Monitoring/Assurance:</u></p> <p>The RSD will monitor the infection control binder and new tracking sheets for completeness with physician antibiotic orders monthly for 6 months. The RSD will do quality checks for staff compliance with catheter care, hand washing, linens, and antibiotic orders and will document any findings. The audit will begin 4/28/14 and will be done 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then 1 time a week for 4 weeks. Deficiencies in this practice will be reported to the DON and the Infection Control Officer for review to determine if further actions are necessary. All monitoring will be documented and retained.</p>		

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F 441	<p>Continued From page 85</p> <p>nurse was asked if the facility had a system to track if the physician was ordering an antibiotic for improper usage. The example of Resident #4's eye antibiotic for as needed, with a diagnosis of infection, with no specific organism, or type of infection, was shown to the IC nurse. The IC Nurse stated, "That is a problem. I wasn't doing it then but that should have been caught." The IC nurse verified the facility had no way of tracking this.</p> <p>On 3/27/14 at 4:00 pm, the DON was asked about the order for resident #4, she stated, "I did question that and told the nurse it needed to be taken care of. It has not been taken care of and I will check on that." When asked about the tracking system for improper usage, the DON stated, "We need to do that."</p> <p>2. Resident #1 was admitted to the facility on 8/17/07 with diagnoses that included Neurogenic bladder.</p> <p>The resident's Narrative Care plan dated July 2013, documented in part: *Page 7: "I have neurogenic bladder and require the use of an indwelling Foley catheter. This is changed monthly and PRN by the LN. Make sure that the down drain bag is below the level of my bladder at all times and that it has a cover over it. Check kinks in the tube each time you help me reposition. I need to have a cath secure on at all times."</p> <p>On 3/24/14 at approximately 2:00 pm, during the Tour of the facility, the resident was observed in bed, with the resident's foley catheter bag laying on the floor next to her bed.</p>	F 441			

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F 441	<p>Continued From page 86</p> <p>On 3/25/14 at 11:52 am, CNA #2 and CNA #6 were observed to assist the resident from a lounge chair in the TV room to her wheelchair. The CNA's used a gait belt, CNA #2 placed the resident's foley catheter bag on the floor while she assisted the resident to stand. When the resident stood up, CNA #2 picked the bag up from the floor and hooked the foley catheter bag to the pocket of the pant leg of her uniform. Once the resident was seated in her wheelchair, CNA #2 positioned the catheter on the metal under her wheelchair.</p> <p>On 3/27/14 at 5:00 pm, the Administrator and DON were informed of the findings. No further information was provided.</p> <p>3. Resident #7 was admitted to the facility on 2/28/07 with diagnoses which included severe leg weakness, presbycusis (hearing loss), lumbar myelopathy, and urinary retention.</p> <p>The resident's current care plan (CP), dated 2/14, included in the "ADL's will be met daily" section the resident was incontinent of stool and had a catheter.</p> <p>On 3/25/14 at 9:40 a.m. Resident #7 was observed in the common area during the exercise activity. The Resident's catheter was to be observed on the floor. LN #3 shown the tubing was on the floor and stated it should not be there.</p> <p>On 3/27/14 at 5:00 p.m. the Administrator and the DON were informed of the above concern. The facility provided no further information.</p>	F 441			

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F 468 SS-E	<p><b>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</b></p> <p>The facility must equip corridors with firmly secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, it was determined the facility failed to ensure 3 of 8 (#4, 5, 7) sampled residents, 1 random resident (#9), and any resident that could access the hall had handrails that were not damaged. The deficient practice had the potential to cause more than minimal harm when the handrail outside the Men's Bathroom had a broken support and was loose. Findings included:</p> <p>On 3/24/14 at 4:25 pm, the surveyor observed the handrail to the left of the resident men's bathroom door to be loose and the metal bracket nearest to the door was broken.</p> <p>On 3/25/14 at 9:37 am, the surveyor observed Resident #9 ambulate from the resident's men's bathroom with the use of his walker. The handrail remained loose and the metal bracket was broken.</p> <p>On 3/25/14 at 5:59 pm, the surveyor observed that the handrail remained loose and the bracket was still broken.</p> <p>On 3/27/14 at 9:10 am, during the environmental tour with the Maintenance employee, the surveyor asked him about the broken handrail. He stated, "I had no idea that it was broke (sic), but all it needs is a bracket. I will get that fixed."</p>	F 468	<p><b>F468 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</b></p> <p><u>Residents with the potential to be affected:</u> All residents and their family and friends have the potential to be affected.</p> <p><u>Corrective Actions:</u> The handrail was repaired prior to the surveyors' exit from the facility.</p> <p><u>Measures to Prevent Recurrence:</u> The Administrator or designee will conduct checks to assure the handrails are firmly attached and that they are in good repair.</p> <p><u>Monitoring/Assurance:</u> The Administrator or designee will monitor that the handrails are properly attached and in good repair. This will begin the week of 4/14/14 and be done weekly for seven weeks, then monthly for four months. Any discrepancies will be discussed in the QA Committee.</p>	<b>12MAY14</b>

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F 468	Continued From page 88 On 3/27/14 at 1:50 pm, the Maintenance employee told the surveyor, "I have fixed the handrail and put the door back on." The Maintenance employee was asked how the maintenance department was notified that something required repair. He replied, "We have a work order system." The Maintenance employee was asked if had received an order to repair the handrail, to which he replied, "No, we hadn't."	F 468		
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR  The facility must designate a physician to serve as medical director.  The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the Medical Director failed to evaluate and resolve resident medical issues and coordinate medical care. This affected 3 of 7 sampled residents (#s 1, 6, & 7) with reoccurring stage 2 pressure ulcers. These residents were harmed when preventative measures were not implemented and the residents' developed reoccurring Stage 2 pressure ulcers. Additionally the Medical Director failed to provide clinical leadership to the facility by:	F 501	<b>F 501 483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR</b>  <u>Residents with the potential to be affected:</u> All residents have the potential to be affected.  <u>Corrective Actions:</u> On 4/03/14, the facility Medical Director attended to all residents under his charge. Additionally, on 4/24/14, the Medical Director attended the Quality Assurance Committee meeting as well as the Infection Control meeting and the Pharmacy Review Committee meeting. He will attend meetings quarterly for the Quality Assurance Committee, the Infection Control Committee, and the Pharmacy Review Committee. The Medical Director and staff will have the opportunity for direct communication related to resident care plans, pharmacological interventions, infection prevention, quality care, and any	12MAY14

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F 501	<p>Continued From page 89</p> <p>* Attending the Quality Assurance Committee meetings. The lack of the Medical Director's participation in the Committee meetings had the potential to affect all residents residing at the facility.</p> <p>* Ensuring required physician visits were made. This affected 3 of 7 sampled resident's (#s 1, 3 and 6).</p> <p>* Ensuring individualized care plans were developed for residents with dementia receiving psychopharmacological medication. This affected 2 of 2 residents (#2 and #5) diagnosed with dementia who received psychopharmacological medication.</p> <p>* Ensuring resident's pain was addressed in a timely manner. This affected 2 of 5 (#4 and #3) sampled residents.</p> <p>* Ensuring antipsychotic medication gradual dose reductions were attempted or rationale was provided. This affected 2 of 2 (#2 and #5) who received antipsychotic medication.</p> <p>* Ensuring the Medical Director was available to address resident's health concerns in a timely manner. This had the potential to affect all residents who resided at the facility. Findings include:</p> <p>1. Resident #6 was harmed when preventive measures were not implemented and the resident had a reoccurrence of six Stage 2 pressure ulcers to her coccyx.</p> <p>Resident #1 was harmed when preventive measures were not in place and she suffered the reoccurrence of a Stage 2 pressure ulcer.</p> <p>Resident #7 was harmed when a reoccurring Stage 2 pressure ulcer developed under his catheter tubing and a stage 2 pressure ulcer</p>	F 501	<p>other health issues at these meetings. Each of the respective Committee chairs will send an electronic copy of all committee minutes to the Medical Director for all meetings held. The Medical Director will also be available via electronic device or phone for any other resident or health concerns by the staff.</p> <p><u>Measures to Prevent Recurrence:</u> The Administrator will monitor the Medical Director's attendance at the Quality Assurance, Infection Control, and Pharmacy Review Committee meetings to ensure quarterly attendance. The Director of Nursing will contact the Medical Director and Administrator with any facility issues related to resident cares.</p> <p><u>Monitoring/Assurance:</u> The Administrator will monitor the Medical Director's attendance at the Quality Assurance, Infection Control, and Pharmacy Review Committee meetings to ensure quarterly attendance for 1 year, beginning 4/24/14. The Director of Nursing will contact the Medical Director and Administrator with any facility issues related to resident cares.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135066</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>POWER COUNTY NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 ROOSEVELT STREET AMERICAN FALLS, ID 83211</b>		
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F 501	<p>Continued From page 90 developed due to his incontinence brief.</p> <p>Please refer to F 314 regarding resident's being harmed by the failure of the medical director to provide oversight and coordination of medical care.</p> <p>2. On 3/27/14 at 2:00 p.m. the Quality Assurance Committee (QAC) co-chairman stated the Medical Director from the hospital attended the QAC meetings but the Medical Director of the facility did not. When asked if there was written information from the QAC meeting given to the facility the co-chairman stated no. The co-coordinator was not aware of how the information was communicated to the facility Medical Director.</p> <p>3. The Medical Director had not ensured required physicians visits were done. Refer to F 387.</p> <p>4. The Medical Director did not ensure residents' with a diagnoses of dementia who received psychopharmacological interventions had individualized care plans. Refer to F 309.</p> <p>5. Resident's pain issues were not addressed in a timely manner. Refer to F 309 and F 315.</p> <p>6. Gradual Dose Reductions of antipsychotic medications were completed or rationale provided for continued use. Refer to F 329.</p> <p>7. The facility failed to ensure the Medical Director was available to address issues when the primary physician was unavailable.</p> <p>On 3/26/14 at 2:20 pm, the DON was asked about contacting the facility Medical Director. The</p>	F 501			

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F 501	Continued From page 91 DON stated the Medical Director had instructed the facility to only contact him by using the IPAD, the facility was not to call him. The DON pointed to the IPAD on a counter in the nurses station.  On 3/27/14 at approximately 3:30 p.m. the Administrator stated the prior Medical Director had been gone since 10/3/13. The current Medical Director had been to the facility and visited with the Administrator a "couple of times." The Administrator was informed the Medical Director had not participated in the QA meetings as required. Additionally the Medical Director had not provided guidance to ensure the resident's were seen by the Physician as required and had not provided oversight to prevent harm.	F 501		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520	<b>F 520 483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS</b>  <u>Residents with the potential to be affected:</u> All residents have the potential to be affected.  <u>Corrective Actions:</u> The facility Medical Director is the designated physician to attend a meeting quarterly for the Quality Assurance Performance Improvement Committee. The Medical Director met with the other required members on 4/24/14. The Quality Assurance Committee Chair will send an electronic copy of all committee minutes to the	<b>12MAY14</b>

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F 520	<p>Continued From page 92 requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the Quality Assurance Program, it was determined the facility failed to ensure a designated physician attended the Quality Assurance Committee (QAC) meetings where he/she could provide timely medical guidance or input. This had the potential to affect all residents of the facility. Findings included:</p> <p>This failure resulted in the designated physician to be unable to provide timely medical guidance or input at the QAC meetings.</p> <p>The QAC co-chairman was interviewed on 3/27/14 at 2:00 p.m. and stated the medical director did not attend the QA monthly meetings. The 11/13/13 and 1/15/14/ QAC minutes documented the Administrator was present but did not document the Medical Director of the facility was present. The co-chairman stated the Medical Director from the hospital attended but the one from the facility did not. When asked if there was written communication about the meeting between the two Medical Directors she stated no.</p> <p>The facility failed to ensure the designated physician attended the QAC meetings as required.</p>	F 520	<p>Medical Director and to all committee members for all meetings held.</p> <p><u>Measures to Prevent Recurrence:</u> The Administrator will assure that the Medical Director and other members of the committee, who are required to attend, will attend the Quality Assurance Committee Meetings at least quarterly.</p> <p><u>Monitoring/Assurance:</u> The Administrator will monitor for physician quarterly attendance at the Quality Assurance Performance Improvement Committee meeting. The first meeting was held 4/24/14. The monitoring will begin 4/24/14 and will be done quarterly for one year.</p>		

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: Sherri Case, BSW, LSW, QIPD Susan Gollobit, RN</p>	C 000	<p><b>RECEIVED</b></p> <p><b>MAY 14 2014</b></p> <p><b>FACILITY STANDARDS</b></p>		
C 125	<p><b>02.100,03,c,ix Treated with Respect/Dignity</b></p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 regarding dignity issues.</p>	C 125		<p><b>C125 02.100,03,c.ix</b></p> <p>Please refer to the corrective action for federal citation F241 on page 5 of 93, of the form CMS-2567 as it relates to dignity and respect.</p>	12MAY14
C 175	<p><b>02.100,12,f Immediate Investigation of Incident/Injury</b></p> <p>f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please see F 225 as it relates to incident investigations.</p>	C 175		<p><b>C175 02.100,12,f</b></p> <p>Please refer to the corrective action for federal citation F225 on page 3 of 93, of the form CMS-2567 as it relates to incident investigations.</p>	12MAY14
C 293	<p><b>02.107,04,b Therapeutic Diets per Physician Orders</b></p> <p>b. Therapeutic diets shall be</p>	C 293		<p><b>C293 02.107,04,b</b></p> <p>Please refer to the corrective action for federal citation F367 on page 71 of 93,</p>	12MAY14

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>12 MAY 2014</b>
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C 293	Continued From page 1 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	of the form CMS-2567 as it relates to incident investigations.	
C 389	02.120,03,d Sturdy Handrails on Both Sides of Halls  d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/residents. This Rule is not met as evidenced by: Refer to F468 as it relates to broken handrails.	C 389	<b>C389 02.120,03,d</b>  Please refer to the corrective action for federal citation F468 on page 88 of 93, of the form CMS-2567 as it relates to broken handrails.	<b>12MAY14</b>
C 412	02.120,05,l Cold Water Drinking Fountain Requirements  l. A drinking fountain connected to cold running water and which is accessible to both wheelchair and nonwheelchair patients/residents shall be located in each nursing or staff unit. This Rule is not met as evidenced by: Based on observation, it was determined the facility did not have a drinking fountain located in each nursing or staff unit that was connected to cold running water and could be accessed by both residents who used wheelchairs and those who did not. Findings include:  During observations on 3/24/14 it was noted that there was no water fountain available for	C 412	<b>C412 02.120,05,l</b>  Please see attached request for waiver for the requirement to have a water fountain available for residents on the ground floor of the nursing home.	<b>12MAY14</b>

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C 412	Continued From page 2 residents.  The Administrator stated on 3/28/14 at 9:00 a.m. the facility was requesting a waiver of this requirement.	C 412		
C 643	02.150,01 INFECTION CONTROL  150. INFECTION CONTROL.  01. Policies and Procedures. Policies and procedures shall be written which govern the prevention, control and investigation of infections. They shall include at least: This Rule is not met as evidenced by: Please refer to F 441 as it relates to policies and procedures for infection control.	C 643	<b>C643 02.150,01,</b>  Please refer to the corrective action for federal citation F441 on page 84 of 93, of the form CMS-2567 as it relates to policies and procedures for infection control.	<b>12MAY14</b>
C 650	02.150,01,a,vii Resident Care Practices  vii. Resident care practices, i.e., catheter care, dressings, decubitus care, isolation procedures. This Rule is not met as evidenced by: Refer to F 315 as it relates to catheters.	C 650	<b>C650 02.150,01,a,vii</b>  Please refer to the corrective action for federal citation F315 on page 44 of 93, of the form CMS-2567 as it relates to catheters.	<b>12MAY14</b>
C 664	02.150,02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) meeting attendance	C 664	<b>C664 02.150,02,a</b>  Required Members of Committee  <u>Residents with the potential to be affected:</u> All residents have the potential to be affected.	<b>12MAY14</b>

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C 664	Continued From page 3  records, it was determined the facility did not ensure the Medical Director and the Pharmacist attended/participated in quarterly ICC meetings. This failure created the potential for a negative impact on all residents, staff, and visitors in the facility when ICC members were not involved in the ICC meetings. Findings included:  On 3/27/14 at 11:00 am, the surveyor interviewed the ICN [Infection Control Nurse]. When asked if the Medical Director and the Pharmacist attended the IC meetings, the ICN stated, " No." The ICN was asked to provide the attendance records of the meetings.  On 3/28/14 prior to the exit meeting at 9:40 am, the ICN provided a signature sheet for the ICC meeting dated 8/21/2013, and stated "It is the only one I have." When asked if there were any since August 2013, she stated, "No."	C 664	<u>Corrective Action:</u> The Infection Control Committee met on 4/24/14. The agenda and attendance is attached. Future meetings were scheduled.  <u>Measures to prevent recurrence:</u> The Administrator will assure that the members of the committee will attend at least quarterly.  <u>Monitoring/Assurance:</u> The Administrator will verify quarterly prior to the meetings that all required members of the committee will be in attendance. This monitoring will begin with the meeting dated 4/24/14 and continue for the entire year.	
C 729	02.154.01,a Scope, Characteristics, Standards Services  a. Assist in defining scope, characteristics, and standards for services provided; This Rule is not met as evidenced by: Refer to F 501 as it relates to the Medical Director participation on the Quality Assurance Committee..	C 729	<b>C729 02.154,01,a</b>  Please refer to the corrective action for federal citation F501 on page 89 of 93, of the form CMS-2567 as it relates to Medical Director participation on the Quality Assurance Committee.	<b>12MAY14</b>
C 731	02.154.01,c Consult/Assist Overall Management of Services  c. Consult and assist in the overall management and delivery of patient care services. This Rule is not met as evidenced by:	C 731	<b>C731 02.154,01,c</b>  Please refer to the corrective action for federal citation F501 on page 89 of 93,	<b>12MAY14</b>

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C 731	Continued From page 4 Please refer F 501 as it relates to the Medical Director of the facility.	C 731	of the form CMS-2567 as it relates to Medical Director of the facility.	
C 733	02.154,02,b Frequency of Physician Visits  b. Each skilled nursing patient shall be seen by the attending physician at least once every thirty (30) days for the first ninety (90) days following admission. Thereafter, an alternative schedule may be adopted for patient/ resident visits based on physician's determination of need, and so justified in the patient's/resident's medical record. At no time may visits exceed ninety (90) day intervals. All physicians' visits shall be recorded in the patient's/ resident's medical record, with a physician's progress note. This Rule is not met as evidenced by: Refer to F 387 as it relates to physician visits.	C 733	<b>C733 02.154,02,b</b>  Please refer to the corrective action for federal citation F387 on page 76 of 93, of the form CMS-2567 as it relates to physician visits.	<b>12MAY14</b>
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: Refer to F241 regarding dignity issues during dining.	C 784	<b>C784 02.200,03,b</b>  Please refer to the corrective action for federal citation F241 on page 5 of 93, of the form CMS-2567 as it relates to dignity issues during dining.	<b>12MAY14</b>
C 787	02.200,03,b,iii Fluid/Nutritional Intake  iii. Adequate fluid and nutritional	C 787	<b>C787 02.200,03,b,iii</b>  Please refer to the corrective action for federal citation F327 on page 53 of 93, of the form CMS-2567 as it relates to resident hydration status and adaptive equipment for eating.	<b>12MAY14</b>

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C 787	Continued From page 5  intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Refer to F327 regarding resident hydration status and adaptive equipment for eating.	C 787		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered  iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F-328 as it relates to Respiratory Care.	C 788	<b>C788 02.200,03,b,iv</b>  Please refer to the corrective action for federal citation F328 on page 63 of 93, of the form CMS-2567 as it relates to Respiratory Care.	<b>12MAY14</b>
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 see F 314 as it pertains to pressure ulcers.	C 789	<b>C789 02.200,03,b,v</b>  Please refer to the corrective action for federal citation F314 on page 18 of 93, of the form CMS-2567 as it pertains to pressure ulcers.	<b>12MAY14</b>
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders  04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following:	C 798	<b>C798 02.200,04,a</b>  Please refer to the corrective action for federal citation F332 on page 69 of 93, of the form CMS-2567 as it relates to medication errors.	<b>12MAY14</b>

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C 798	Continued From page 6  a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F 332 as it related to medication errors.	C 798		
C 823	02.201,01,d Review Narcotic and Dangerous Med Logs  d. Reviewing the narcotic and dangerous drug records at least every thirty (30) days and certifying to the administrator that this inventory is correct.  This Rule is not met as evidenced by: Please refer to F431 as it relates to controlled medications.	C 823	<b>C823 02.201,01,d</b>  Please refer to the corrective action for federal citation F431 on page 80 of 93, of the form CMS-2567 as it relates to controlled medications.	<b>12MAY14</b>