



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 1703

April 29, 2014

Joseph B. Rudd, Administrator
Apex Center
8211 Ustick Road
Boise, ID 83704-5756

FILE COPY

Provider #: 135079

Dear Mr. Rudd:

On **April 11, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Apex Center 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) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and

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return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 12, 2014**. Failure to submit an acceptable PoC by **May 12, 2014**, may result in the imposition of civil monetary penalties by **June 2, 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).

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.

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- 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **May 16, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 16, 2014**. A change in the seriousness of the deficiencies on **May 16, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 16, 2014** includes the following:

Denial of payment for new admissions effective **July 11, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 11, 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, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 11, 2014** and continue until substantial

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compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

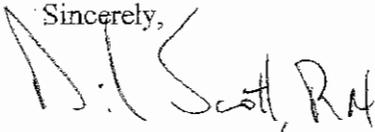
[2001-10 Long Term Care Informal Dispute Resolution Process](#)

[2001-10 IDR Request Form](#)

This request must be received by **May 12, 2014**. If your request for informal dispute resolution is received after **May 12, 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,



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

DS/dmj
Enclosures

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

PRINTED: 07/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/11/2014
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NAME OF PROVIDER OR SUPPLIER APEX CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during your annual Federal recertification and complaint investigation survey. <i>This report reflects changes resulting from the Informal Dispute Resolution (IDR) process.</i></p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Nina Sanderson, BSW, LSW Susan Goliobit, RN Lauren Hoard, RN, BSN Jana Duncan, RN, MSN Noel Mathews, MSW</p> <p>The survey team entered the facility on 4/7/14, and exited the facility on 4/11/14.</p> <p>Survey definitions: ADLs = Activities of Daily Living AFO = Ankle Foot Orthosis BLE = Bilateral Lower Extremity CGA = Contact Guard Assistance CNA = Certified Nursing Assistant C/O = Complains Of CVA = Cerebrovascular Accident H&P = History and Physical LE = Lower Extremity MAR = Medication Administration Record NG = Nasogastric OT = Occupational Therapy PRN = As needed PT = Physical Therapy Q2H = Every 2 hours qd = every day ROM = Range of Motion rt = Right R/T = Related To TAR = Treatment Administration Record</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare - Apex Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p><i>per phone conversation with admin. on 8/18/2014 @ 2:13 D.S.</i></p> <p>RECEIVED AUG - 6 2014 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>J B Kald</i>	TITLE Administrator	(X6) DATE 8 5 14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 THA = Total Hip Arthroplasty T.O. = Telephone Order UM = Unit Manager WBAT = Weight Bearing As Tolerated	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:	F 164	F164 PRIVACY AND CONFIDENTIALITY Corrective actions for residents affected: Resident #11 had their tube feeding and NG tube discontinued on 4/10/14 per orders received from resident #11's primary care physician. LSW completed a psychosocial assessment on 4/16/14 related to their tube feeding being exposed and no adverse psychosocial effects noted. Resident #21 discharged from facility on 5/4/2014. Resident #22 had a psychosocial assessment completed on 4/16/14 by a Licensed Social Worker related to being weighed in the hallway with no adverse psychosocial effects noted. Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:	5/12/14

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F 164	<p>Continued From page 2</p> <p>Based on observation, resident and staff interview, and record review it was determined the facility failed to provide privacy for residents during the administration of tube feeding, and when residents were being weighed. This was true for 1 of 15 sampled residents (#11), and 2 random residents (#s 21 and 22) sampled for privacy. The deficient practice had the potential to cause more than minimal psychosocial harm when private information regarding these residents was available for public view. Findings included:</p> <p>1. Resident #11 was admitted to the facility on 3/31/14 following a CVA.</p> <p>No MDS for Resident #11 had been completed at the time of the survey on 4/7/14.</p> <p>Resident #11's admission physician's orders documented the resident was to receive Jevity 1.2 via NG tube at 80 milliliters per hour, 22 hours per day.</p> <p>The resident's tube feeding bottle, with the contents and flow rate, was visible in public areas on the following occasions: *4/7/14 at 1:00, when the resident was sitting in the TV lounge across from the west nurse's station. The surveyor was approximately 15 feet away, and could read this information clearly. *4/8/14 at 11:20 AM, same location and circumstance, *4/8/14 at 12:00 noon, in the west dining room while working with speech therapy.</p> <p>On 4/9/14 at 6:15 PM, the Administrator, DNS, and CMO were informed of the surveyor's findings.</p>	F 164	<p>Residents with tube feedings were observed to ensure privacy was provided regarding type, and flow rate provided on or before 4/25/14 by the Director of Nursing Services and RN weekend manager. No further privacy concerns were noted. Residents were observed having weights obtained on or before 5/12/14 by members of the nurse management team with no privacy concerns noted.</p> <p>Measures and systemic changes to prevent recurrence: Staff including identified CNA, were re-educated by Nurse Practice Educator or designee on or before 5/2/14 related to providing privacy when completing weights with use of the newly added privacy screen and to ensure that tube feedings are covered when leaving their room and entering a public area.</p>	

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F 164	<p>Continued From page 3</p> <p>On 4/10/14 at 8:15 AM, Resident #11 was observed sitting in the TV lounge across from the west nurse's station. The tube feeding apparatus was covered with a pillow case, with no private information visible.</p> <p>2. On 4/7/14 at 8:15 AM, during the initial tour of the facility, a scale was observed along the left wall at the entrance of the 500 hallway, near the nurse's station. There were no walls, curtains, or other means to protect resident privacy should a resident be weighed on that scale. A similar scale was noted at the entrance to the 100 hallway.</p> <p>On 4/7/14 at 3:45 PM, Random Resident #21 was observed to be weighed by CNA #7. The surveyor was standing approximately 7 feet away. CNA #7 stated, "You weigh 270 pounds with the [wheel] chair." The read-out panel of the scale was clearly visible in the hallway, and read, "270.0" A visitor to the facility walked past the resident as this was occurring. Resident #21 did not respond. CNA #7 was asked if it was customary for the facility to weigh residents in the hallway. CNA #7 stated, "Yes, but we don't always announce the weight aloud." When asked if there were ways to protect the resident's privacy while being weighed, CNA #7 stated, "Well, if there's a resident in the room across the hallway, we can close the door to that room. But otherwise, no. There is nothing we can do." CNA #7 was asked if there was another place for the residents to be weighed which may offer more privacy for the residents. CNA #7 stated, "Well, there's another scale on the other side [aforementioned scale at the entrance to the 100 hallway], but it's no more private than this one is."</p>	F 164	<p>Monitoring Corrective Action for sustained corrections:</p> <p>Beginning the week of 5/12/14 members of the Interdisciplinary Team will complete privacy audits of weights and tube feedings for five residents x 4 weeks and then monthly for 2 months. The result of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly for three months, findings will be immediately corrected. The Licensed Social Worker will be responsible for monitoring and follow up.</p> <p style="text-align: right;">Completion date: 5/12/14</p>	

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F 164	<p>Continued From page 4</p> <p>3. On 4/10/14 at 9:15 AM, Random Resident #22 was observed to stand on the scale at the entrance to the 100 hallway. Standing 5-10 feet away, the surveyor was able to read the resident's weight as 173 pounds. After leaving the scale, the resident stated to the surveyor he liked to weigh himself every day. When asked of he was comfortable weighing in such a public setting, or if he would like more privacy, the resident stated, "Truthfully, more privacy would be nice."</p> <p>On 4/10/14 at 12:25 PM, the Administrator was informed of the surveyor's concerns with resident privacy as weights were taken. The Administrator stated, "It's been that way for 30 years, and it's never been a problem before."</p> <p>On 4/10/14 at 6:00 PM, the Administrator, DNS, CMO, and SDC were again informed of the surveyor's findings. The Administrator stated he was confident the surveyor did not have an interview with Resident #22, as that particular resident was non-interviewable. As such, the Administrator questioned how the surveyor had ascertained it was a violation of the resident's privacy to be weighed in the hallway. The Administrator also provided a typed document from LSW #8, dated 4/10/14 at 3:30 PM. LSW #8 documented Resident #22 was not embarrassed to have his weight taken in the hallway, and did not feel the need for a more private space for his weight to be taken. Both Resident #22 and LSW #8 signed the document. However, this did not resolve the surveyor's concerns regarding Resident #22's previous statements, nor regarding the protection of privacy for residents who were unable to speak for themselves.</p>	F 164	

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F 165 F 165 SS=E	Continued From page 5 483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on resident group interview, family interview, staff interview, and review of the facility's Grievance/Concern Policy, it was determined the facility failed to inform residents how they might file a grievance with the facility, nor empower residents to file a formal grievance without assistance and permission from the nursing staff. This was true for 7 of 15 residents in the resident group, and 1 Anonymous Resident. The deficient practice had the potential for more than minimal harm when residents experienced frustration with trying to make their concerns known and get resolution to their grievances with the facility, or felt they may be retaliated against for reporting grievances. Findings included: 1. On 4/8/14 at 10:40 AM, during the resident group, 7 of the 15 residents in attendance stated they had ongoing issues with grievance resolution with the facility. The residents stated they had expressed concerns verbally to various staff members, but had inconsistent results with follow-up from the facility acknowledging the concern or the resolution to the concern. The residents stated they wished there was a way they could file a grievance in writing, so they	F 165 F 165	F165 RIGHT TO FILE GRIEVANCES WITHOUT FEAR OF REPRISAL Corrective actions for residents affected: Specific residents were not identified in the citation. The Activities Department representative held a Resident council meeting on 4/22/14 and residents in attendance were re-educated on right to file grievances. No resident concerns were voiced at time of meeting. A letter to families was sent by facility administrator on May 6, 2014 notifying of grievance filing process. Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: The Sol-Oasis Program Director interviewed alert and oriented residents not in attendance of 4/22/14 resident council on or before 5/8/14 to assure they understood the process for	5/12/14

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F 165	<p>Continued From page 6</p> <p>could keep track of whom they had talked to and when. The residents stated they were not confident their concerns were passed on to facility management. The residents were asked if they had been made aware of the facility's grievance procedure when they were admitted to the facility. The group felt they may have been informed, but they had either been admitted so long ago they had forgotten, or there had been so much information discussed during the admissions process they weren't even aware of that policy. One resident stated, "All I remember is they had me sign a paper saying I wouldn't sue them."</p> <p>The facility's Grievance and Concern Policy documented, in part, "All patients and/or their representatives may voice grievances/concerns and recommendations for changes...A description of the procedure for voicing grievances/concerns will be on each unit in a prominent location...Formal grievances may be registered by telephone mail, office visit, or direct outreach to staff...Upon receipt of the grievance/concern the Grievance/Concern Form will be initiated by the staff member receiving the concern and documented on the Grievance/Concern Log...The department manager will contact the person filing the grievance to acknowledge receipt...notify the person filing the grievance of resolution within 72 hours...If grievance/concern is unable to be resolved satisfactorily, refer the patient/representative to the Regional Vice President of Operations and/or Manager of Clinical Operations for assistance..."</p> <p>Five CNAs were interviewed regarding their understanding of the facility's process for a resident who expressed ongoing issues with</p>	F 165	<p>filing a grievance. Education was provided to residents as indicated at time of review by LSW or designee.</p> <p>Measures and systemic changes to prevent recurrence: Maintenance Director put drop boxes in place on or before 5/12/14 to allow residents and their families to file grievances without notifying staff. Staff were re-educated on or before 5/2/14 by Nurse Practice Educator or designee related to grievance process including but not limited to location of the drop boxes which will allow resident to independently file grievances, assist residents with filling grievance form out as requested by resident or family and to alert members of the interdisciplinary team if residents voice concerns for additional follow up if indicated.</p>

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F 165	Continued From page 7 unresolved concerns. *CNA #10 stated they had worked at the facility for 3 years. The CNA stated the resident would be directed to take their concern to the Administrator or LSW #8 if the concern had not been resolved. The CNA stated there was no official form on which a resident could file a grievance, but, "I could help them write it on a plain piece of paper, I guess." *CNA #11 stated they had worked at the facility for one year. The CNA stated LSW #8, the Sol-Oasis Program Manager (SOPM), or the ombudsman would probably be the people who could help a resident with an ongoing grievance. CNA #11 stated they thought there was a form which could be used for a resident to file a written grievance, but if there was such a form, the resident would only be able to access it by asking the nurse, and would not be able to initiate it on their own. *CNA #12 stated LSW #8 or the SOPM could help a resident with an unresolved concern, but a resident could only access the form to file a written grievance by asking the nurse for such a form. *CNA #13 stated if a resident had an ongoing unresolved grievance, the nurse would have to be told so the nurse could decide whether or not to file a report. *CNA #14 stated if a resident had an ongoing unresolved concern they would have to let the nurse know so the nurse could decide whether or not to fill out a form. On 4/10/14 at 6:00 PM, the Administrator, DNS, CMO, and SDC were informed of the surveyor's concern with resident grievances. The Administrator stated the regulation only required the residents were able to voice grievances, so	F 165	Monitoring Corrective Action for sustained corrections: Beginning the week of 5/12/14 the LSW or designee will complete six weekly interviews for 4 weeks then six monthly for 2 months on resident and staff knowledge of the grievance process. Additionally, review of the grievance process will be completed each month in resident council for 3 months. The results of these audits will be reviewed with Quality Assurance Performance Improvement Committee monthly for three months. The Administrator will be responsible for monitoring and follow up. Completion date: 5/12/14		

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F 165	Continued From page 8 he did not feel the facility could be cited for not providing a way for the residents to file a written grievance without going through the nurse. 2. On 4/10/14 at 4:00 p.m., an anonymous resident and resident's responsible party (RP) were asked if they knew how to file a grievance with the facility. The RP stated, "Haven't heard a thing about it." When asked if the RP wanted the surveyor to request a staff member to provide them with information on the grievance process, the RP stated, "It's a double edge sword," and expressed fear that filing a grievance might cause a decrease in the level of care the anonymous resident received.	F 165	F172 ACCESS AND VISITATION RIGHTS Corrective actions for residents affected: Resident #3's was assessed for urinary incontinence on 4/17/14 by the Assistant Director of Nursing and plan of care related to incontinence was updated by Assistant Director of Nursing on 4/20/14.	
F 172 SS=D	483.10(j)(1)&(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS The resident has the right and the facility must provide immediate access to any resident by the following: Any representative of the Secretary; Any representative of the State; The resident's individual physician; The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965); The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act); The agency responsible for the protection and	F 172	RN unit manager observed plan of care related to incontinence on 5/8/14 and resident continues to receive services per plan of care without adverse effect noted at this time. Licensed Social Worker #15 and Unit Manager #3 were re-educated by facility Administrator on 5/8/14 related to surveyor's access to residents. Identifying other residents having the potential to be affected by the same deficient	5/12/14

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F 172	<p>Continued From page 9</p> <p>advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);</p> <p>Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.</p> <p>The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, it was determined the facility did not allow the survey team to observe staff caring for a resident, after the resident had been selected for sample and did not object to the surveyors observing the nature of cares provided. This was true for 1 of 15 sampled residents (Resident #3). The deficient practice had the potential to cause more than minimal harm when it could not be ascertained if the resident was offered the opportunity to have her toileting needs addressed per her plan of care. Findings included:</p> <p>Resident #3 was admitted to the facility on 11/19/13 with multiple diagnoses which included advanced dementia.</p>	F 172	<p>practice, and what corrective action will be taken: Staff members will be interviewed regarding knowledge of the right to surveyor's access residents by the Director of Nursing Services on or before 5/9/14. Re-education was provided to staff as indicated at time of interview by Director of Nursing Services or designee as required.</p> <p>Measures and systemic changes to prevent recurrence: Staff were re-educated by Nurse Practice Educator or designee on or before 5/2/14 related to surveyor's access to residents and the survey process.</p> <p>Monitoring Corrective Action for sustained corrections:</p>	

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F 172	<p>Continued From page 10</p> <p>Resident #3's most recent MDS assessment, dated 1/31/14, coded the resident was totally dependent of two persons for transfers and toilet use.</p> <p>Resident #3's care plan for incontinence, initiated on 1/25/13 and revised on 2/13/14, documented interventions of, "Prompt to toilet before and after meals," initiated 1/31/14; and, "Incontinent Program: Containment; check for wetness [before meals, after meals, at bedtime, and] on rounds during the night," initiated 11/25/13.</p> <p>On 4/8/14 at 8:25 AM, Resident #3 was observed by 2 surveyors sitting in the hallway outside her room. UM #3 approached the resident with the mechanical lift, stating she was planning to transfer the resident into bed. The surveyors asked the resident if she would be agreeable to them watching the staff in the room. The resident agreed to the observation. UM #3 then excused herself, "for a minute."</p> <p>On 4/8/14 at 8:30 AM, while waiting for UM #3 to return, LSW #15 approached the surveyors. LSW #15 stated, "You can't go in there (the resident room). She (the resident) is cognitively impaired. She can't give consent." LSW #15 then moved so as to physically place herself between the surveyors and the doorway to the resident's room. Meanwhile, UM #3 entered the room with the mechanical lift and closed the door. The survey Team Coordinator approached, and attempted to explain the survey process to LSW #15, along with surveyor observations of transfers and resident cares. LSW #15 stated, "It doesn't matter. She can't give consent. You should have called her family before you ever talked to her."</p>	F 172	<p>Beginning the week of 5/12/14 members of the Interdisciplinary Team will complete five weekly interviews for 4 weeks then five monthly for 2 months on staff's knowledge of surveyors right to access residents. The result of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly for three months. The Licensed Social Worker will be responsible for monitoring and follow up.</p> <p>Completion date: 5/12/14</p>

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F 172	Continued From page 11 On 4/8/14 at 8:40 AM, the Team Coordinator and surveyor met with the Administrator. The Administrator stated LSW #15 was a new employee to the facility, and new to long-term care, so she did not understand surveyor access to the residents. The Administrator stated he would in-service both LSW #15 and UM #3 so as to prevent further barriers. However, the Administrator's response did not resolve the concern of the surveyors being unable to assess whether or not the resident had been transferred and offered the toilet per her plan of care.	F 172	F174 RIGHT TO MAKE PRIVATE PHONE CALLS Corrective actions for residents affected: Resident #6 was notified on or before 5/9/14 by RN unit manager in regards to location of phones available for resident use and privacy available.	5/12/14
F 174 SS=E	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on individual and group interviews, the facility failed to provide reasonable access to the use of a telephone where calls could be made without being overheard. This affected 1 of 16 sampled residents (#6) and 9 of 15 residents in the group interview and had the potential for harm related to loss of self esteem due to public disclosure of personal health information.	F 174	Maintenance Director put in a phone on the 400 hall library on 4/18/14. Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: Resident council was held on 4/22/14 and residents in attendance were educated by activity staff facilitating meeting on location of telephone and if needed to ask center staff for assistance with location for private phone call. LSW completed interviews on or before 5/8/14 of residents and staff for knowledge of location	

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F 174	<p>Continued From page 12</p> <p>1. On 4/8/14 at 8:00 AM, Resident #6 was asked about privacy and phone use. The resident said, "I use the phone at the desk. It can be a problem for me because there are two guys who park there and make it hard to get to." She reported she did not have privacy when making phone calls and no other phones were available for her to use.</p> <p>2. On 4/8/14 at 10:40 AM, 9 of 15 residents in the Resident Group stated they did not have a place to make private telephone calls without being overheard by staff. The residents stated the facility had a portable phone, but it was not uncommon for that phone to be out of order. Some of the residents stated their rooms or the resident common areas were both so far from the portable phone base, that the phone lacked range for them to talk in private.</p> <p>Five CNAs were asked how they would assist a resident to make a call in private. *On 4/10/14 at 8:20 AM, CNA #10 stated there was a portable phone available to the residents, although sometimes it did not have enough range to reach the rooms at the end of the halls. CNA #10 also stated the portable phone was out of order at times, so the residents had to use the phone at the nurse's station until it could be fixed. *On 4/10/14 at 8:40 AM, CNA #11 stated there was a phone in the day room at the end of the 200 hall for the residents residing in that area of the facility to use, otherwise the residents were welcome to use the phone at the nurse's station. *On 4/10/14 at 9:45 AM, CNA #12 stated the facility had a cordless phone, and the one phone</p>	F 174	<p>of phones and resident's right to make private phone calls. Re-education was completed at time of interviews.</p> <p>Measures and systemic changes to prevent recurrence: Maintenance Director put in a phone on the 400 hall library on 4/18/14. Staff were re-educated on or before 5/2/14 by Nurse Practice Educator or designee related to placement of phone and to offer residents to use 400 hall library phone or portable phone if noted to be making public calls at the nurse's station to ensure resident's right to make private phone calls were upheld.</p> <p>Monitoring Corrective Action for sustained corrections: Beginning the week of 5/12/14 members of the Interdisciplinary Team will complete six weekly interviews for 4 weeks then six monthly</p>

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F 174	Continued From page 13 at the end of the 200 hall. However, the CNA stated for the residents she normally cared for it was not really an issue because most of them had personal cell phones. *On 4/10/14 at 10:15 AM, CNA #13 stated if a resident requested to make a phone call in private, he would help the resident look for an empty room with a phone in it. The CNA stated if he could not locate such a room, he would ask a nurse for guidance. *On 4/10/14 at 2:30 PM, CNA #14 stated as far as he knew, the residents had phones in their rooms. The CNA stated in some cases, those phones did not work and needed to be fixed. On 4/10/14 at 6:00 PM, the Administrator, DNS, CMO, and SDC were informed of the surveyor's findings. The Administrator stated the facility had a portable phone available for the residents, but did not know how far the range was for that phone. The facility offered no further information.	F 174	for 2 months on resident and staff knowledge of the locations available to make private phone calls. The results of these audits will be reviewed with Quality Assurance Performance Improvement Committee monthly for three months. The Director of Nursing Services will be responsible for monitoring and follow up. Completion date:	5/12/14
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure a resident was as free from physical restraints as possible. This was true for 2 of 4 residents (Resident #s 3 and 11) sampled for physical restraints. The deficient	F 221		5/12/14

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F 221	<p>Continued From page 14</p> <p>practice had the potential to cause more than minimal harm when residents were unable to access personal belongings, see to their personal comfort, or utilize side rails for mobility. Findings included:</p> <p>1. Resident #11 was admitted to the facility on 3/31/14 following a CVA with left sided weakness and dysphagia. Resident #11 had his nutritional needs met via an NG tube.</p> <p>At the time the survey was started, Resident #11 had not had an MDS completed.</p> <p>a. On 3/31/14 at 12:15 PM, Resident #11's Transfer Orders from the acute care hospital to the facility documented, "Mitt to be placed on [right] hand to protect NG from being pulled out. Remove mitt every 2 hours for 30 min[utes] and provide supervision..." [NOTE: Resident #11 had left sided weakness from his CVA, therefore was not able to use either his left hand or arm.]</p> <p>On 3/31/14 at 2:00 PM, a Nursing Assessment Form documented the resident was oriented to person and time; made independent, consistent, and reasonable decisions; and did not resist care.</p> <p>On 3/31/14 at 10:00 PM, Resident #11's Interdisciplinary Progress Notes (PNs) documented, "...Non-compliant [with] keeping mitt on [right] hand. Education to importance of not pulling NG tube out [and] keeping mitt on..." [NOTE: There was no documentation prior to this notation that the resident had been observed pulling on NG tube. There was no documentation as to how and why the resident was "non-compliant" with the mitt. There was no documentation as to other interventions to keep</p>	F 221	<p>F221 USE OF RESTRAINTS Corrective actions for residents affected: Resident #11 had mitt discontinued per MD order by resident #11's primary care physician on 4/10/14 following the discontinuation of their NG tube. Resident was assessed for any adverse psychosocial effects related to use of mitt by facility social worker on 4/9/14 with none noted at time of assessment. Resident #11 was assessed by the physical therapist on 4/15/14 and side rails were determined to be appropriate and safe for use. Resident #11 skin was assessed by Director of Nursing services on 5/9/14 for any skin breakdown or evidence of circulation issues with none noted. Resident #3 had their bilateral 1/2 side rails discontinued on 4/10/14.</p>

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F 221	<p>Continued From page 15</p> <p>the resident from pulling on his NG other than the mitt.]</p> <p>On 4/1/14 at 4:40 PM, Resident #11's PNs documented, "...refused mit [sic] but was not pulling at Ng [sic] tube or foley..."</p> <p>On 4/1/14 at 5:30 PM, Resident #11's PNs documented, "Resident had NG tube come out. Said it was from sneezing or coughing...resident has agreed to wear mit [sic] when family is not present."</p> <p>On 4/2/14, Resident #11's care plan documented a focus area of, "Use mitt to right hand of an external device for prevention removal of NG tube [related to] cognitive impairment." Interventions were documented as OT and PT screen and evaluation and to observe skin every shift for signs of pressure areas. On 4/3/14, interventions of, "Touch light call light," and, "Remove [every] 2 hours [with] supervision," were added. [NOTE: There were no interventions as to how to assist the resident to access personal items, such as his telephone, remote control, or eye glasses. There was no indication on the resident's care plan how long he was to be without the restraint when it was released. There was no documentation of lesser restrictive interventions having been attempted, or whether or not those interventions were successful.]</p> <p>On 4/2/14 at 3:00 AM, Resident #11's PNs documented, "...No noted pulling out of NG tube when mitt off [with] supervision as per order..."</p> <p>On 4/2/14, at an unknown time, a "Device Evaluation" form for Resident #11 documented the resident was to have a mitt to the right hand.</p>	F 221	<p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:</p> <p>The Director of Nursing has reviewed current residents with orders for mitts on 5/6/14. No other residents were utilizing mitts at time of review. A review of current residents utilizing side rails was also completed by members of the nurse management team on or before 5/10/14 to ensure that side rail use has been assessed for safety and documentation is present in chart to reflect safe use.</p> <p>Measures and systemic changes to prevent recurrence:</p>	
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F 221	<p>Continued From page 16</p> <p>The space for, "Medical necessity for use" area of the form documented, "cognition impaired pull NG tube." The area of the form to documented interventions attempted documented PT and OT referral. The question, "Have the above interventions failed?" was answered with, "No." The question, "Based on the previous failed attempts, what is the current plan?" was answered with, "New Admit."</p> <p>On 4/3/14 at 3:25 AM, Resident #11's PNs documented, "...Found res[ident] [with] mitt off hand [and] on bed by legs [and] NG tube in [right] hand. When asked what happened res[ident] said he was looking for the phone to call his son...Res[ident] stated he had been sneezing when tube came out. Res[ident] re-educated re[garding] use of mitt..." [NOTE: This was the second time the resident had reported sneezing as the cause of his NG tube coming out. However, there was no assessment from the facility regarding this as a possibility.]</p> <p>On 4/7/14 at 1:00 PM, Resident #11 was observed sitting in the day room across from the west nurse's station. He had an NG tube protruding from his left nostril. He was wearing a white cloth mitt on his right hand. The mitt was an oval shape, approximately one foot long and ten inches around. With the mitt on, the resident's fingers were encased in a mesh covering. He was unable to move his fingers independently, or to grasp with his right hand. He was unable to move his left arm or hand due the impairment on that side from his CVA. An unidentified staff member stopped, removed the mitt for less than a minute, then replaced the mitt and quickly walked away.</p> <p>On 4/7/14 at 1:10 PM, Resident #11 was</p>	F 221	<p>Staff were re-educated on or before 5/2/14 by Nurse Practice Educator or designee related to thoroughly assessing resident and documenting findings prior to the implementation of a restraint or ½ rails.</p> <p>Monitoring Corrective Action for sustained corrections: Beginning the week of 5/12/14 members of the nurse management team will complete six weekly audits for 4 weeks and monthly for 2 months on to ensure documentation of assessment for appropriate and safe use of side rails and mitts on residents prior to implementation of these devices. The results of these audits will be reviewed with Quality Assurance Performance Improvement Committee monthly for three months. The Director of Nursing Services will be responsible for monitoring and follow up.</p>	

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F 221	<p>Continued From page 17</p> <p>observed laying in his bed in his room. The mitt was in place on his right hand. His over bed table was next to the right hand side of his bed. His remote control and a flip-type cell phone were on the over bed table. The resident stated he was unable to move his left arm or hand because he had recently had a stroke, and that he had the mitt on his right hand to keep him from pulling his NG tube out. The resident was asked if he pulled at the NG tube. He stated, "No. It gets a little itchy sometimes, and when I have sneezed it has accidentally come out." The resident was asked how he would physically answer his cell phone if it rang. With his right hand encased in the mitt, the resident fumbled to grasp the phone for a few seconds, then looked at the surveyors and shrugged.</p> <p>On 4/7/14 at 2:00 PM, the resident was observed again laying in his bed in his room. The television was on, with a rerun of an old sitcom playing. The resident was asked if he enjoyed that program. The resident stated, "No. It's stupid." The resident was asked if he could change the station to something he liked. Again, with his right hand encased in the mitt, the resident fumbled to grasp the remote control for a few minutes, then shrugged and stated, "That's just what they put on. They'll come back in a little while and I'll have them change it."</p> <p>On 4/8/14 at 3:30 AM, Resident #11's PNs documented, "...Staff continues to place mitt on [right hand]. Res[ident] is noncompliant with keeping it on..." [NOTE: There was no documentation as to whether or not the resident was observed to be pulling at his NG tube when the mitt was off.]</p>	F 221	<p>Completion date:</p>	<p>5/12/14</p>

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F 221	<p>Continued From page 18</p> <p>On 4/8/14 at 7:45 AM, Resident #11 was observed laying in his bed, wearing a hospital gown. The white mitt was in place on his right hand. His over bed table was next to his bed on the right side, with his eye glasses and cell phone on it. The resident appeared frustrated, and stated, "My wife has called four times this morning, and I haven't been able to answer the phone." The resident then fumbled to pick up his eye glasses from the table. He was unable to grasp them, and asked for assistance to put them on, stating, "I like to see who I'm talking to." The resident then looked at the mitt on his hand and stated, "It pinches around the wrist a little," and began to repeatedly flick his wrist with a fair amount of force, stating, "Maybe I can get it off."</p> <p>On 4/8/14 at 10:05 AM, Resident #11 was observed in bed, watching television. The resident was asked if he enjoyed the program he was watching. The resident stated, "No." The resident was asked how he could tell what else was on, and change the channel. The resident groped around the top of the overbed table with his mitted hand for several seconds. He then looked at his nightstand, approximately 3 feet away, where the TV channel list and his remote control were located. The resident asked for the channel list to be handed to him so he could select a more preferable program, but was unable to grasp the list with his hand encased in the mitt.</p> <p>On 4/8/14 at 10:45 AM, Resident #11's PNs documented, "...Spoke [with] resident about phones remote in relationship to staff assist he stated they have offer [sic] to change channel [and] help [with] phone spoke [with] staff [and] have been offering assist's [sic]."</p>	F 221		

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F 221	<p>Continued From page 19</p> <p>On 4/8/14 at 2:45 PM, Resident #11 was observed in his room, laying in bed. The mitt was in place on his right hand. The resident was attempting to scratch his head behind his right ear, using his right hand. With the mitt in place, the resident was only able to rub the mitt over the general area. The resident stated, "I wonder why my head itches so bad. They don't rinse the soap out," while his attempts at scratching became more animated. The surveyor asked the resident how he was able to scratch without using his fingers. The resident took his hand away from his head, looked at it, shrugged, then returned to the rubbing/scratching motion.</p> <p>On 4/9/14 at 10:20 AM, Resident #11 was observed sitting in his room in his wheelchair, watching television. The resident welcomed the surveyors into the room, holding up his right hand, which was in the mitt, and swinging his arm through the air. The resident stated, "Can you take this thing off? My circulation's not too good." The resident began flicking his right hand with a forceful motion, attempting to dislodge the mitt without success. The surveyors left the room to alert staff to the resident's request, and returned approximately a minute later with UM #3. UM #3 stated the resident had the mitt off at breakfast time to work with therapy, which she thought was about 9:00 AM, stating, "He's only had it on an hour and a half or so," Resident #11 stated, "It's irritating. It itches." UM #3 then removed the mitt and examined the skin underneath it. No issues were noted with the resident's skin. The resident immediately began flexing his fingers. UM #3 was asked how the resident would access personal items, or address an itch, with the mitt in place. UM #3 stated, "We're between a rock and a hard</p>	F 221		

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F 221	<p>Continued From page 20</p> <p>place. He has pulled his feeding tube out twice." The surveyors asked UM #3 if the resident had actually been observed to pull out the tube, and whether or not the facility would have investigated the resident's statements of the tube coming out via sneezing. UM #3 stated it was possible the facility had created an incident report to investigate further, but she could not be sure.</p> <p>On 4/9/14 at 12:42 PM, Resident #11's PNs documented, "Psychosocial Assessment...Res[ident] states he likes the mit [sic] at times, takes the mit [sic] off himself...asked res[ident] to show how he removes the mit [sic]. Res[ident] shakes his hand until mit [sic] becomes loose and tosses it off...res[ident] was asked if he can utilize his remote he states he can but will call for assistance if needed [sic]...contacted res[ident]'s spouse who states she wants the mit [sic] and signed off for res[ident] to use the mit[sic]. ..."</p> <p>On 4/9/14 at 3:50 PM, the DNS and CMO were asked about the mitt for Resident #11. The DNS stated the mitt had been ordered on admission to the facility, as the resident had pulled the NG tube out in the hospital. The DNS was asked if the mitt had been re-assessed as necessary upon admission to the facility. The DNS stated it was, and offered the Device Evaluation form dated 4/2/14. [NOTE: The resident had been admitted to the facility on 3/31/14.] The DNS was asked about the circumstances under which the feeding tube had become dislodged in the facility. The DNS stated on the first occasion, the resident had been in his room with his family, was not wearing the mitt, and inadvertently swiped at his face. The DNS could not explain how the added bulk of the mitt would have prevented this instance from</p>	F 221		
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F 221	<p>Continued From page 21</p> <p>occurring. The DNS stated on the second occasion, the resident was found without his mitt, so the facility assumed he had removed his mitt and pulled out the tube. The DNS was asked if anyone had seen the resident pull at the tube. The DNS stated, "No." The DNS was asked if the facility had investigated the resident's statements that the tube came out from sneezing. The DNS stated, "No."</p> <p>On 4/9/14 at 5:45 PM, Resident #11's PNs documented, "After shower resident began sneezing and coughing and about 6 [inches] of the NG tube came out through his nose..."</p> <p>Resident #11 was restrained when his one functional hand was placed in a mitt, preventing him from accessing his personal belongings and addressing his personal comfort. The facility did not re-assess the necessity of this device upon admission, nor develop lesser restrictive alternatives to the use of the restraint. The facility stated the mitt was in place to prevent the resident from pulling out his NG tube, without investigating the root cause of the NG tube becoming dislodged.</p> <p>b. Resident #11's All Active Orders (Recapitulation Orders) for March 2014 documented, "1/2 side rail X 2 for bed enabler."</p> <p>On 4/1/14, a facility "Device Evaluation" form for Resident #11's 1/2 side rails documented: **"N/A" (Not applicable) for range of motion limitations for his hands, arms, legs, and feet, including those on his left side affected by his CVA. **"Impaired balance" and "Leans to the left side." **"Patient has no purposeful movement that is</p>	F 221	

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F 221	<p>Continued From page 22</p> <p>impeded by side rail use." **If side rails are in use, they are considered to be a positioning device." **"Interventions Attempted to Date" were documented as, "PT/OT referral." **"Have the above interventions failed?" was documented as, "No." **"Based on the previous failed attempts, what is the current plan?" was documented as, "New Admit." **"Can patient self release the device on command?" was answered as, "Yes." **"Medical necessity for use:" was documented as, "improve bed mobility." **"When is device used?" was documented as, "at all times."</p> <p>Resident #11 was observed laying in his bed with 1/2 side rails up on 4/7/14 at 2:00 PM, 4/8/14 at 7:45 AM, 8:10 AM, 10:05 AM, and 2:45 PM.</p> <p>On 4/7/14 at 2:00 PM, Resident #11 was asked why he had the side rails in place. Resident #11 stated, "I don't know. To move with?" The resident was asked, but unable to demonstrate, how he would use the rails to move.</p> <p>On 4/8/14 at 2:45 PM, Resident #11 was asked to demonstrate how he would self-release the side rails if he decided he did not want them up. The resident moved his mitted right hand from under the covers, fumbled at the right side rail for a moment, then stated, "I know enough to stay away from those. I'll get my neck caught or break my leg off. Don't worry about those. I know enough to stay away from those."</p> <p>On 4/9/14 at 3:50 PM, the DNS, CMO, and UM #3 were interviewed about the side rail use for</p>	F 221		

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F 221	<p>Continued From page 23</p> <p>Resident #11. UM #3 stated the side rails were used when staff came into the room to assist the resident with bed mobility. UM #3 stated the side rails were left in the "up" position even when the staff was not present because the resident would be encouraged to use them on his own. The DNS, CMO, and UM #3 were informed of the resident's statements regarding entrapment and injury, as well as the resident's inability to demonstrate he could self-release them, as documented on the side rail assessment. The DNS stated it was mis-coded that the resident could self-release the side rail, as the facility was aware he would be unable to do so. The DNS stated the facility normally placed a sticker on the consent form stating side rails were safe for the resident, but was unable to describe the process by which safety would be assessed. The DNS was asked for a copy of the consent form with the safety sticker, but the form was not provided.</p> <p>On 4/10/14 at 6:00 PM, the Administrator, DNS, CMO, and SDC were informed of the surveyor's findings. The facility offered no further information regarding mitt or the side rails for Resident #11.</p> <p>2. Resident #3 was admitted to the facility on 11/19/13 with multiple diagnoses including advanced dementia and acute on chronic systolic heart failure. The resident was later diagnosed with a chronic right clavicle fracture, pre-dating her admission to the facility.</p> <p>Resident #3's most recent quarterly MDS assessment, dated 1/31/14, coded: *BIMS of 4, indicating severely impaired cognition; *Extensive assistance of 2 required for bed</p>	F 221			

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F 221	Continued From page 24 mobility. Resident #3's "All Active Orders" (Recapitulation Orders) for April 2014 documented, "Bilateral 1/2 side rails to assist with bed mobility," dated 11/19/13. On 4/8/14 at 1:10 PM, the surveyor observed Resident #3 to be repositioned in bed by CNA #13 and CNA #16. CNA #16 cued, and attempted to assist, Resident #3 to use her side rails to turn side to side in bed while she was positioned. The resident would hold tightly onto CNA #16's hands and arms, but did not grasp either side rail even with cues and assistance.	F 221		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, it was determined the facility failed to provide residents with the opportunity to make choices regarding aspects of their care important to them. This was true for 1 random resident	F 242		5/12/14

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F 242	<p>Continued From page 25</p> <p>(#19), of 12 residents sampled for resident choice. The deficient practice had the potential to cause more than minimal harm if experienced weight loss when served food and beverages they did not like. Findings included:</p> <p>2. Random Resident #19 was admitted to the facility on 10/28/13 with multiple diagnoses.</p> <p>Resident #19's most recent quarterly MDS assessment, dated 2/18/14 documented the resident was cognitively intact with a BIMS of 15.</p> <p>A Food Preference Questionnaire, dated 12/3/13 for Resident #19 documented the resident preferred chocolate milk or chocolate health shakes.</p> <p>A Food Preference Questionnaire, dated 1/14/14 for Resident #19 documented the resident wanted yogurt for breakfast.</p> <p>A Diet Order and Communication Form for Resident #19, dated 1/15/14, documented the resident wanted yogurt at breakfast, cottage cheese at lunch and extra fruit. The form also documented the resident did not like pancakes, waffles or stuffing.</p> <p>On 4/7/14 at 8:50 a.m., during initial tour, Resident #19 was sitting up in bed with her breakfast tray setting on top of her bedside table which was over her lap. A carton of strawberry milk was on the breakfast tray. The resident expressed concern she was receiving a different resident's food requests because she had recently moved to her current room. A meal paper to pick food items for the following meals was</p>	F 242	<p>F242 RESIDENT PREFERENCE</p> <p>Corrective Actions for Residents Affected; Resident #19 had her meal preferences and room number updated on the tray card on 4/23/14 by the facility's Dietary Manager. Resident #19 was observed receiving her meal preferences on 4/29/14 by the facility's Assistant Director of Nursing Services.</p> <p>Identifying other residents having the potential to be affected, and what corrective action will be taken; Members of the nurse management team completed a review of the facility's dining rooms to assure resident's meal preferences were provided on 4/29/14. Director of Nursing completed a review of tray cards to ensure room numbers were current on 5/12/14.</p> <p>Measures and systemic changes to prevent reoccurrence;</p>

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F 242	<p>Continued From page 26</p> <p>placed on her breakfast tray. The bottom of the paper had Resident #19's last name and the room number 606. [Note: Resident #19 no longer resided in room 606.] The resident said, "I don't like strawberry milk," and added she told the facility multiple times but nothing had changed. As the surveyor exited the room CNA #16 entered the resident's room and asked if the resident wanted something else to eat. The resident requested yogurt and the CNA said the facility did not have any yogurt.</p> <p>On 4/8/14 at 1:55 p.m., Resident #19 said she received strawberry milk again, sausage and french toast, all of which she did not like. The resident stated, "I like vanilla, I like chocolate, I do not like strawberry."</p> <p>On 4/9/14 at 12:21 p.m., the Food Services Supervisor (FSS) was asked how residents let her know about food preferences. She said she visits with residents about food likes and dislikes and keeps a log book. The FSS was also asked if she carried yogurt and she stated, "I always have yogurt on hand."</p> <p>On 4/9/14 at 12:40 p.m., when asked how she knows about resident room changes, she said she hears about them via email, from Social service or at stand-up meetings, and added she tried to see new admits within the first 24-48 hours. The FSS was informed Resident #19 had concerns with meals.</p> <p>Interdisciplinary Progress Notes written by the FSS for Resident #19, dated 4/9/14, documented, "Visited with Resident [and] up-date request at breakfast. Will continue to follow/visit resident [and] meet request as possible."</p>	F 242	<p>Staff were re-educated on or before 5/2/14 by the facility's nurse practice educator on honoring resident's preferences of food likes and dislikes, current room number on tray card and to notify center kitchen staff when served a dislike item.</p> <p>Monitoring Corrective Actions for sustained corrections;</p> <p>Members of the interdisciplinary team will complete five audits each week for 2 weeks, 3 times weekly for an additional 2 weeks then 1 time weekly for 8 weeks to assure resident meal preferences are honored and room number is current beginning the week of 5/12/14. The results of these audits will be reviewed in the center's quality assurance and performance improvement committee monthly for three months. The facility's Dietary Manager will be responsible for monitoring and follow up.</p> <p>Completion date: 5/12/14</p>	

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F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and record review the facility failed to revise care plans for 5 of 18 (1, 4, 5, 6, 10) sampled residents and to ensure 1 of 18 (#6) sampled residents, and 9 of 15 residents in the group meeting, were invited to participate in planning of their care and treatments, or changes in their</p>	F 280		5/12/14

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F 280	Continued From page 28 care or treatment. The deficient practice had the potential to cause more than minimal harm when: -Resident #1 was care planned to have 1:1 assist with meals, and was not revised when the resident no longer needed assist with meals; -Resident #4 was care planned for the use of a brace, which the resident did not use in the facility; -Resident #5 had developed a pressure sore and Protective boots were not implemented on the care plan when the physician ordered them; -Resident #6 had interventions on the care plan that had been discontinued and the care plan had not been revised when the changes occurred. The resident was not invited to her care conferences; -Resident #10 was on a antipsychotic medication, with no behaviors or interventions care planned; -9 of 15 resident's in the resident group meeting stated they were not aware of care planning meetings and had not been invited to attend the meetings. Findings included: 1. Resident #5 was admitted to the facility on 5/29/13 with diagnoses that included, hemiplegia cerebrovascular disease, dementia with Lewy bodies, UTI [urinary tract infection], muscle weakness(generalized). The resident's care plan documented: *Focus: "Potential for unavoidable skin breakdown related to: decline with mobility, episodes of B&B [Bowel and Bladder] incontinence, decline in cognition related to Lewy Body Dementia, poor nutritional status, noncompliance, preferred body positioning by resident-Blood blister to right heel with debridement on 1-8-2014 to reveal unstageable pressure ulcer." Date Initiated: 5/30/13 Revision	F 280	F280 CARE PLANS Corrective Actions for Residents Affected; Resident #1 had their care plan updated on 4/20/14 by Director of Nursing Services to reflect independence with dining after set-up. Resident #4 had their care plan updated on 4/14/14 by RN Unit Manager discontinuing the use of the ankle foot orthotic. Resident #5 had their care plan updated on 4/20/14 by the Director of Nursing Services regarding the use of bilateral heel protector boots. Resident #6 had their care plan updated on 4/14/14 by RN unit manager to reflect current fall interventions. Resident #10 had their behavior care plan updated on 5/8/14 by Licensed Social Worker to include specific behaviors monitored and non-drug interventions for behavior management.		

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Continued From page 29
on: 1/21/14.
*Interventions:
-"Elevate heels off of bed with pillows as resident allows." Date Initiated 5/30/13 Revision on: 1/17/14
-"Use draw sheet for lifting and repositioning." Date Initiated: 5/30/13.
-"Assist to turn and reposition as needed." Date Initiated: 5/30/13.
-"Pressure reducing/relieving devices as ordered." Date Initiated: 5/30/13.
-"Weekly skin assessment." Date Initiated: 5/30/13.

*MD order: 12/23/13, Change in patient status / purpose of fax: "Blood blister to [right] heel. Iodine [and] optifoam until resolved?" Physician order/response: "Ok- elevate heels in bed, foot/heel protectors"
*Note: The new order for foot/heel protectors [both heels] had not been added to the care plan.

The resident's Significant change MDS dated 1/8/14, documented significant change in:
*BIMS: 8, cognition moderately impaired.
*Unhealed Pressure ulcer Stage 1 or higher: Yes.
*Number of unstageable pressure ulcers due to coverage of wound bed by slough and / or eschar: Unstageable: Deep tissue, 1.
*Pressure ulcer length: 6.0 cm [centimeter].
*Pressure ulcer width: 7.5 cm.
*Pressure ulcer depth: [blank]
*Skin and Ulcer treatment: Check all that apply;
A. Pressure reducing device for chair. B. Pressure reducing device for bed.

On 4/9/14 at 9:17 am, the surveyor met with the DON and CMO. The surveyor asked if the boots were on the care plan, she stated, "They are not,

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Resident #6 was invited to a care conference on 4/14/14 by Licensed Social Worker and attended care conference. Residents were educated during resident council on 4/22/14 by facility's Activity Assistant regarding care conferences. No concerns were voiced by residents during resident council meeting.

Identifying other residents having the potential to be affected, and what corrective action will be taken:
A review of the last 90 days of quarterly assessments was completed by Licensed Social Worker on 4/29/14 to assure care conferences were held. Care conferences were scheduled by licensed social worker as indicated at time of review. Members of the nurse management team completed a review of current residents' care plans on or before 5/10/14 and care plans were updated accordingly to reflect current interventions and resident status

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F 280	<p>Continued From page 30</p> <p>I already checked it." The surveyor asked the DON and MCO if the 'Assist to turn and reposition as needed,' on the care plan should have parameters, as the resident was at risk for pressure ulcers, the DON and MCO did not respond.</p> <p>2. Resident #10 was readmitted to the facility on 3/24/14 from the hospital with diagnoses that included depressive disorder, and psychosis unspecified.</p> <p>The resident's Significant change MDS dated 3/31/14 documented in part: *BIMS score: 12- Cognition moderately impaired. *Signs and Symptoms of delirium: Disorganized thinking- Behavior present, fluctuates. *Potential indicators of Psychosis: Delusions. *Active diagnosis: Unspecified paranoid state. *Medication received: Antipsychotic- Given 7 out of 7 days. *Care Area Assessment Summary triggered: Psychotropic drug use- Care planning decision was marked to be completed.</p> <p>The Physician Progress note dated 3/28/14 documented in part: *Assessment and Plan: "The patient with a diagnosis of psychotic disorder, unspecified, depressive disorder. Is currently on sertraline 75 mg and Risperdal 0.5 mg at bedtime daily. Benefits outweigh the risks. The patient's psychotic symptoms are quite severe and involve visual hallucinations, persecutory delusions, I suspect the patient has underlying advanced dementia also and follow up as needed. Staff is to use nondrug strategies to manage the patient's agitation."</p>	F 280	<p>Measures and systemic changes to prevent reoccurrence; Nurse Managers, Licensed Social Workers, and Sol-Oasis Program Director were re-educated on 5/9/14 by the facility's Director of Nursing Services regarding inviting residents and family to care conference reviews and to document invitations in the medical record. Members of the interdisciplinary team who participate in care planning were re-educated related to updating care plans on or before 5/10/14 by the Director of Nursing Services.</p> <p>Monitoring Corrective Actions for sustained corrections;</p> <p>Members of the nurse management team will complete 12 care plan audits each week for 1 month then 12 care plan audits monthly for two months to assure care plans are current for resident beginning the week of</p>

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F 280	<p>Continued From page 31</p> <p>The resident's Care Plan documented in part: *Focus: "I am currently utilizing drugs that have an altering effect on the mind related to my history of depression and anxiety." Date Initiated: 8/1/13 Revision on: 8/1/13 *Interventions: -"My medications will be evaluated for their effectiveness and side effects for possible decrease/elimination of psychotropic drugs." Date initiated: 8/1/13 -"My mood and behaviors will be observed and monitored for my medications effectiveness." Date Initiated: 8/1/13. *Focus: "Risk for falls related to: use of psychotropic medications, impaired balance, pain, generalized weakness." Date Initiated: 7/31/13. *Interventions: -"Evaluate effectiveness and monitor for side effects of psychotropic drugs." Date Initiated: 7/31/13 NOTE: The care plan did not address the behaviors, or side effects that were to be monitored, which were pertinent to the resident. The care plan did not provide nondrug interventions, as the physician documented would be used for agitation, in his progress note dated 3/28/14. The care plan had not been updated since returning from the hospital, and the significant change MDS was completed on 3/31/14.</p> <p>On 4/10/14 at 3:30 pm, the surveyor asked the DON and Administrator for the care plan on behaviors for the resident, the DON stated, "It's not on there," and she asked, "Is there a delirium care plan?"</p> <p>On 4/11/14 at 9:00 am, the DON provided</p>	F 280	<p>5/12/14. Licensed Social Worker will complete one time weekly audits to correlate with the MDS schedule for scheduling care conferences for 1 month then monthly for two months to assure care conference is held and resident is invited to attend. The results of these audits will be reviewed in the center's quality assurance and performance improvement Committee monthly for three months. The Director of Nursing Services will be responsible for monitoring and follow up.</p> <p>Completion date: 5/12/14</p>

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F 280	<p>Continued From page 32</p> <p>documentation for benefits outweigh the risk, for the use of Risperdal and nurse notes. The surveyor asked for the documentation that monitored the behaviors and the behavior care plan and she stated, "The only care plan there is, is on delirium and not on behaviors, so I am not going there."</p> <p>On 4/10/14 at 6:00 pm the Administrator, DON and the MCO were informed of the findings. No additional information was provided.</p> <p>3. Resident #1 was admitted to the facility on 9/10/13 with multiple diagnoses which included dysphasia and dementia with behavioral disturbance.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 1/28/14, documented in part:</p> <ul style="list-style-type: none"> * Severely impaired cognition with a BIMS of 4; * Limited assistance needed with 1 person for eating; * No signs and symptoms of possible swallowing disorder; and, * On a mechanically altered diet. <p>The April 2014 recapitulated Physician's Orders for Resident #1 documented, "Texture: Dysphagia Advance." Ordered on 11/4/13.</p> <p>Resident #1's Care Plan documented in part:</p> <ul style="list-style-type: none"> * Focus - Self Care Deficit cognitive impairment, Hx [history] of fracture, impaired coordination, pain, physical limitations." Initiated on 9/10/13 and revised on 12/24/13; and, * Interventions - "Provided 1:1 [one on one] assist while eating and drinking." Initiated on 9/10/13. <p>The surveyor observed Resident #1 during meals on:</p>	F 280		

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F 280	<p>Continued From page 33</p> <p>* 4/8/14 at 7:57 a.m., the resident was sitting in her wheelchair at a table in the East side dining room. Breakfast had been served and the resident was eating her meal independently; and,</p> <p>* 4/8/14 at 12:23 p.m., the resident was sitting in her wheelchair at a table in the East side dining room. The lunch meal had been served and the resident was eating independently.</p> <p>On 4/10/14 at 9:10 a.m., the DON was asked what assistance Resident #1 needed for eating. She stated the resident, "Needs to have setup and cueing," and added the resident might need encouragement if she was not eating. The surveyor showed the DON Resident #1's Care Plan which instructed staff to provide 1:1 assistance with meals. The DON stated, "That should have been dc'd [discontinued] from the Care Plan." The DON was informed of the meal observations of Resident #1 eating independently. No further information was provided.</p> <p>4. Resident #6 was admitted to the facility on 3/17/05 and readmitted on 12/28/11, with multiple diagnoses including CHF (congestive heart failure) and Depression.</p> <p>The 4/18/13 significant change MDS coded the resident:</p> <ul style="list-style-type: none"> -was cognitively intact; -required no assistance with bed mobility and transfers; -required 1 staff member to assist with dressing and bathing; and -had no falls since prior assessment. <p>The 1/8/14 quarterly MDS coded the resident:</p> <ul style="list-style-type: none"> -had severely impaired cognitive skills; -required no assistance with bed mobility or 	F 280		

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F 280	<p>Continued From page 34</p> <p>transfers; -required 2 or more staff members to assist with dressing and bathing; and -had no falls since prior assessment.</p> <p>The resident's Care Plan printed 3/25/14, had the focus area, "I am a fall risk, Potential for Injury related to: Polypharmacy use of psychotropic medication weakness impaired mobility, impaired safety awareness requires assist of staff with all basic/mobility ADLS to level indicated," was initiated on 11/11/09, and revised on 1/21/14. The goal was: "to be assessed if fall occurs." Interventions include in part: "-Pressure alarm to bed to increase safety awareness, Initiated 5/26/2012; -Tag alarm while in w/c [wheelchair] to increase safety awareness, Initiated 6/11/12; and -[Resident] prefers to remain in bed in her room, Initiated on 5/14/10 and revised on 8/11/10. "</p> <p>On 4/7/14 at 12:55 PM, Resident #6 was observed sitting in a wheelchair in her room. She was dressed, wearing white socks and sweater with sweat pants. There was no tag alarm on her wheelchair or pressure alarm on her bed. The resident was observed multiple times on 4/7/14, 4/8/14, and 4/9/14, and did not have a tag alarm on her chair or pressure alarm on her bed. Additionally, the resident was observed in her wheelchair in her room, hallway, and dining room multiple times on 4/7/14, 4/8/14, and 4/9/14.</p> <p>On 4/10/14, the facility provided another care plan printed 1/21/14, which documented the same care plan as listed above but with the following changes: "-Pressure alarm to bed to increase safety awareness, Initiated 5/26/2012," with a line</p>	F 280		
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F 280	<p>Continued From page 35</p> <p>written through the statement and hand written "D/C [discontinue] 5/8/13 order," with initials circled;</p> <p>- "Tag alarm while in w/c to increase safety awareness, Initiated 6/11/12;" A line written through the statement and hand written "D/C 5/8/13 order," with initials circled; and</p> <p>- "[Resident] prefers to remain in bed in her room, Initiated on 5/14/10 and revised on 8/11/10." A line was crossed over this statement with hand written "D/C" next to the text.</p> <p>On 4/10/14 at 9:30 AM, the DON was interviewed regarding care plans and the changes noted when a second copy was received from the facility. When asked about the resident's care plan recent hand written changes, the DON said, "I don't know when the care plan was updated. The order was done and the resident's care plan was not updated. I'm unsure of the time lapse." When asked who usually updates care plans, the DON said, "The nurse manager, the [Unit Manager Name], or the assistant director. Sometimes the floor nurses update the care plans too." When asked how the staff know how to appropriately take care of residents when the care plans aren't updated, she said the staff or CNA's use ADL [activity of daily living] care cards. When asked if Resident #6 was in need of fall interventions that were care planned, the DON said, "No, she has gone roughly 14 months without a fall."</p> <p>Similar findings for Resident #4. Resident #4's Care Plan documented she was supposed to wear an AFO on her right ankle. The resident did not have an AFO, nor did she have a Physician's order to wear an AFO.</p>	F 280	

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F 280	<p>Continued From page 36</p> <p>On 4/8/14 at approximately 8:00 AM, Resident #6 was interviewed. When questioned regarding care planning meetings or meeting held by the facility to discuss her care and progress she reported she had not been invited to attend meetings held by the facility about her care.</p> <p>On 4/11/14 at approximately 8:30 AM, The following typed note was received from the facility: "Statement: [Resident #6] Date: April 11, 2014 Time: 0806 I [Resident #6] had a care conference with [Staff member #8] and my [family member]. During the care conference we discussed a living will in which [staff member #3] assisted me in making one through the legal aide website. I did not understand what a care conference was. I am not an attorney and don't always know what I am being asked. I think people just put what they want to put. It was never explained to me what a care conference was." This document was signed by Resident #6, Staff member #8, and Staff member #17.</p> <p>No further documentation regarding care conferences was provided about when this care conference was held, whether an interdisciplinary team was present, or what was discussed during the conference.</p> <p>5. On 4/8/14 at 10:40 AM, 9 of 15 residents in the resident group stated they were unaware the facility held care meetings to discuss each residents' care plan. The residents stated they had not been invited to attend these meetings, were not aware the facility had a care plan for each of them, and had not had the opportunity to</p>	F 280		

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F 280	<p>Continued From page 37</p> <p>have input on their care plans. Of the 9 residents who spoke out about this, all said they would like to attend those meetings and/or have input on the development of their care plans.</p> <p>On 4/8/14 at 4:30 PM, the facility was asked for their policy and procedure for resident care plans, along with documentation of resident input into care plan development.</p> <p>On 4/9/14 at 9:30 AM, the facility provided a policy for Care Plans, effective 6/1/01, revised on 3/1/14. The policy documented, in part, "...Purpose...to promote participation pf the patient/Health Care Decision Maker (HCDM) in planning care. Practice Standards...Ensure patient/HCDM is notified of care plan date...Provide update to patient/HCDM if he/she is unable to attend and document in Progress Note..." When asked for further documentation, the Administrator stated the typical process was for one of the social workers to contact the resident's family to arrange a time when the family could attend a care conference, then let the resident know if it was appropriate for the resident to attend. However, the Administrator did not believe that would be documented anywhere in the resident record.</p> <p>On 4/9/14 at 6:00 PM, the Administrator, DNS, CMO, and SDC were informed of the surveyors concerns. The facility offered no further information.</p> <p>6. Resident #4 was admitted to the facility with multiple diagnoses to include, Epilepsy, muscle weakness, and hemiplegia.</p> <p>The resident's most recent Quarterly MDS, dated 12/14/13, documented the following information:</p>	F 280		

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F 280	<p>Continued From page 38</p> <ul style="list-style-type: none"> - Cognitively intact with a BIMS of 14; - Extensive assist of two people with bed mobility, transfers, dressing, toilet use, and bathing; and - Functional limitation in range of motion for upper and lower extremity. <p>The resident's Self Care Care Plan and Pain Care Plan initiated on 9/10/2013 and revised on 4/3/14 documented the following:</p> <ul style="list-style-type: none"> - Self Care Care Plan, initiated on 4/3/14, Apply splint to rt (right) ankle as resident will allow. - Pain Care Plan, initiated on 4/13/14, Apply splint/brace to rt (right) ankle. <p>On 4/7/14, 4/8/14, 4/9/14, and 4/10/14, the resident was observed to be up in her wheel chair without an splint on her right ankle.</p> <p>On 4/9/14, at 2:45 PM, the resident was interviewed about wearing a splint. The resident stated she was suppose to have an AFO for her right ankle, but doesn't have one. She stated she used to wear the splint all the time before she came to the facility. She said she felt like if she had the AFO brace it would help her be able to walk. The surveyor asked the resident if she had brought it to the staffs attention and she said she had, but, "The facility would make up some excuse about not having it."</p> <p>On 4/10/14, at 3:53 AM, UM #25 was interviewed related to the resident's missing splint. The UM stated she was unable to find a physician's order for the AFO and the resident never came in with an AFO. She stated the AFO should not have been put on the Care Plan. The UM stated she felt like the AFO would be beneficial for the resident and she would be checking with therapy.</p>	F 280			

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F 309 F 309 SS=D	Continued From page 39 483.25 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, medical record review, staff and resident interview, it was determined the facility failed to: - Ensure a resident who had an order for geri-sleeves was wearing them; and - Ensure a resident received an increased dose of a medication for three days after the order was received. This was true for 2 of 11 (#4 and #8) sampled residents. This failed practice had the potential for more than minimal harm if Resident #4 had elevated ammonia levels and Resident #8 developed skin tears. 1. Resident #4 was admitted to the facility with multiple diagnoses to include, Epilepsy, muscle weakness, anxiety, depression, and hemiplegia. The resident's all active orders for March 2014 documented, Lactulose 45 ml Solution by mouth q day for elevated ammonia levels. On 3/25/14, a faxed communication was sent to the physician related to the resident's elevated ammonia levels.	F 309 F 309	F309 SERVICES TO MAINTAIN HIGHEST PRACTICABLE WELL-BEING Corrective actions for residents affected: Resident #4 had an ammonia level drawn on 4/15/14 with results indicating improvement per Nurse Practitioner. Resident #8 was observed with long sleeves in place by RN unit manager on 4/14/14. Resident #8's order for geri-sleeves was clarified to include as she allows on 5/9/14 by RN Unit Manager. Resident #8's care plan updated by Director of Nursing Services on 4/20/14 for long sleeves or geri-sleeves as the resident allows. Resident #8's skin remains intact to bilateral upper extremities as of 5/12/14. Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:	5/12/14

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F 309	<p>Continued From page 40</p> <p>On 3/26/14, the facility received communication back from the physician with the following new order, "Lactulose to be increased to 30 mls BID, for elevated ammonia levels with a repeat ammonia level to be drawn in 1 week.</p> <p>On 3/31/14, a faxed communication was sent to the physician which indicated the Pt did not start the increased Lactulose dose on 3/26/14. The increased dose was not started until 3/29/14, or 3 days after the order was received.</p> <p>On 4/11/14, at 11:05 AM, UM #25 was interviewed. The UM stated the Lactulose dose prior to 3/26/14 was 45 mls qd (everyday). The surveyor asked the UM when the dose increase to 30 mls bid (twice daily) was suppose to take place. The UM stated it was suppose to be on 3/26/14, but did not happen until 3/29/14. The UM was asked why the increased dose was not give to the resident on 3/26/14. The UM stated the order was in PCC (Point Click Care) but did not get transcribed correctly to the MAR.</p> <p>No further information was provided by the facility to resolve this issue.</p> <p>2. Resident #8 was admitted to the facility on 3/6/13 with multiple diagnoses which included dementia, syncope and muscle weakness.</p> <p>Resident #8's most recent significant change MDS assessment, dated 2/5/14, documented in part: * Severely impaired cognition with a BIMS of 2; and, * Extensive assistance needed with 1 person for</p>	F 309	<p>Nurse managers completed a review of new orders for the last 30 days to assure orders implemented and transcribed correctly to the medication/treatment administration record on or before 4/30/14. No corrections needed at time of review. Residents were observed with geri-sleeves as ordered in place during rounds on or before 5/10/14 by Director of Nursing Services.</p> <p>Measures and systemic changes to prevent recurrence: Staff were re-educated by Nurse Practice Educator or designee on or before 5/2/14 related to following MD orders and ensuring that orders are transcribed to medication/treatment administration record correctly. In addition, to notify MD if a resident refuses treatments and to update care plan as indicated by refusals or resident</p>	

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F 309	<p>Continued From page 41</p> <p>bed mobility, transfers, dressing, eating, personal hygiene, bathing and toilet use.</p> <p>April 2014 recapitulated Physician's Orders for Resident #8 documented in part, "Geri-sleeves to BUE [bilateral upper extremities] when wearing short sleeved shirts. - Night Shift, Day Shift Everyday." Order date 3/28/14.</p> <p>Resident #8's Care Plan documented in part: * Focus - "Potential for skin breakdown related to: Dx [diagnosis] of DM [diabetes mellitus] with insulin, advanced age requiring assist with ADLS [activities of daily living]." Date initiated 3/11/13 and revised on 4/7/14; and, * Interventions - "Geri-sleeves to bilateral upper extremities with short sleeve shirts." Date initiated 3/28/14.</p> <p>An April 2014 Treatment Administration Record for Resident #8 documented, "Geri-sleeves to BUE when wearing short sleeved shirts" was completed from 4/1/14 to 4/8/14.</p> <p>The surveyor made the following observations of Resident #8: * 4/8/14 at 8:04 a.m., resident was sitting in the wheelchair in her room wearing a pink short sleeve shirt with no geri-sleeves; * 4/8/14 at 12:03 p.m., resident was lying on top of her bed wearing the pink short sleeve shirt with no geri-sleeves; and, * 4/9/14 at 8:45 a.m., resident was sitting in the wheelchair in her room wearing a pink short sleeve shirt with no geri-sleeves.</p> <p>On 4/9/14 at 8:58 a.m., the DON was asked if Resident #8 was to wear geri-sleeves. She stated, "If she agrees to wear them, as she</p>	F 309	<p>preferences as ordered.</p> <p>Monitoring Corrective Action for sustained corrections: Beginning the week of 5/12/14 members of the nurse management team will complete five audits per week for 4 weeks then once weekly for 2 months related to medication orders being accurately transcribed to the medication/treatment administration records to ensure implementation of orders. In addition members of the nurse management team will complete audits three times a week for 4 weeks and then once weekly for 2 months to ensure geri-sleeves are in place as ordered. The result of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly for three months. The Director of Nursing Services will be responsible for</p>

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F 309	Continued From page 42 allows." When asked if the "as she allows" was on the Physician's order the DON said it should be on the Care Plan. After having the DON review the Care Plan she was asked if it was there and she stated, "No." The DON was asked why the resident needed to wear geri-sleeves she stated the resident, "Had a skin tear." The DON was informed of the observations of Resident #8 wearing a short sleeve shirt with no geri-sleeves. No further information was provided.	F 309	monitoring and follow up.		
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, record review, and staff and resident interview, it was determined the facility failed to provide necessary care for residents at risk for developing pressure ulcers. This was the case for 2 of 4 (#2 & #5) sampled residents reviewed for pressure ulcers. The deficient practice caused harm to Resident #5 when the facility failed to implement interventions to prevent the resident from developing a stage III pressure ulcer to his right heel. Resident #2 did not have a pressure reducing cushion in his wheelchair as care planned. Findings Include:	F 314	Completion date:	5/12/14	5/12/14

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F 314	<p>Continued From page 43</p> <p>1. Resident #5 was admitted to the facility on 5/29/13 with diagnoses that included, hemiplegia cerebrovascular disease, dementia with Lewy Body dementia, a urinary tract infection, and generalized muscle weakness.</p> <p>The resident's Quarterly MDS dated 11/18/13, documented: *BIMS score: 12, cognition moderately impaired. *Rejection of cares: No, behavior not exhibited *Bed mobility, transfers, dressing, toilet use, personal hygiene and bathing - Extensive 1 person assist for *Eating: Independent set up only. *Functional limitation in Range of Motion: Upper extremity, impairment on one side. Lower extremity, impairment on one side. *Urinary continence: Occasionally incontinent. *Bowel continence: Frequently incontinent. *Risk of Pressure Ulcers: Yes *Unhealed pressure ulcer- Stage 1 or higher: No.</p> <p>The resident's Significant Change MDS dated 1/8/14, was the same with the following exceptions: *BIMS: 8, cognition moderately impaired. *Bed mobility, transfers, dressing and toilet use: Total 2 person assist. *Personal Hygiene: Limited 1 person assist. *Urinary continence: Frequently incontinent. *Bowel continence: Always incontinent. *Unhealed Pressure ulcer Stage 1 or higher: Yes. *Number of unstageable pressure ulcers ... 1. *Pressure ulcer length: 6.0 cm [centimeter]. *Pressure ulcer width: 7.5 cm. *Pressure ulcer depth: [blank] *Skin and Ulcer treatment: Check all that apply; A. Pressure reducing device for chair. B.</p>	F 314	<p>F314 WOUNDS Corrective actions for residents affected: Resident # 2 was observed with their wheelchair cushion in place by RN Unit Manager on 4/14/14. Resident #2's wounds were assessed and measured by facility wound RN on 4/23/14 and indicated healthy tissue without signs or symptoms of infection. Resident #2 was also educated about the importance of keeping wheel chair cushion in place by the facility wound's RN on 4/23/14. Resident #2 was seen by facility's wound nurse practitioner on 4/30/14 and was educated on the importance of pressure relief. Resident #2's care plan was updated to check for cushion placement by Director of Nursing Services on 5/12/14.</p> <p>Resident #5 wound was reassessed and measured on 4/23/14 by facility's wound RN and noted healthy tissue</p>	

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F 314	<p>Continued From page 44 Pressure reducing device for bed. C. Turning/ repositioning program was not checked as implemented.</p> <p>The resident's Braden scale- For Predicting Pressure Sore Risk documented: -10/3/13: 19, "Mild Risk: Total score 15-18." -1/19/14: 13, "Moderate Risk: Total score 13-14." -1/30/14: 17, "Mild risk."</p> <p>The resident's care plan documented: *Focus: "Potential for unavoidable skin breakdown...Blood blister to right heel with debridement on 1-8-2014 to reveal unstageable pressure ulcer." *Interventions: -"Elevate heels off of bed with pillows as resident allows." Initiated 5/30/13 Revised 1/17/14. -"Use draw sheet for lifting and repositioning." Initiated 5/30/13 -"Assist to turn and reposition as needed." Initiated 5/30/13 -"Pressure reducing/relieving devices as ordered." Initiated 5/30/13 -"Weekly skin assessment." Initiated 5/30/13 -"OT [Occupational therapy] eval[uate] and treat related to decreased PO[by mouth] intake and need for built up utensils." Initiated 11/8/13 -"OT recommends use of built up utensils to promote self-feeding [and] [increase] nutritional intake." Initiated 11/25/13 -"NP [Nurse Practitioner] notified of ADL decline - new order for labs." Initiated 12/9/13 -"Treatment of UTI causing increased confusion and behaviors." Initiated 12/11/13 -"MD ordered treatments to pressure ulcer right heel." Initiated 1/8/14</p> <p>*Focus: "Self Care Deficit ... " *Interventions:</p>	F 314	<p>without signs and symptoms of infection. Resident #5 continues to utilize pressure reducing mattress to his bed as well as boots to his feet to ensure pressure is reduced. A new nutritional assessment was completed on 5/9/14 by center registered dietician. No nutritional concerns were noted at time of assessment. Resident #5 received education by RN unit manager on 5/9/14 to ensure he keeps his boots on feet to promote wound healing and decrease pressure. Resident #5 activities of daily living flow sheets were also reviewed by Director of Nursing Services on or before 4/30/14 and care plan updated at time of review. Resident #12 was discharged from the facility on 4/10/14.</p> <p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:</p>	

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F 314	<p>Continued From page 45</p> <p>- "Adjust level of care according to individual needs and report persistent changes to physician and family." Initiated 7/26/13</p> <p>- "Nonslip footwear when OOB [out of bed]." Initiated 10/25/13 "To L[left] foot until ulcer resolved [and] boot removed." The second section of this intervention was hand written and did not have an initiation date.</p> <p>- "Res.[ident] may not always be able to make needs known staff to anticipate and meet his needs." Initiated 10/25/13</p> <p>- " W/c[wheelchair] as primary means of locomotion on and off the unit self/staff propelled." Initiated 10/25/13</p> <p>* Focus: "I have potential for chronic/progressive decline ..."</p> <p>*Interventions: - "Use verbal and physical prompts so that I will be able to remember what to do when asked." Initiated/Revised 5/30/13</p> <p>*Focus: "Risk for falls ..."</p> <p>*Interventions: - "Concave mattress to define edge of bed." Initiated: 10/6/13</p> <p>*Focus: "Alteration in Skin Integrity r/t: Foot ulcer."</p> <p>*Interventions: (All initiated 2/21/14) - "Administer medications as ordered." - "Weekly wound measurements." - "Daily foot care and observe for s/s [signs and symptoms] of infection." - "Inspect and monitor feet for redness, edema, open area or injury. Report any abnormal findings to physician." - "Monitor for s/s of pain and administer pain medication as ordered."</p>	F 314	<p>Members of nurse management updated resident's Braden scale to assess risk for skin breakdown related to changes in mobility and updated care plans accordingly on or before 4/25/14. Licensed Nurses completed skin assessments of residents on 5/6/14 to identify any skin issues. No pressure areas were noted on skin assessments of current residents. Members of the Interdisciplinary Team reviewed resident's wheelchair cushion use on or before 4/25/14 to ensure placement as ordered. No corrections needed at time of review. Wound RN completed a review to ensure current residents with pressure wounds were being monitored weekly on or before 5/12/14.</p> <p>Measures and systemic changes to prevent recurrence:</p>	
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F 314	<p>Continued From page 46</p> <p>-"Weekly skin assessment per protocol."</p> <p>*Focus: "Potential for decline with ambulation." *Interventions: -"FYI:[for your information] wound on lateral aspect right heel. When working with res[ident] take heel cushion off and put grip sock on right foot and shoe on left." Initiated 2/21/14</p> <p>Behavior Monthly Flow Sheets for November 2013 through March 2014 documented the resident had a few behaviors related to throwing things, being " jittery " and threatening to leave in November with no behaviors exhibited after that. The flow sheets did not identify or track any behaviors related to the refusal of care.</p> <p>The resident's TAR [treatment administration record] dated November, December 2013, January, February, and March 2014, documented the resident was provided: *Float heels with pillows while in bed. Start date: 5/29/13.</p> <p>The Interdisciplinary Team notes [IDT], Nurse Practitioner Wound Clinic [NPWC], facility Skin Nurse Skin Integrity report [SNIR], SN IDT note, MD orders, Resident's TAR, Labs, documented:</p> <p>*IDT Notes from 9/1/13 through 12/4/13 noted no significant change in condition related to edema, complaints of pain, the presence of wounds, etc. A 10/12/13 night shift note documented the resident had a " pressure reducing device for bed " which was not identified and the resident was " not " on a turning schedule.</p> <p>*IDT: 12/7/13 Nsg, "Res[ident] [with] some weakness this AM when being assisted out of</p>	F 314	<p>Staff were re-educated on or before 5/2/14 by Nurse Practice Educator or designee related to ensuring pressuring reducing measures are in place for residents as ordered and to ensure that residents with wounds have a skin integrity report initiated including measurements with weekly follow up until wound is resolved per policy and the need to review CP for resident with changes of condition to assess for possible additional measures to promote skin integrity</p> <p>Monitoring Corrective Action for sustained corrections: Beginning the week of 5/12/14 members of the nurse management team will complete once weekly audits for 4 weeks then monthly for 2 months on residents with changes of condition warranting changes in plan of care related to skin and that pressure wounds are being monitored weekly until healed.</p>

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F 314

Continued From page 47
bed[~~crossed out~~] chair. 2 CNA's were attempting to stand res[~~ident~~], who is usually a 1 person assist. CNA's were unable to hold all of resident's wt.[~~weight~~] [and] he had to be lowered to the floor. [No] injuries occurred."

*IDT: 12/8/13 4:35 am Nsg, "Staff states res. [increase] in confusion. Example: Resident was attempting to bite plate and eat it at dinnertime. Staff also state Resident has had a great change in strength; no longer able to assist him one person transfers. Will cont. to monitor."

*IDT: 12/8/13 5:00 pm Nsg, "140/90, R[~~respirations~~]-24, P[~~pulse~~]-92, T[~~temperature~~]-99.9, O2 [oxygen saturation] 96% RA [room air]. PERRLA [pupils equal, round, reactive, light accommodation], [heart] RRR [regular, rate and rhythm], Lungs diminished [at] bases, B.S.[~~bowel sounds~~] x 4, abd[~~abdomen~~] soft non tender, Resident 'Shivering and unable to warm up,' notified N.P. of [change] of condition,... N/O[~~new order~~] CXR [chest xray], CBC [complete blood count], CMP [comprehensive metabolic panel] and ammonia.

*IDT: 12/9/13 5:00 am Nsg, "...T 99.6... Labs drawn, except UA[urine analysis] not obtained. Attempted to arouse resident, would not awaken. Resident has been asleep since 1900[7:00 pm]. Will attempt to obtain UA again. Cont. to monitor for [changes] in condition."

A change in condition was noted; however, the care plan was not modified to address these changes including a plan for more frequent repositioning

*NP visit: 12/9/13, "Following up with the patient

F 314

Additionally members of the Interdisciplinary Team will complete six audits weekly for 1 month then monthly for 2 months related to wheelchair cushions being in place and in use per plan of care. The results of these audits will be reviewed with Quality Assurance Performance Improvement Committee monthly for three months. The Director of Nursing Services will be responsible for monitoring and follow up.

Completion date:

5/12/14

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F 314	<p>Continued From page 48</p> <p>who over the weekend had a change in condition. He exhibited some increased confusion and generalized weakness, had to be helped lowered to the floor. He did have fever and some diminished breath sounds. Chest xray was obtained, negative for any pneumonia or pneumothorax. We did obtain also some blood work which shows slightly elevated white count at 12.9 and elevated ammonia at 46. In speaking with [resident] today, he notes that he is feeling ill, just kind of crummy, but nothing specific. He did have a slight headache. He is not necessarily having any trouble breathing or pain anywhere. His appetite has been slightly poor over the last few days. He just wants to stay in bed. His wife is at his side, has not noticed any specific changes other than just not feeling well."</p> <p>*Examination:</p> <p>-General: "The patient is lying in bed. He is alert and makes eye contact to answer questions, but generally seems sedate. Appears in no physical distress."</p> <p>Musculoskeletal: "No edema to lower extremities."</p> <p>*Assessment and Plan: "Fever, very mild at 99." "Concern is for an infection. Will go ahead and get a urine sample, rule out urinary tract infection. He has had some generalized weakness and confusion. We have safety measures in place to ensure that he does not fall and with the elevated ammonia level will go ahead and start him on some Lactulose."</p> <p>*IDT: 12/9/13 3:00 pm Nsg, "N/O start Lactulose 30 ml[milliliter] Q.D. [every day], CBC, CMP, ammonia 12/13/13."</p> <p>*IDT: 12/11/13 2:30 am Nsg, "T-98.1 O2 91% P-90 R-18 BP[blood pressure] 138/72. No</p>	F 314		

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F 314	<p>Continued From page 49</p> <p>adverse effects to Lactulose noted. Res. was alert but confused per baseline.</p> <p>*IDT: 12/11/13 2:30 pm Nsg, "98, 126/80, 73, 18, 93% RA [No] s/sx[sign/symptoms] ADR [adverse drug reaction] to lactulose. Res very tired this shift, [increase] weakness requiring more assistance from staff ... No anxiety, agitation noted...</p> <p>*IDT notes for 12/12-21/13 documented the resident continued on antibiotics for a UTI and spent time in bed in the afternoon and slept through the night. Neither the notes nor the care plan address how often he is repositioned. Nor do the notes address any redness or bogginess of the heel prior to 12/23/13.</p> <p>*IDT: 12/23/13 5:45 am, Nsg, "[No] latent s/s of ADR to Abx for UTI. Iodine [and] optifoam applied to [right] heel for Blood Blister, will cont. to monitor for changes. resident has had [no] c/o pain/discomfort [with urination r/t UTI."</p> <p>*MD order: 12/23/13, Change in patient status / purpose of fax: "Blood blister to [right] heel. Iodine [and] optifoam until resolved?" Physician order/response: "Ok- elevate heels in bed, foot/heel protectors"</p> <p>The order did not give parameters for frequency of the dressing change. The new order for foot/heel protectors [both heels] had not been added to the care plan. During the survey the resident was observed with a heel protector on the right foot not on the left foot (see observation below).</p> <p>*IDT: 12/25/13 4:20 am, Nsg, "Dsg [changed] to</p>	F 314		

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F 314	<p>Continued From page 50 [right] heel as per order."</p> <p>The 12/25 IDT note was the first note after the blood blister was documented on 12/23 at 5:45 am, which was approximately 48 hours later. The IDT note did not document an assessment to the right heel for 12/24.</p> <p>*TAR: The resident's December TAR documented a 15 pound (#) weight loss. The resident weighed 261# on 12/23 and 246# on 12/30/13. The TAR documented skin checks done on the night shift with skin intact on 12/3, 12/10, and 12/17 and not intact on 12/24.</p> <p>*NP: 1/6/14, "Did have a change in condition with regards to an infection. This was treated. He has recovered quite nicely. He does have an ulceration on his right heel from a blister that popped. This is healing nicely. Followed by our nursing staff and wound care team. In speaking with [resident's name] today, he notes that he is doing well. He is not having pain anywhere except for on his heel when he hits it just right. Denies any trouble breathing, that his appetite has been excellent. He thinks he has lost about four pounds which he is okay with."</p> <p>*Examination: Musculoskeletal- "No edema to lower extremities. Right lower extremity with wound wrapping in place and Prevaion boot."</p> <p>*The IDT notes did not document the status of the resident, or the wound from 12/25 to 1/7/14. The NP documented the wound was healing nicely; however, there was no evidence that it was measured or assessed to identify if it had gotten better or worse.</p> <p>*SNIR: Initial Date: "1/8/14"</p>	F 314		

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F 314	<p>Continued From page 51</p> <p>-Initial Status: "IHA" [In house acquired].</p> <p>-Stage: "U" [Unstageable].</p> <p>-Circle Primary Type of Wound: "Pressure"</p> <p>*SN IDT: 1/8/14 12:00 pm, Nsg, "Wound note. Res seen by wound team for [right] heel. Wound measuring 6 cm x 7.5 cm [with] min[imal] SS[erosanguinous] drainage. Wound NP debrided eschar tissue. Wound bed is 20% eschar [and] 80% dermus [with] healthy wound edges [and] healthy surrounding tissues. D/C current treatment orders, start clean [with] wound cleanser, apply Santyl to eschar tissue only, and cover [with] a foam dressing to entire wound daily. Wound team will cont. to follow.</p> <p>This is the first documentation of the size of the wound which measured 6 cm x 7.5 cm, 12 days after the wound was first documented on 12/23, and the first time the SN had documented on it with the NPWC. The treatment which was initially ordered on 12/23/13, and not clarified as to how often the dressing was to be changed, was changed on the first visit of the NPWC.</p> <p>*NPWC: 1/8/14, Chief Complaint: "Right lower extremity deep tissue injury." Subjective: "He now has developed a deep tissue injury to his right lower extremity... Once it was noted that he had a deep tissue injury, they have attempted to utilize a Prevalon boot. The patient has apparently refused that as well. Today he has an area of eschar at this right heel and some necrotic callus. Extremities: "The patient's right heel has an area of concern that measures 6.0x 7.5 cm x surface. It is about 10% eschar and 90% necrotic callus. There is no obvious open area. The periwound area is clean, dry and intact. There is no discharge."</p>	F 314		

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F 314	<p>Continued From page 52</p> <p>-Plan: "Unfortunately, the patients dietary issues combined with his history of dementia makes him high risk for developing wounds such as these. Due to some refusal of offloading, his poor intake and his inability to comply with positioning, this wound was unavoidable. I do believe we can heal this quite nicely and in fact I utilized a 5 mm [millimeter] curet to remove much of this callus. I did get into some bleeding subcutaneous tissue but the majority of the tissue that I see is still dermal tissue. I was able to remove some surface eschar from a small area; however, much of that eschar still remains. We will utilize Santyl to the eschar area, cover the remainder of the wound area and try to keep a moist wound healing environment. I spoke with the patient at length regarding offloading and diet issues. Recommend we use Prevalon boots and keep his heel floated at all times. The patient reports his understanding. We will continue to work with him and follow him weekly and p.r.n."</p> <p>The NPWC documented the resident, "apparently has refused to have heels floated." However, there was no evidence of this in the medical record and the care plan did not address refusals or attempts to find an alternative if the resident did refuse to have his heels floated.</p> <p>*NPWC: 1/14/14, Objective : Extremities: "Right heel wound laterally measures 3.2 x 2.1 x 0.2, it is 100% eschar. Periwound area is clean, dry and intact. there is no periwound erythema or induration. there is mild amount of discharge, no odor." Plan: "Continue to offload, continued to treat with Santyl."</p> <p>*MD order: 1/15/14: Change in patient status/ purpose of fax: "Res has an order to ensure res</p>	F 314		

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F 314	<p>Continued From page 53</p> <p>walks to meals. Res. does not amb[ulate] [at] this time d/t [due to] decline/weakness. Also has a wound to [right] heel [and] is non wt[weight] bearing [at] this time. May we d/c [discontinue]? Thanks!" Physician order/ response: "OK."</p> <p>The facility obtained an order to discontinue the resident's walking program to meals, due to his decline and was non weight bearing due to the pressure ulcer he had acquired in December.</p> <p>*IDT: 1/17/14 2:20 pm, Nsg, " Res. frequently crosses legs [at] ankles and prefers this positioning. Floating heels has been done [with] resident [and] frequently he reverts back to crossing legs. Res. utilizing prevalon boot currently. N.O.[new order] PT/OT eval [and treat] received this wk [week] to promote strength. Res. has been unable to participate in walk to dine d/t physical inability. Spouse frequently brings snacks to res. and reminds him to [not] cross legs."</p> <p>*NPWC: 1/22/14, Subjective: " ...developed a heel ulcer due to some confusion and inability to offload himself. Once this area was discovered, we have had excellent progress in healing this. It has been offloaded appropriately with the Prevalon boot with aggressive wound care. The patient has improved dramatically. There was 1 large wound that is now down to 2 smaller wounds. There is no fever or chills." Extremities: His left heel wound is now 2. The medial wound is 2 x 1 x essentially less than 0.51 with 100% granulation tissue. Periwound area is new epithelium. The lateral wound is 1.5 x 2.4 x essentially surface. It is very thin loose slough. Periwound area is new epithelium. there is mild amount of serosanguineous drainage, no odor."</p>	F 314		

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F 314	<p>Continued From page 54</p> <p>With the treatment and the use of the Prevalon boot, which was implemented after the pressure ulcer developed, the wound was noted to be healing. The NPWC documented the wound to be the left heel, with no other documentation of left. Documentation had been on the right heel, prior to and after this.</p> <p>*NPWC: 2/12/14, Objective: Extremities: Right lateral heel has a wound that measures 2 x 2 x 0.3, 95% slough in the wound bed, 5% granulation tissue. Periwound area is slightly macerated." Assessment: "Pressure ulcer of the right heel, unstageable." Plan: "Likely this will be a Stage III." I recommend we continue offloading with Prevalon boots and monitor him weekly."</p> <p>*NPWC: 2/26/14, Objective: Extremities: "The patient has mild lower extremity edema. His right heel wound measures 1.8 x 1.6 x 0.5. It is 100% slough in wound bed." Plan: "Due to the amount of slough in the wound bed, I did elect to sharply debride. Postdebridement measurement is 1.8 x 1.6 x 0.5."</p> <p>*IDT: 2/26/14 3:00 am, Nsg, "Res. Found sitting on floor at 0015." 1/2 bilateral side rails and non-skid socks were in place at time of fall. Note: It was documented that the resident had non-skid socks in place, not Prevalon boots.</p> <p>*NPWC: 3/5/14, Objective: Extremities: "Right heel lateral aspect wound measures 1.7 x 1.0 x 0.2. Wound bed is 50% granulation, 50% adherent slough. " Assessment: "Right heel pressure ulcer, unstageable." Office Progress Note: Plan: "Recommend we change this from Iodosorb to Maxorb AG to the wound bed, cover</p>	F 314		

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F 314	<p>Continued From page 55</p> <p>dressing and continue to offload as we have with Prevalon boot and frequent turning due to his improvement in his overall condition. We are reversing his change in condition to reverse the unavoidable, as I stated previously, he is improving and he is continuing to heal nicely... "</p> <p>*NPWC: 3/26/14, Subjective: "[Resident's name] has a stage 3 pressure ulcer. It has historically been improving over the last few weeks; however, we are having some moisture balance issues today. It is a little bit damp with some maceration." Objective: Extremities: "His right lateral heel wound measures 1.5 x 2 x 0.4, 20% granulation tissue in the wound bed."</p> <p>On 4/7/14 at 1:35 pm, the surveyor observed the resident seated in his w/c beside his bed. The resident had a blue boot on the right foot and the left foot had a black shoe on it.</p> <p>On 4/7/14 at 2:05 pm, the surveyor observed the resident in bed. The resident had a blue boot on the right foot and the left foot had a beige colored anti-skid sock on it.</p> <p>The resident's heels were not floated and the left foot did not have a heel protector.</p> <p>On 4/8/14 at 8:00 am, the surveyor observed the resident in bed, on his back. The resident's right foot had a blue boot on it. The left foot was bare, and both heels were directly rested on the bed. The resident was asked how he thought he had gotten the sore on his right heel. The resident stated, "I don't know, they say it was from crossing my leg and putting pressure on it. It hurts when I walk on it, so I don't walk on it as much. It's healing from the inside out." The resident was asked how often the dressing was</p>	F 314		
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F 314	<p>Continued From page 56</p> <p>changed and if the boot bothered him and he replied, "Once a day. No it doesn't bother me." The surveyor clarified with the resident why he only had 1 boot on the right foot and asked him if it would bother him to have a boot on both feet, the resident answered, "Nope." CNA #11 and CNA #18 provided morning cares for the resident. When the boot was removed from the right foot the heel had a dressing in place. CNA #11 attempted to put the resident's beige non-skid socks on his feet and stated, "This sock is too tight I am going to get a little bit bigger one." CNA #11 left the room and returned with a pair of gray non-skid socks, which were put on the resident, with a blue boot to the right foot and a black shoe to the left foot.</p> <p>On 4/8/14 at 10:35 am and 11:15 am, the surveyor observed the resident seated in his w/c in his room. The resident's right foot had a blue boot on it and the left foot had a black shoe on it.</p> <p>On 4/8/14 at 12:40 pm, the surveyor asked LN #20 what he knew about the development of the pressure sore to the resident's right foot. The LN stated, "I don't know much about it. I worked the night shift til 3 weeks ago. From what I have seen it looks like it is getting better. They have changed the dressings because it was too wet. He doesn't complain about pain when I ask him."</p> <p>On 4/8/14 at 2:02 pm and 3:00 pm, the surveyor observed the resident in bed on his back, with the blue boot on the right foot and a gray non-skid sock on the left foot. The heels were directly on the bed.</p> <p>On 4/8/14 at 3:10 pm, the surveyor asked the SN if the MD order for the resident's heel protectors</p>	F 314		

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F 314	<p>Continued From page 57</p> <p>were for 1 boot or for 2, she stated, "I think there should be orders for both." The surveyor and the SN observed the resident in bed. The SN verified both feet were on the bed, with the blue boot on the right foot and the gray nonskid sock on the left foot. The SN stated, "I thought the left should be floated. I will have to look." The SN was asked if she thought it was ok that the feet were not floated as ordered, and she stated, "No, they should be floated, both of them." The SN checked the resident's TAR and stated, "He has an order for heels to be floated." The SN was asked by the surveyor, what would that be, and she replied, "Pillows, we use pillows so they are floated and not touching the bed."</p> <p>On 4/9/14 at 8:42 am, the surveyor observed the resident seated in his w/c by the nurses station. The right foot had a blue boot on and the left foot had a black shoe on it. The surveyor asked the resident how his foot was, he stated, "Not too bad today. They are going to come and change it today." The surveyor stated that's good and the resident stated, "Yeah, will be good to get this boot off and a shoe on so I can walk some."</p> <p>On 4/9/14 at 9:17 am, the surveyor met with the DON and CMO. The surveyor asked them what interventions had been put in place to prevent skin breakdown when the resident became acutely ill in December. The DON stated, "We noticed a decline starting in November. He had difficulty with self-feeding. He was moved to an assist table. His wife came in to help feed him and brought him food." The surveyor asked how did you change the physical care of the resident when you identified he had begun to decline? The DON and MCO did not respond. The CMO and DON were asked why the resident had 1 blue</p>	F 314		
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F 314	<p>Continued From page 58</p> <p>boot instead of 2, and the DON stated, "I don't know if at one point he had 2 boots." The surveyor asked if the boots were on the care plan, she stated, "They are not, I already checked it." The surveyor asked about the resident's rejection of cares and no behaviors since November, and the DON stated, "He is definitely doing a lot better." The DON and MCO were asked about the care plan that stated "as needed" for repositioning, the DON and MCO did not respond. The surveyor asked why the care plan related to offload heels was written for, 'as the resident allows', the DON stated it was because, "He moves his feet."</p> <p>On 4/9/14 at 9:45 am, surveyor observed LN #22 change the dressing to the resident's right heel. The LN asked the resident if he was having pain, the resident stated, "No." The left foot had a gray nonskid sock on and was floated on a folded pillow under the left ankle. The right foot had a blue boot on and was directly on the bed. The right heel did not have a dressing on it, LN#22 stated, "It fell off in the shower this morning." The LN was asked what she thought might have caused the pressure ulcer and stated, "It was the way he was resting it on his foot pedal."</p> <p>On 4/9/14 at 2:25 pm, 3:15 pm and 4:52 pm the surveyor observed the resident seated in his w/c with his right foot in a blue boot and the left foot had a black shoe on it.</p> <p>On 4/9/14 at 3:00 pm, the DON stated to the surveyor, "We are still looking at [resident's name], the regulations and the guidelines. We recognized the decline. I don't feel it happened in December. His bed mobility did not change, they are still providing assist." The surveyor stated the</p>	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2014
NAME OF PROVIDER OR SUPPLIER APEX CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704		
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F 314	<p>Continued From page 59</p> <p>concerns of the skin breakdown prevention, not being care planned, or changed when the decline occurred, whether in October or in December when he became acutely ill. The surveyor asked the DON, what new interventions for the skin do you have, the DON did not respond.</p> <p>On 4/10/14 at 8:57 am, the surveyor observed the resident in bed, eating breakfast. The resident had blue boots on both feet, with a pillow under his feet, with the heels directly on the pillow, not floated. The surveyor asked the resident how he liked the new boots, and he stated, "Wonderful, that heel will get better."</p> <p>On 4/10/14 at 9:10 am, the surveyor and the DON went into the resident's room and observed the resident's heels. The DON agreed the resident's heels were on the pillow and not floated.</p> <p>On 4/10/14 at 3:55 pm, 2 surveyors met with the Administrator, DON and CMO. The Administrator presented the timeline of the resident from admission to the facility. During the presentation the Administrator stated the resident was "Placed on a multi-layer Visco mattress when he was admitted." The surveyor asked about the intervention of the mattress being changed to a concave mattress d/t to falls in October. The DON stated "I am sure he is on one of our new facility mattresses." The Administrator stated, "From May 2013 through December 2013 the resident went without skin issues. During his entire medical stay his conditions have fluctuated d/t multiple comorbidities. There were no changes made directly to his plan of care related to his decline as it was not needed during the first</p>	F 314		

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F 314	<p>Continued From page 60</p> <p>part of December." The surveyor asked, at what point during a resident's decline do you start to make changes on a care plan, and the MCO stated, "So you are looking for a physical intervention, because I think there was a lot of medical interventions." The MCO stated, "He[resident] even told me that he moves his feet too much to float his heels with a pillow. How can it be pressure in bed if he is moving his feet." The surveyor stated, if he is constantly moving his feet maybe there is an element of friction, and the CMO stated, "I thought friction doesn't count for pressure sores."</p> <p>The facility identified the resident had a decline in his meal intake in November 2013 and implemented built up utensils. In December 2013 the resident had declines in ADL's with increase confusion and behaviors and the development of a UTi. The resident's care plan for skin break breakdown which was initiated when the resident was admitted was not revised until 1/17/14, which was 17 days after the resident developed the pressure ulcer. The care plan did not document changes in interventions to accommodate the resident's decline, or any refusals, to protect the resident's skin from breakdown. The Care plan's intervention of turn and reposition, initiated 5/30/13, had no parameters and had not been implemented, per staff documentation on 10/12/13 and the MDS's dated 11/18/13 and 1/8/14. The record did not document the resident had been informed of the possible consequences of skin breakdown when interventions were refused, prior to the NPWC discussion with him on 1/8/14, which was after the development of the pressure ulcer on 12/23/13. Observations at the time of the survey revealed the resident's heels were not consistently floated and the left foot did</p>	F 314		
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F 314	<p>Continued From page 61 not have a heel protector as ordered on 12/23/13.</p> <p>2. Resident #12 was admitted to the facility on 7/22/13 and readmitted on 3/11/14 with multiple diagnoses which included anoxic brain damage, diabetes and muscular wasting.</p> <p>Resident #12's most recent quarterly MDS assessment, dated 3/23/14, documented in part: * Intact cognition with a BIMS of 13; * Extensive assistance needed with 1 person for bed mobility, transfers, eating, personal hygiene and bathing; * Totally dependent with 1 person for toilet use and locomotion on and off the unit; * At risk for pressure ulcers; and, * One stage 2 pressure ulcer present upon admission.</p> <p>March 2014 recapitulated Physician's Orders for Resident #12 documented in part: * "Float heels with pillows in bed as resident allows;" * "Pressure reducing mattress to bed;" * "Pressure-redistribution cushion to chair;" * "Repositioning, showering and lying down education by LN to resident every shift. - Night Shift, Day Shift Everyday;" * "Skin at risk assessment-Check skin completely. Is skin intact? Y/N [Yes/No] - Day Shift Specific days of week: Wed[nesday];" and, * "WOUND TO LEFT COCCYX. CLEAN WITH WOUND CLEANSER AND APPLY FOAM DRSG Q [Dressing every] 3 DAYS. - Night Shift Everyday."</p> <p>Resident #12's March 2014 Care Plan documented in part: * Focus - "Resident has impaired skin integrity r/t</p>	F 314		

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F 314	<p>Continued From page 62</p> <p>[related to] pressure ulcer to coccyx secondary to: nutritional deficit, immobility, non-compliance with therapeutic regime;" and,</p> <p>* Interventions - "...Document on flow sheet: mark "Y" [Yes] - skin intact. Mark "N" [No] - skin not intact; Monitor healing process and notify MD and responsible party if no improvement. Change treatment as indicated; Weekly skin assessments and measure pressure ulcers."</p> <p>A Nursing Assessment form completed on 3/11/14 documented on a body diagram Resident #12 had a 1 cm [centimeter] by 1 cm open wound to the left buttock.</p> <p>Interdisciplinary Progress Notes for Resident #12 on 3/11/14, "...Open area on Lt [left] buttock 1cm x [by] 1 cm..." and on 3/26/14, "Wound Note. Lt buttock wound on admit measured 1 cm x 1 cm stage 2 [with] orders for Xenaderm [with] a cover of optifoam Q [every] 3 days. Res.[ident] seen by wound nurse today. L [left] buttock has superficial wound measuring 1 cm x 0.7 cm [with no] depth [and no] drainage at this time, healthy edges [and] surrounding tissues. D/C [discontinue] current drsg [dressing changes and] start: L buttock clean [with] wound cleanser, apply Xenaderm to wound bed and cover [with] border gauze, Daily [and] PRN [as needed]. Will cont[inue] to monitor. Educated res. on being in bed [and] off loading left buttock as much as possible between meals [and] smoke breaks."</p> <p>The March 2014 Treatment Administration Record (TAR) for Resident #12 documented the left buttock wound orders were implemented as ordered. The skin at risk assessments were completed as ordered and documented the skin was not intact.</p>	F 314		

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F 314	<p>Continued From page 63</p> <p>Interdisciplinary Progress Notes for Resident #12, dated 4/5/14, documented in part, "...pt. got tx [treatment] to coccyx/buttocks [at] 2300 [11:00 p.m.] for wound. Cleansed [with] wound cleanser, applied Xenaderm, skin prep [and] island gauze drsg. [No] drainage from site. [No] drsg was on prior to tx [treatment]."</p> <p>The April 2014 TAR for Resident #12 documented skin at risk assessments were completed as ordered. The skin assessment dated 4/2/14 documented the skin was not intact. The skin assessment dated 4/9/14 documented the skin was intact.</p> <p>On 4/10/14 at 1:55 p.m., LN #4 was asked if she had any skin assessment sheets or pressure ulcer sheets for Resident #12's pressure ulcer. She stated, "I don't have anything."</p> <p>On 4/10/14 at 2:00 p.m., LN #5 was asked if she had seen the left buttock wound on Resident #12 since she had documented 4/9/14 the skin was intact on the skin at risk assessment. She said she had not seen the wound for a while but the night nurse reported there was a layer of skin over the wound.</p> <p>On 4/10/14 at 2:05 p.m., Unit Manager (UM) #6 was asked how the wound nurse was notified of a wound present on a resident on admission. She said whoever puts in the orders will notify the wound nurse. The UM was asked who put in the orders for Resident #12 at which she replied, "That would be me." UM #6 was asked if she recalled notifying the wound nurse about Resident #12's wound to the left buttock, she stated, "I don't remember."</p>	F 314		
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F 314	<p>Continued From page 64</p> <p>On 4/10/14 at 4:35 p.m., UM #6 and LN #4 accompanied the surveyor to observe the left buttock wound on Resident #12. The wound was no longer open and had a deep red scar. LN #4 measured the area to be 1.2 cm by 0.4 cm.</p> <p>The Policy and Procedure for Monitoring Outcomes, no date provided, documented in part, "...3. MONITOR ACTUAL WOUNDS DAILY: a. Inspect daily for any new complication... b. Document daily monitoring on the TAR and/or in Nurses' Note... 5. Interdisciplinary Wound Rounds: Re-evaluate interventions and treatment plan at least weekly and consider alterations for any patient not responding as per plan of care... 7. Monitor all wounds using the Wound Management Tracking Tool and/or electronic monthly data collection. 8. Complete the Clinical Outcomes Report (COR) according to policy."</p> <p>Note: There was no documented evidence in Resident #12's clinical record the wound was monitored daily, interdisciplinary wound rounds were completed, and that the Management Tracking Tool or Clinical Outcomes Report were completed. In addition, the wound was only measured 3 times; once on admission on 3/11/14, 3/26/14, and on 4/10/14 at the surveyor's request. The wound was not assessed 14 days from 3/11/14 to 3/26/14, and 14 days from 3/26/14 to 4/10/14.</p> <p>On 4/10/14 at 5:40 p.m., the Administrator and DON were informed of the pressure ulcer issue. No further information was provided.</p> <p>2. Resident #2 was admitted to the facility on 10/21/12 with multiple diagnoses which included pressure ulcer stage IV, paranoid schizophrenia,</p>	F 314		

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F 314	<p>Continued From page 65 and abnormal posture.</p> <p>The resident's quarterly MDS dated 9/25/13, documented: -was severely cognitively impaired; -had occasional rejection of cares; -required 2 or more staff members to assist with transfers and bed mobility; -required 2 or more staff members to assist with personal hygiene and bathing; and -had 2 stage 3 pressure ulcers and 1 stage 4 pressure ulcer.</p> <p>The resident's quarterly MDS dated 12/26/13, documented: -was moderately cognitively impaired; -occasionally rejected care; -required 2 or more staff members to assist with transfers and bed mobility; -required 2 or more staff members to assist with personal hygiene and bathing; and -had a stage 1 pressure ulcer or higher.</p> <p>The resident's annual MDS dated 3/3/14, documented: -was moderately cognitively impaired; -did not reject care; -required 2 or more staff members to assist with transfers and bed mobility; -required 2 or more staff members to assist with personal hygiene and bathing; and -had 3 stage 3 pressure ulcers and 1 unstageable pressure ulcer.</p> <p>The resident's current Care Plan, dated 3/21/2012, with revision date of 2/21/13, documented the focus of: "I have the potential for further skin breakdown related to: immobility, cognitive impairment, anemia, and</p>	F 314		
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F 314	<p>Continued From page 66</p> <p>non-compliance, hx [history] of skin breakdown, impaired skin sensitivity and neuropathy." Interventions included "Wheelchair cushion for pressure relief," initiated on 6/19/12.</p> <p>The resident's Interdisciplinary Progress [IDPN] notes documented: - "4/7/14 at (1:00PM), Wound note. Res[ident] seen by wound nurse. L[eft] IT [ischial tuberosity] measuring 0.5cm x 0.3cm x <0.1cm [with] min[imal] serous drainage... R[ight] IT measuring 0.2cm x 0.8cm x <0.1cm [with] min[imal] serous drainage... to follow weekly." [Note: January - current IDPN notes were reviewed and there was no reference to a pressure reducing cushion being in place or assessed for the resident.]</p> <p>The resident's Skin Integrity Report documented: Right IT, Pressure, Stage II, Initial date of wound 10/5/12: - "1/22/14, 1cm x closes x 0.3cm; - 2/3/14, 1.4cm x closes x 0.1cm; - 2/14/14, 1cm x closes x -; - 2/19/14, 0.8cm x closes x 0.5cm; - 2/24/14, 0.8cm x closes x 0.4cm; - 3/3/14, 0.7 cm x closes x 0.7cm; - 3/19/14, 0.3cm x 0.4 cm x <0.1cm; - 3/26/14, 0.3cm x 0.8cm x <0.1cm; - 3/31/14, 0.2cm x 0.8cm x <0.1cm; and - 4/7/14, 0.2cm x 0.8cm x <0.1 cm." Left IT, Pressure, Stage 4, Initial date of wound 10/5/12: - "1/22/14, Resolved; - 2/3/14, I[ntact]; - 2/14/14, I[ntact]; - 2/19/14, 0.2cm x 0.2cm x <0.1cm; - 2/24/14, 0.2cm x 0.2 cm x <0.1cm; - 3/3/14, 0.5cm x 0.3cm x -;</p>	F 314			

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F 314	<p>Continued From page 67</p> <p>-3/19/14, 0.6cm x 0.5cm x <0.1cm; -3/26/14, 0.7cm x 0.4cm x <0.1cm; -3/31/14, 0.5cm x 0.2cm x <0.1cm; and -4/7/14, 0.5cm x 0.3cm x <0.1cm." [Note: The section "Care Plan Updated" for both of these wounds remained blank for all the dates wound care was documented.]</p> <p>The resident was observed on 4/7/14 at 1:00 PM, 1:30 PM, 2:10 PM, 2:50 PM, and 3:40 PM, in his wheelchair with no pressure reducing cushion in place.</p> <p>The resident was observed on 4/8/14 at 8:00 AM, 9:50 AM, 10:15 AM, 10:25 AM, 12:05 PM, 12:30 PM, 3:05 PM, sitting upright in his wheelchair with no pressure reducing cushion in place.</p> <p>On 4/8/14 at 3:15 PM, the DON was interviewed regarding resident #2's pressure ulcers and interventions. The DON stated the resident had a long history of non compliance with interventions and cares but had recent improvement in December 2013 and January 2014 with compliance. When asked why the resident was not using the pressure reducing cushion in his wheelchair as care planned, the DON said, "What?" Then went to the resident's room, where he was observed by the surveyor and the DON to be sitting upright in his wheelchair watching TV, without a pressure reducing cushion in place. The DON asked the resident where his pressure reducing cushion was. The resident replied, "I don't want it. I took it back 1 to 2 months ago. I left it by the therapy room. It wasn't doing me any good." The resident demonstrated that he was sitting on a towel and said, "This is what I am using."</p> <p>The resident's 4/8/14 untimed IDPN documented,</p>	F 314		
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F 314	<p>Continued From page 68</p> <p>"Res[ident] noted to not be using provided pressure reducing cushion in w/c and sits on the s/c seat cushion using rolled towels to self-load himself. Res[ident] educated on importance of changing position and utilizing provided pressure relieving cushion. Res[ident] agreed to use cushion in electric w/c but said he will continue to do as he has been doing and remove it if it starts irritating him."</p> <p>On 4/9/14 at 3:30 PM, the IDPN documented, "This RN and PTA [physical therapy assistant] worked [with] res[ident] on possible cushion for res[ident]. Res[ident] stated he did not want his old cushion back because it felt like he was 'on a bed of nails.' New cushion placed. Res[ident] stated it felt pretty good and would try it. Dysom [sic] placed to prevent cushion from sliding by PTA res[ident] stood up 1X [times 1 with] therapist and declined to do so again."</p> <p>On 4/10/14 at 9:20 AM, the DON was interviewed regarding resident #2's care plans. She said, "I don't know when he removed the cushion. He likes to rotate cushions and likes to remove it. He took the cushion to the OT golf course. We need to do something where we check on it daily... We updated his care plan regarding the cushion."</p> <p>The facility documented an intervention on the resident's care plan dated 4/8/14, under the care plan with focus are of, "I have the potential for further skin breakdown related to: immobility, cognitive impairment, anemia, and non-compliance, hx [history] of skin breakdown, impaired skin sensitivity and neuropathy," which documented in part, "Res[ident] provided [with] education [related to] w/c [wheelchair] cushion use. Res[ident] reports he is [changing] cushion to reg[ular] w/c cushion seating ad lib [sic] staff to</p>	F 314		

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F 314	Continued From page 69 encourage compliance. Res[ident] self-offloads in w/c [with] use of towels. On 4/9/14 at 6:00 PM, the Administrator and DON were notified of the issue. Additional information was received from the facility on 4/14/14 at 3:52 PM via fax. However the information provided did not resolve the concern.	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 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and resident interview, it was determined the facility failed to ensure an indwelling foley catheter was only used when clinically indicated, to provide adequate incontinence care and to evaluate a resident with incontinence for a toilet training program. This was true for 3 of 11 sampled residents (#s 3, 9 and 11) reviewed for indwelling catheters and incontinence. This had the potential to harm the resident if they developed urinary tract infections,	F 315	F315 URINARY CONTINENCE Corrective actions for residents affected: Resident #9 discharged from the facility on 4/16/14. Resident #9's catheter was discontinued by a licensed nurse per MD order prior to discharge from facility on 4/10/14. Resident #11 had his catheter discontinued by a licensed nurse per MD order on 4/11/14. Resident #11's catheter was replaced on 4/14/14 per physician order by facility licensed nurse due to retention of urine and order is complete with catheter and balloon size. A urology consultation was requested and order was received on 4/14/14. Resident #3 had a bowel and bladder assessment completed on 4/17/14 by facility RN. Resident #3's care plan was updated on 4/20/14 by the Assistant Director of Nursing related to toileting needs based on assessment findings.	5/12/14

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F 315	<p>Continued From page 70</p> <p>experienced skin breakdown or decreased bladder function. Findings included:</p> <p>1. Resident #9 was admitted to the facility on 3/27/14 with multiple diagnoses which included fractured vertebrae and failure to thrive.</p> <p>The admission MDS assessment for Resident #9, dated 4/3/14, documented in part:</p> <ul style="list-style-type: none"> * Cognitively intact with a BIMS of 15; * Foley catheter; and, * No toileting program. <p>Resident #9's March 2014 recapitulated Physician's Orders documented, "Change cath[eter] Qmonth [every month] (FR: 16, CC: 10, DX [diagnosis]: edema - Night Shift For 1 days, starting on 1 [first] of every month urinary retention."</p> <p>Note: The foley catheter size, balloon size, and diagnosis were written in with black pen.</p> <p>Resident #9's April 2014 recapitulated Physician's Orders documented, "Change cath Qmonth (FR: ____, CC: ____, DX: ____) - Night Shift For 1 days, starting on 1 of every month."</p> <p>Note: The foley catheter size, balloon size and diagnosis were not filled in.</p> <p>The April 2014 MAR (Medication Administration Record) for Resident #9 documented, "Change cath Qmonth (FR: 16, CC: 10, DX: edema) Start Date: 3/27/2014 Night Shift Monthly duration on 1st [first] for 1 days."</p> <p>Resident #9's Care Plan documented in part:</p> <ul style="list-style-type: none"> * Focus - "Resident requires foley catheter related to: urinary retention." Date initiated 3/28/14 and revision on 3/28/14; and, 	F 315	<p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: Current residents with indwelling catheters were reviewed for appropriate clinically indicated diagnoses and catheter and balloon sizes were included in orders by Assistant Director of Nursing Services on 4/22/14. Residents with urinary incontinence toileting plans were reviewed to assure toileting plans were on the care plan and being followed on or before 5/10/14 by members of the nurse management team per bowel and bladder assessments.</p> <p>Measures and systemic changes to prevent</p>	
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Continued From page 71

* Interventions - "DC [discontinue] when appropriate per MD order." Date initiated 3/28/14. A hand written intervention documented, "Foley 16 F [French with] 10 cc [cubic centimeter]change Q month Dx urinary retention" with initials and a date of 3/27/14.

On 4/7/14 at 2:50 p.m., Resident #9 was asked why he had the foley catheter. He said it was because he couldn't get up to the bathroom enough due to getting rid of all the excess fluid in his body.

On 4/9/14 at 4:52 p.m., Unit Manager (UM) #3 and the ADON were interviewed regarding Resident #9 and the indwelling foley catheter. The UM was asked what size catheter the resident had and she said it was clarified on 4/7/14 as a 16 French 10 cc. When asked why the size wasn't on the April 2014 recapitulation Physician's Orders, the UM stated the size would not be on admit orders, but the facility clarified and it was then added in the computer and to next month's recaps. [Note: The size was hand written on the March 2014 recapitulation orders.] The UM was asked why Resident #9 had the catheter at which she replied, "Retention." The UM was shown the resident's MAR which documented the indication as edema. When asked why, UM #3 stated, "I don't know why that would say edema." The ADON added it was the night nurse who had written edema for the diagnosis/indication on the MAR. The UM said she would look in the resident's chart for clarification regarding the diagnosis requiring use of the foley catheter. [Note: No information was provided for indication of use.] UM #3 was shown the hand written intervention added to the resident's care plan dated 3/27/14. She was

F 315

recurrence:

Staff were re-educated by Nurse Practice Educator or designee on or before 5/2/14 related to ensuring that residents admitted with indwelling catheters have a diagnosis to support its use that are clinically indicated and size of catheter and balloon are to be included in orders. Also to ensure that residents care plans are updated according to the bowel and bladder assessment findings to meet individual resident needs including facility policy for filling out bowel and bladder assessments.

Monitoring Corrective Action for sustained corrections:

Beginning the week of 5/12/14 members of the nurse management team will complete once weekly audits for 4 weeks then once monthly for 2 months on incontinent residents' toileting care plans to assure they are followed and

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F 315	<p>Continued From page 72</p> <p>asked why the date was a day before the foley catheter care plan was initiated. The UM said the date written was the date it was clarified, but not the date initiated. UM #3 was asked if there was a plan to discontinue the foley catheter. She said she had 2 patients scheduled to discontinue foley's that week, "But to be honest with you I haven't done it." The UM confirmed Resident #9 was one of the two residents. The Policy and Procedure for foley catheters was requested and provided.</p> <p>The Policy and Procedure for Catheter: Urinary - Justification for Use, dated 8/15/05 and revised on 1/2/14, documented in part: * "Patients who have urinary catheters will be assessed to determine appropriateness for use based on the following criteria: Indwelling: Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, and which is characterized by (must have all three): Documented post void residual (PVR) volumes in a range over 200 ml [milliliters], Inability to manage the retention/incontinence with intermittent catheterization, and Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction... If patient's situation does not meet any of the criteria, notify physician/mid-level provider to obtain orders for catheter removal..." Note: There was no documented evidence in the resident's chart he met the identified situations identified in the Policy and Procedure.</p> <p>On 4/10/14 at 5:40 p.m., the Administrator and DON were informed of the foley catheter issue. No further information was provided.</p>	F 315	<p>that bowel and bladder assessments filled out per facility policy. Additionally members of the nurse management team will complete once weekly audits for 4 weeks then once monthly for 2 months to assure residents with catheters have orders indicating size and diagnosis for use. The result of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly for three months. The Director of Nursing Services will be responsible for monitoring and follow up.</p> <p>Completion date:</p>	5/12/14

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F 315	<p>Continued From page 73</p> <p>2. Resident #11 was admitted to the facility on 3/31/14 following a CVA with left sided weakness. At the time of survey, no MDS assessment had been completed.</p> <p>On 3/31/14, Resident #11's Nursing Assessment form documented the resident had an, "Internal Catheter." The size was documented as, "16," the diagnosis was documented as, "10." The areas of the form for "Balloon size" and "Reason", were blank.</p> <p>On 4/1/14, a physician's order for Resident #11 documented, "Catheter order. Change cath (catheter) [every] month." There were spaces for the size of the catheter tubing and balloon, as well as a space for a diagnosis for the use of the catheter. All of those spaces were blank.</p> <p>Resident #11 was observed with urinary catheter tubing and drain bag on 4/7/14 at 2:00 PM, 4/8/14 at 7:45 AM, 8:10 AM, and 10:05 AM, and 4/9/14 at 10:20 AM.</p> <p>On 4/9/14 at 3:50 PM, the DNS and CMO were asked about the catheter for Resident #11. After reviewing the order with the blank spaces, the DNS stated the order had been clarified to include all of the required information, and a copy of the updated order would be provided to the surveyor. [NOTE: Documentation of this order being clarified was not provided by the time of the survey exit.] When asked why the resident required the use of a foley catheter, the DNS stated, "Urinary retention." When asked for documentation regarding that diagnosis, the DNS stated she would have to review the resident's record from the acute care hospital prior to his admission to find that information. [NOTE:</p>	F 315			

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F 315	<p>Continued From page 74</p> <p>Documentation of the diagnosis for the use of the foley catheter was not provided by the time of the survey exit.] The DNS was asked what the facility's procedure would typically be for a resident admitted with a foley catheter with no clear indication as to why the catheter was present. The DNS stated the facility would normally ascertain the diagnosis at the time of admission, then attempt to discontinue the catheter if possible. The DNS stated the facility would monitor the success of the discontinuation of the catheter by monitoring post-void residual values, and if the determination was made the catheter needed to be re-inserted, the facility would request a urology consult for the resident. The DNS was asked where the facility was in this process for Resident #11. The DNS stated, "[Resident #11] has only been here a week. We haven't had time to do any of that yet."</p> <p>On 4/10/14 Resident #11's physician's orders documented the urinary catheter was to be discontinued, with post-void residuals to be monitored for 3 days.</p> <p>On 4/10/14 at 6:00 PM, the Administrator, DNS, CMO, and SDC were informed of the surveyor's findings. The facility offered no further information.</p> <p>3. The facility's policy for Continence Management, dated 6/1/96 with a revision date of 1/2/14, documented, in part: *"...the Bowel and Bladder Continence Evaluation...will be completed if the patient is incontinent upon admission or re-admission...or with a change in continence status. Continence status will be reviewed quarterly and with significant change as part of the nursing</p>	F 315		
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F 315	<p>Continued From page 75 assessment...</p> <p>*Practice standards...Identify patient's continence status and need for management by reviewing the nursing assessment...If the patient is incontinent...address transient causes for incontinence...develop a care plan based on information from assessments and Diaries..."</p> <p>Resident # 3 was admitted to the facility on 11/19/13 with multiple diagnoses including advanced dementia.</p> <p>Resident # 3's admission MDS, dated 11/26/13, coded: *Extensive assistance of 2 persons for toilet use; *Frequently incontinent of both bowel and bladder; and *A BIMS of 6, indicating severely impaired cognition.</p> <p>On 11/25/13, a "Bowel and Bladder Continence Evaluation" form for Resident #3 documented a 72-hour voiding diary for the resident, between 11/20/13 and 11/22/13. The resident's voiding patterns were documented each hour, for a total of 72 documentation opportunities: *53 episodes of the resident being continent, but dribbling upon standing. *7 episodes of the resident being assisted to the toilet to void successfully. *2 episodes of the resident being wet. *9 episodes of the resident being incontinent of bladder. *1 episode of the resident being incontinent of bowel. *The area of the form for the facility to determine if medical diagnoses, including end-stage dementia, were present for the resident, was checked as, "No."</p>	F 315		
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F 315	<p>Continued From page 76</p> <p>Resident #3's care plan documented: *Focus of, "[Bowel and Bladder] incontinence [related to a diagnosis of] Alzheimer's disease with cognitive deficits - may not recognize the urge to toilet." Initiated 11/25/13, revised on 2/13/14. *Goal of, "Resident will be clean, dry, and odor free." Date initiated as 11/25/13, revised on 2/13/14. *Interventions of, "Incontinent Program: Containment; check for wetness [before and after meals, at bedtime, and] on rounds during the night." Initiated 11/25/13.</p> <p>On 11/26/13 a physician's progress note for Resident #3 documented, "...severe baseline dementia...no changes, I believe she is at her baseline at this time..."</p> <p>On 1/21/14, a physician's progress note documented, "...Dementia, no changes. It is mild to moderate..."</p> <p>On 1/31/14, a care plan intervention of, "Prompt to toilet before and after meals," was added. The previous intervention of containment was not discontinued.</p> <p>Resident #3's most recent quarterly MDS, dated 1/31/14, coded: *Totally dependent on 2 persons for toilet use; *Always incontinent of both bowel and bladder; and *A BIMS of 4, indicating severely impaired cognition.</p> <p>Resident #3's record also contained a second "Bowel and Bladder Continence Evaluation" form.</p>	F 315		

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F 315	<p>Continued From page 77</p> <p>The form was not dated or signed. The area of the form for the facility to determine if medical diagnoses, including end-stage dementia, were present for the resident, was checked as, "Yes," with the word "dementia" circled, but not, "end stage." The remainder of the form, including the reason for the evaluation, 72 hour voiding diary, and type of toileting program, were all blank.</p> <p>On 4/8/14, at 8:02 AM, Resident #3 was observed being pushed in her wheelchair down the hallway from the dining room to the television lounge across from the west nurse's station. The resident was observed to remain there until 8:25 AM, when she was transported from that setting to the hallway just outside the entrance to her room. UM #3 was taking the resident into her room, along with the Hoyer lift, but closed the door and would not allow the surveyors to observe whether or not the resident was prompted to toilet, per her care plan.</p> <p>On 4/8/14 at 12:25 PM, RN #4 was assisting Resident #3 with her lunch. When the resident stated she was done, RN #4 asked another staff member to take the resident to the television room across from the west hallway. The resident was observed in that setting until 12:45, when the Activities Director offered to take the resident outside. The resident agreed, was offered a sweater, and immediately taken outside. At 1:05 PM, the Activities Director returned inside with the resident, with the resident stating she was ready to rest. CNAs #13 and 16 assisted the resident to her room, and used the mechanical lift to assist the resident to bed. They did not prompt the resident to toilet, nor did they check to see if she had soiled her brief. The nightstand near the bed had only a lamp on it. The resident was observed</p>	F 315		

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F 315	<p>Continued From page 78</p> <p>to be sleeping in her bed approximately 10 minutes later.</p> <p>On 4/8/14 at 2:50 PM, Resident #3 was observed in bed in the same position. An adult brief and package of wipes was now laying on the nightstand with the lamp.</p> <p>On 4/10/14 at 10:35 AM, the DNS and CMO were asked about the toileting plan for Resident #3. The DNS stated the facility typically completed a bowel and bladder evaluation of voiding patterns upon admission, quarterly, and with every change of condition. The DNS identified a "containment" plan for toileting to be checking the resident to see if their brief had been soiled, then changing the brief if needed. After reviewing Resident #3's care plan, with the interventions for both containment and prompted toileting, the DNS stated, "She is not continent at all at this time. She has no sensation to void. The containment care plan is more accurate at this time, based on end-stage dementia." The DNS was asked how the facility had determined the resident had end-stage dementia. The DNS stated, "Well, she was recently been put on comfort care, per hospice criteria. She is non-verbal and can't walk." [NOTE: The surveyors had been able to verbally interact with the resident on several occasions throughout the survey.] When informed of the surveyors having verbal conversations with the resident, the DNS stated, "Well, she's not completely non-verbal." The DNS reviewed the Bowel and Bladder evaluation forms for Resident #3. The DNS was unable to explain why a care plan for containment would have been developed based on the first assessment, versus scheduled or prompted voiding. The DNS was further unable to explain what prompted the change in the</p>	F 315		

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F 315	Continued From page 79 resident's care plan to prompted voiding on 1/31/14. When asked about the surveyors observations that prompted voiding had not occurred, the DNS stated again she felt the containment care plan was more accurate for this resident. The DNS was unable to explain how a diagnosis of dementia meant a resident could not benefit from either prompted or scheduled voiding. The DNS stated the second bowel and bladder evaluation form should have been completed, dated, and signed to further explain the resident's continence status. On 4/10/14 at 6:00 PM, the Administrator, DNS, CMO, and SDC were informed of the surveyor's findings. The facility offered no further information.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview, it was determined the facility failed to: * Ensure adequate care plan interventions were in place upon admission; * Revise care planned safety interventions to prevent falls; and	F 323		5/12/14

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F 323	<p>Continued From page 80</p> <p>* Assess the safety of side rails for use by residents</p> <p>This was ture for 3 residents sampled (#s 1, 7, and 17) for falls and had the potential for more than minimal harm should any of the residents sustain an injury due to a fall or the unsafe use of siderails. Findings include:</p> <p>Resident #7 was admitted to the facility on 3/4/14 and readmitted on 3/15/14 with multiple diagnoses to include, hip fracture, joint replacement, dislocation of prosthetic joint, Alzheimers and history of falls.</p> <p>Resident #7's Transfer Order/Instructions from the hospital, dated 3/4/14, documented the resident was to have, "Fall Precautions, activity as tolerated, and weight bearing as tolerated."</p> <p>The Transfer Order/Instructions, from the hospital, dated 3/3/14, and the "All Active Orders" for Aprii 2014, did not document whether or not the resident was to have hip precautions in place.</p> <p>The Resident's Re-admission MDS, dated 3/27/14 documented:</p> <ul style="list-style-type: none"> * Severely cognitively impaired; * Disorganized thinking that fluctuates; * Extensive assist of one person with bed mobility and transfers; * Extensive assist of two people for toilet use and personal hygiene; * Functional limitation of lower extremity; * One "no-injury" fall since admission or prior assessment. <p>Note: Resident #7 was originally admitted to the facility on 3/4/14, discharged to the hospital on</p>	F 323	<p>F323 ACCIDENT AND INCIDENTS</p> <p>Corrective actions for residents affected:</p> <p>Resident #7 had another fall assessment completed by the Assistant Director of Nursing on 4/17/14 and their care plan was updated with current weight bearing status and hip precautions as indicated from physical therapy and MD orders.</p> <p>Resident #11 was assessed by the physical therapist on 4/15/14 and side rails were determined to be appropriate and safe for use. Resident #17 was discharged from the facility on 8/17/2013.</p> <p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:</p>	

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F 323	<p>Continued From page 81</p> <p>3/10/14, and re-admitted to the facility on 3/15/14. All of the resident's Care Plan "initiated dates" were documented as 3/14/14 while the resident was still in the hospital.</p> <p>The Resident's Orthopedic Aftercare secondary to: s/p (status post) joint replacement of right hip care plan and Falls care plan were reviewed and documented the following:</p> <ul style="list-style-type: none"> * Fall CP, dated 3/14/14, - Offer to assist resident to bathroom every 2 hours to increase supervision and meet toileting needs, side rails up x (times) 2 while in bed as an enabler, PT (Physical Therapy) evaluation, place call light within easy reach, and encourage resident to communicate needs/ask for assistance. * Orthopedic Aftercare CP, dated 3/14/14, - Encourage resident to be out of bed as tolerated, observe for changes in ADL function, notify physician as needed, orthopedic consult as need, and report signs of hip dislocation - acute groin pain in operative hip, shortening, or internal rotation of operative hip/extremity. <p>The resident's Incident/Accident Reports, Physical Therapy Notes, Nursing Notes, MARs, TARS, Nurses Notes, Hospital History & Physical, facility faxes and X-ray results were reviewed and documented the following:</p> <p>The Resident's Physical Therapy Evaluation, dated 3/4/14, documented the following:</p> <ul style="list-style-type: none"> * Reason for Referral - Right hip fracture status post ground level fall [at home], WBAT, posterior hip precautions. * Treatment Precautions - WBAT right lower extremity, posterior THA precautions. * Other - CNA educated regarding functional mobility, THA precautions and recommendation 	F 323	<p>Members of the nurse management team completed at risk fall assessments on current residents' on or before 4/25/14 and updated care plan as indicated. Falls occurring in the facility for the past 30 days for current residents were reviewed by Director of Nursing Services on 4/25/14 to ensure care plans are reflective for current risk factors and safety interventions. The Assistant Director of Nursing completed a review of current residents with status post hip fractures for hip precautions on or before 5/12/14.</p> <p>Measures and systemic changes to prevent recurrence:</p> <p>Staff were re-educated on or before 5/2/14 by Nurse Practice Educator or designee related to updating care plans as falls occur to ensure safety measures in place to prevent further falls in addition to</p>

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F 323	<p>Continued From page 82</p> <p>to position pillow between knees in bed.</p> <p>* PT (Physical Therapy) Notes, dated 3/5/14, "PT (patient) was able to amb[ulate] 275 [feet with] CGA on 3/5/14 [without pain].</p> <p>* An Incident/ Accident Report, dated 3/5/14, at 11:50 PM, documented in part the following:</p> <p>* "Resident noted on bathroom floor sitting on bottom, leaning back on hands with feet straight in front of him toward toilet. Stated he had been trying to go to the bathroom...Res[ident] stated he was having some pain and received prn (as needed) Norco 10/325 with good relief found..."</p> <p>* Resident's condition before event/accident was confused;</p> <p>* Care plan updated, "Toileting schedule every 2 hours to prompt resident to void and increase supervision."</p> <p>* NN, dated 3/6/14, at 7:00 AM, "Res[ident] found on bathroom floor at 2350 (11:50 PM), facing toilet [with] feet straight out in front of him, sitting on bottom [and] leaning back on hands. Stated he was trying to go to the bathroom and slipped... Res[ident] complained of pain and received prn Norco with good results. Res[ident] to have Q2H offer to assist to toilet."</p> <p>* NN dated 3/6/14, at 1330 (1:30 PM), "T.O. for Right hip x-ray post fall per Providers Name..."</p> <p>* Diagnostic Laboratories X-ray results, dated 3/6/14, Results, "Prior partial hip replacement prosthesis. The femoral stem shows no evidence of loosening. There is no evidence of dislocation. Mild hypertrophic spurring of the acetabulum..."</p> <p>* PT Notes, "On 3/6/14, he (the resident) was reluctant to bear wt (weight) on (Right) LE (Lower Extremity) and was unable to ambulate. Pt (patient) also acknowledged pain, and pointed to R[ight] hip when questioned re[garding] pain location. Pt also appeared to be 'in pain' with gentle R[ight] LE (hip ROM)... Pt's R[ight] hip is</p>	F 323	<p>assessing side rails for safe use, implementation of care plans at time of admission related to current risk factors and functional status including hip precautions in place or get clarified with MD</p> <p>Monitoring Corrective Action for sustained corrections:</p> <p>Beginning the week of 5/12/14 members of the nurse management team will complete five weekly audits for 2 weeks and then three weekly audits for an additional 2 weeks then five weekly audits for 2 months on residents with dx s/p hip fx or hip surgery to ensure precautions in place or clarification obtained from MD, falls that occur in the facility and the implementation of safety measures and/or increased supervision. Additionally, members of the nurse management team will complete audits once weekly for 4 weeks and then once monthly audits for 2 months on appropriate and safe use of side</p>	

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F 323	Continued From page 83 internally rotated at rest in sitting, placed small ball between knees to facilitate more neutral hip alignment; also located R[ight] foot rest [with] more neutral foot plate angle and located seat regeidizer [sic] to facilitate more neutral hip alignment." * PT notes, dated 3/7/14, "...Pt took 7 small steps and wanted to sit [secondary] to pain in R[ight] hip. Attempted AROM/PROM (Active Range of Motion/Passive Range of Motion) [with] BLE to increase ambulation mm (millimeter) strength [with zero] resistance. D/t (due to) pain and dementia pt had difficulty tolerating much LE therapy..." * PT notes, dated 3/8/14, "Therapy consists of attempts to engage pt in therapy. Would not open his eyes but did answer questions with yes/no response. Spoke with nurse who relates that pain pill [was given] 5 hours ago but he is on a strong doses..." * NN notes, dated 3/9/14, at 1:00 AM, "...Does not use call light although shown, staff checking on him 'frequently' to ensure needs met. Pain controlled well [with] scheduled and prn Norco..." *PT notes, dated 3/10/14, "Therapeutic Activity: Pt lying in bed, asleep, pt responding, yet not keeping eyes open. Initiated gentle R[ight] LE ROM. Pt grimaced and placed hand on R[ight] hip (eyes closed), then noted that R[ight] LE is markedly externally rotated and R[ight] LE appears significantly shorter than the L[eft]. Gently palpated hip was difficult to determine location of femoral head; however it appears that it may be superior and posterior compared to L[eft]... Marked R[ight] LE external rotation [with] shortened limb were not present upon PT initial eval[uation] on 3/4/14. Educated CNA's re[garding] related to assisting pt [with] neutral R[ight] LE alignment when cleaning and dressing.	F 323	rails including documentation of assessment The results of these audits will be reviewed with Quality Assurance Performance Improvement Committee monthly for three months. The Director of Nursing Services will be responsible for monitoring and follow up. Completion date:	5/12/14	

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F 323	<p>Continued From page 84 Pt hospitalized with dislocated hip."</p> <p>An Incident/Accident Report, dated 3/10/14, at 4:00 PM, documented: * "Resident was in bed at approximately 1600. therapy noted that right leg was shorter than left and rotated. X-ray ordered and noted that right hip dislocated. Resident admitted to center on 3/4/14 following a right hip repair. Admitted with orders for WBAT and 'no noted hip precautions'..."</p> <p>* NN, dated 3/10/14, at 6:00 PM, "[At] 1600 (4:00 PM), when resident was in bed therapy noted that his R[ight] leg was shorter than his left and externally rotated. Provider notified and received order for an x-ray. X-ray taken and R[ight] hip was dislocated. Provider notified at 1700 (5:00 PM) and order received to send [patient] to ER.</p> <p>The resident's H&P from the Emergency Room, dated, 3/10/14, documented the the following, "It is unclear what has happened in the last several days, but today, it was noted that he [the resident] was holding his right hip and that it was externally rotated and somewhat shortened. It is unclear if the patient fell or not, as he has profound dementia and only answers yes/no intermittently." The resident after x-ray was found to have a "Right hip dislocation with periprosthetic fracture." The resident was admitted to the hospital and had revision of his right hip done. The resident was admitted to the Orthopedic floor and underwent a revision of his right hip. The resident was then re-admitted to the facility on 3/15/14.</p> <p>* An Incident/Accident Report dated 3/25/14, at 1:20 PM, "This nurse was pulled into res[idents] room by aide when entered room res was on his</p>	F 323		

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F 323	Continued From page 85 knees in the praying position over his bed. wc (wheel chair) at foot of bed with foot pedals on. when asked what happened res stated that he was trying to get into bed. x 2 assist into bed 0 (zero) c/o pain noted with legs or hips with palpation. Resident was moved to room more proximal to nurses station following his re-admission. Resident is on every 2 hours prompt void." On 4/10/14, at 2:05 PM, the DNS, Physical Therapist, and Administrator were interviewed. The Physical Therapist was asked what the process is for a newly admitted resident with Physical Therapy orders status post hip arthroplasty. The Therapist stated an assessment is completed on the resident, on the day of admission. The DNS was asked what interventions were implemented after the resident fell to increase supervision. The DNS and Administrator stated, "Offer to assist resident to bathroom every 2 hours to increase supervision and toileting needs," was added to the care plan. The surveyor asked how toileting the resident every 2 hours was increased supervision. The Administrator stated the resident's room is on a high traffic hall and therefore more frequent checks are done just with staff passing by the resident's room. The Administrator was asked to explain what "frequent checks" meant. The Administrator stated "frequent checks" does not imply a specific time, but is more frequent than every 2 hours. The Administrator was asked what had been identified as the cause of the fracture and dislocation. The Administrator stated, "The ER identified the cause of the fracture was related to a fall, but I feel there was a miscommunication." The DNS was asked what additional interventions were implemented on the	F 323			

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F 323	<p>Continued From page 86</p> <p>care plan after the resident's re-admission on 3/15/14. The Administrator stated there was no need to change interventions when the resident returned because the, " interventions in place prior to the fall were appropriate."</p> <p>The Additional information provided by the facility did not resolve concerns related to the lack of hip precautions or care plan interventions.</p> <p>2. Resident #1 was admitted to the facility on 3/31/14 with multiple diagnoses, including a CVA with left sided weakness.</p> <p>Resident #1 did not have a completed MDS at the time of survey.</p> <p>Resident #1's All Active Orders (Recapitulation Orders) for March 2014 documented, "1/2 side rail X 2 for bed enabler."</p> <p>On 4/1/14, a facility "Device Evaluation" form was completed for Resident #1's 1/2 side rails. Please see F 221 for details of the form.</p> <p>Resident #1 was observed laying in his bed with 1/2 side rails up on 4/7/14 at 2:00 PM, 4/8/14 at 7:45 AM, 8:10 AM, 10:05 AM, and 2:45 PM.</p> <p>On 4/9/14 at 3:50 PM, the DNS, CMO, and UM #3 were interviewed about the side rail use for Resident #1. The DNS stated the facility normally placed a sticker on the consent form stating side rails were safe for the resident, but was unable to describe the process by which safety would be assessed. The DNS was asked for a copy of the consent form with the safety sticker, but the form was not provided.</p>	F 323		

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F 323	<p>Continued From page 87</p> <p>The facility offered no further information regarding the side rails for Resident #1.</p> <p>3. Resident #17 was admitted to the facility on 2/6/10, and readmitted on 8/14/13 with multiple diagnoses which included Depression, Hypertension and Diabetes type 2.</p> <p>The resident's annual MDS assessment, dated 5/7/13, documented the resident: -was cognitively intact; -did not require assistance with bed mobility, personal hygiene, toileting, transfer, and walking in the room; -used a walker for ambulation; -was continent of urine and bowel; and -had no falls since prior assessment.</p> <p>The Resident's NQ MDS dated 8/7/13, documented the resident: -was moderately cognitively impaired; -did not require assistance with bed mobility and personal hygiene; -required limited assistance by one staff for transfer and toileting; -required extensive assistance by one staff member for locomotion on the unit in a wheelchair; -was continent of urine and bowel; and -had one fall since prior assessment with no injury.</p> <p>The resident's Care Plan, dated 2/24/10 and updated 8/22/12 had the focus area, "Resident is at risk for self care deficit AEB [as evidenced by]: Decreased strength and mobility." The care plan had no goals identified, but documented the</p>	F 323		

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F 323	<p>Continued From page 88</p> <p>following interventions:</p> <ul style="list-style-type: none"> -Resident is independent with transfers, bed mobility, toileting and dressing. Staff provide assistance PRN [as needed] for bed mobility, transfers, dressing, toileting, Initiated on 2/24/10 and revised on 3/29/13. -Resident utilizes electric wheelchair for on/off unit mobility. Ambulates with walker independently, Initiated on 2/24/10 and revised on 3/29/13." *Under the focus area, "Exhibits inappropriate behavior, resists treatment/care AEB refusing showers/bathing, fall intervention and pressure relieving interventions related to lack of motivation," initiated on 7/11/11 and revised on 10/26/11. The goals were documented, "Resident will comply with care routine/medical regime AEB goal of at least 1 shower/week," initiated on 7/11/11 with the target date of 11/18/13. The interventions included: -Remind resident frequently to utilize call light if attempting to ambulate in room," Initiated 9/26/11. *Under the focus, "Fall history with risk for falls related to: pain, weakness," initiated on 2/6/10 and revised on 5/20/10, goals were documented as, "Resident will have no falls." Interventions included: -Education by NP related to fall history and re-evaluation of therapy goals," Initiated on 10/21/11; -Encourage SBA [stand by assistance] with toileting and ambulation, Initiated 8/25/11; -Remind resident to use call light when attempting to ambulate or transfer, Initiated on 2/6/10; -Reinforce need to call for assistance, Initiated on 2/6/10; and -Encourage resident to communicate needs/ask for assistance, Initiated on 2/6/10". 	F 323		

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F 323	<p>Continued From page 89</p> <p>On 7/3/13, the resident's Incidents and Accidents/Risk Management System documented the resident had an unwitnessed fall with no injury, and documented in part: -Res[ident] stated she miscalculated the distance to her bed and slid herself to the floor when she realized she wasn't close enough. Resident said she wasn't funny [sic] awake. Stated she woke up to go to the bathroom." -The form documented: "Yes" Care Plan updated, and "Yes" Care Card updated followed by a "NA" [not applicable]. -Had One previous fall in the last 31-180 days. -Under Additional comments was documented, "Resident desires independence and is able to utilize call light. Resident pushed the call light after the fall." -Under interventions initiated immediately after the fall was documented, "Assessed for injury. Re-educated resident to utilize call light." -The Root Cause Conclusion documents, "Intrinsic, Resident not fully awake." Note: No interventions were updated in the resident's care plan related to falls on or near this date. Additionally, the resident had utilized the call light after the fall. The intervention did not address the facility's identified root cause of the fall.</p> <p>On 7/14/13 the resident's Incident and Accident/Risk Management System documented the resident had a witnessed fall with no injury and documented the following: -"CNA went into room and found resident standing at the sink looking a little shaky with weak knees. CNA helped resident to floor and called the nurse. Res[ident] was breathing a little hard and hands were shaky. VS [vital signs] done</p>	F 323		

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F 323	<p>Continued From page 90</p> <ul style="list-style-type: none"> - WNL [within normal limits]. BG [blood glucose] 149. No c/o [complaint of] pain. No sign of injury. CNA and resident both stated her head was not hit. Alert and oriented x3 [times 3]. It appeared that she was standing to wash her hands after using the restroom. She stated she was a little dizzy when the nurse was speaking with her. Resident was returned to bed using Hoyer lift." -The care plan was updated on 7/14/13. -Under Intrinsic Factors that may have contributed to the fall, "Decline in Function, Unsteady gait, and visual problems," were selected. -Under additional comments was documented, "Resident functions [sic] independently normally." -Under Recommendations to prevent further falls is documented, "Cardiology consult, labs. Labs refelcted [sic] resident has dx [diagnosis] of lupus. Care conference scheduled to discuss new diagnosis." -The root cause was documented as, "Intrinsic, weakness and lupus." <p>Note: The documentation indicated that this fall was related to a change in resident status related to a new diagnosis, however, the care plan was not updated for safety interventions. Additionally, this was the resident's second fall in 11 days.</p> <p>On 8/8/14, the resident's Incident and Accident/Risk Management System documented in part that the resident had an unwitnessed fall with no injury and included the following in part: -"Staff walking past room heard a crash, upon looking into the room they saw res[ident] sitting on the floor next to her bed facing the door. This nurse was alerted. Neuro checks WNL, res[ident] states she did not hit her head. States her L[eff]t shoulder is hurting but unable to tell if r/t [related to] fall or chronic px [sic]. When asked what</p>	F 323		
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2014
NAME OF PROVIDER OR SUPPLIER APEX CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704		
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F 323	<p>Continued From page 91</p> <p>happened res[ident] states she was reaching for the trash can and slid out of bed onto non-skid mat next to bed. Mech[anical] lift used to transfer res[ident] from floor to [wheelchair]. Will increase supervision with Q1H [every one hour] checks for needs and add res[ident] to falling star program. Family and MD notified."</p> <p>-Care plan updated on 8/8/13.</p> <p>-Under additional comments was documented, "Resident with recent change in condition related to Lupus diagnosis."</p> <p>-The Root Cause Conclusion documented, "Intrinsic, Weakness and increased need for assistance."</p> <p>The Resident's Fall Risk Evaluation dated 8/14/13, documented the resident had a score of 10 out of 16 total, and indicated she was at moderate risk for a fall. A score of 12 or higher indicated the resident was high risk for fall.</p> <p>On 4/11/14 at 8:35 AM, the DON was interviewed regarding the resident's falls and care plan interventions. The DON said, "For the first fall she was alert and oriented on 7/3/13. She just miscalculated her bed. The intervention was re-education. Then she fell on 7/13/13, she was assisted the the ground. She was confused. Because our intervention here was to draw labs we found out the root cause of her fall, which was lupus." When asked what safety interventions were put in place after the second fall when she was noted to be more confused and had a change in medical status, she said, "I don't see interventions for safety either."</p>	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		5/12/14

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F 325	<p>Continued From page 92</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy reviews, it was determined the facility failed to: *Ensure a resident's weight gain was assessed to determine possible cause when the weight gain was severe; *Ensure the resident's nutritional care plan was individualized with facility interventions and resident preferences; *Notify the resident's physician of the weight gain; *Ensure a resident with weight loss was assessed to determine possible cause; and *Ensure nutritional care plan interventions were in place. This affected 2 of 3 (#s 6 & 3) sampled for weight status. This practice created the potential for untreated medical conditions or medication side effects for the resident with weight gain, and potential for the resident to experience a compromised nutrition status with weight loss.</p> <p>The Facility's HealthCare Center policy titled NSG244 Weights and Heights, effective date of 6/1/01 and revised 1/2/14 documented in part:</p>	F 325	<p>F325 NUTRITION</p> <p>Corrective actions for residents affected: Resident #3 was reassessed on 4/15/14 for weight loss by the facility's Registered Dietician. Resident #3 had health shakes implemented and their care plan updated with new intervention for weight loss. Resident #3's physician and family were notified of weight loss on 4/15/14. Resident #3 was reviewed in facility's Clinical At Risk Evaluation Meeting on 4/18/14. Resident #3 was observed as receiving all dietary interventions on 4/28/14 by the Director of Nursing Services. Resident #6 was reviewed on 4/14/14 by the facility's Registered Dietician for weight gain. Resident #6 was consulted for input related to their weight gain on 4/14/14 by the Registered Dietician and their care plan was updated with</p>	
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F 325	Continued From page 93 "Purpose - To obtain baseline weight and identify significant weight change; - To determine possible causes of significant weight change; and - To obtain baseline height. 2. Significant Weight Change Management: 2.1 Significant weight change will be reviewed by the licensed nurse for assessment. 2.1.1 Significant weight change is defined as: 2.1.1.1 5% in one month, 2.1.1.2 10% in six months. 2.2 The licensed nurse will: 2.2.1 Notify the physician/mid-level provider and dietician of significant weight changes; 2.2.2 Document notification of physician/mid-level provider and dietitian in the PCC [sic] Weight Change Progress note. 2.3 The licensed nurse will notify the: 2.3.1 Physician/mid-level provider of the dietitian recommendations; 2.3.2 Family/Health care decision maker of the weight change and dietitian recommendations. Family notification will be documented. 2.4 If a physician/mid-level provider does not implement the dietitian's recommendations, the licensed nurse will document physician's mid-level provider's refusal and add it to the 24-Hour Summary Report 3 The interdisciplinary care plan will be updated to reflect individualized goals and approaches for managing the weight change." 1. Resident #6 was admitted to the facility originally on 3/17/05 and readmitted on 12/28/11 with multiple diagnoses including CHF (congestive heart failure) and Depression. The 1/8/14 quarterly MDS coded the resident:	F 325	new intervention. Family was also notified of weight gain by RN Unit Manager on 4/14/14. Resident #6 was reviewed in facility's Clinical At Risk Evaluation Meeting on 4/18/14 Resident #6's weight gain was presented to facility nurse practitioner on 4/21/14 with no new orders received Resident #6's weight gain was reviewed by facility psychiatrist on 4/17/14 in relation to use of psychotropics for possible cause and no new orders received. Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: A review of significant weight changes over the last 30 days was completed by the registered dietician on 4/27/14 to ensure that practitioner and families were notified as well as interventions in place to	
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F 325	<p>Continued From page 94</p> <p>-had severely impaired cognitive skills; -ate independently with set up help only; and -height was 65 inches, and weight was 157 lbs.</p> <p>The 4/18/13 significant change MDS coded the resident: -was cognitively intact; -ate independently with set up help only; and -height was 65 inches, and weight 119 lbs.</p> <p>The resident's weight summary included: -4/4/13, 123 lbs (5.1% weight gain over 30 days, 18% weight gain over 180 days); -4/18/13, 119 lbs on MDS assessment; -5/13/13, 128 lbs (7.6% weight gain over 30 days, 28% weight gain over 180 days); -6/7/13, 132 lbs (21% weight gain over 180 days); -7/3/13, 135 lbs (23.9% weight gain over 180 days); -8/13 weight was not documented; -9/2/13, 142.5 lbs (15.9 % weight gain over 180 days); -10/4/13, 147 lbs (14.8 % weight gain over 180 days); -11/4/13, 147 lbs; -12/1/13, 148 lbs (12% weight gain over 180 days); -1/2/14, 156.5 lbs (5.7% weight gain over 30 days); -2/3/14 156 lbs; -3/3/14 159 lbs; and -4/4/14, 162 lbs (10.2% weight gain over 180 days)."</p> <p>The resident's care plan, print date 3/4/14, documented a Focus of, "NUTRITIONAL CARE PLAN: unstable health condition, HTN [hypertension], B12 anemia [vitamin B12 specific anemia], anxiety, osteoarthritis, abdominal</p>	F 325	<p>address weight changes. Care plans were updated at time of review. Members of the nurse management team observed residents receiving ordered dietary interventions on 4/28/14.</p> <p>Measures and systemic changes to prevent recurrence: Staff were re-educated by Nurse Practice Educator or designee on or before 5/2/14 related to notifying practioner, family, and registered dietician of significant weight changes. Additionally staff were re-educated by the Nurse Practice Educator or designee on or before 5/2/14 related to the need for ensuring ordered dietary interventions being provided.</p> <p>Registered dietician educated by Manager of Clinical</p>		

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F 325	<p>Continued From page 95</p> <p>pain/N/V [nausea/vomiting]. Date initiated 5/26/2009 and revised on 10/29/13. Goals are documented: 1. To adhere to Diet as ordered with no spicy foods. Intakes >75%. Initiated 5/26/09 with target date 6/22/14, and revised on 3/4/12. 2. Maintain weight - no sig. [significant] changes. Date initiated 5/26/09, target date 6/22/14, and revised on 3/4/14." Interventions include: -"Check lab work as available (initiated 5/26/09); -Diet as ordered w/s nacks [sic] prn [as needed] (initiated 8/21/12); -NSD [sic] to visit for food preferences as needed/requested (initiated 9/21/12); -Provide prescribed diet and monitor closely during meal times (initiated 5/26/2009); -Start small portions (initiated 3/4/14); and -Weight monthly (initiated 5/26/09, and revised on 10/29/13)." [Note: The resident experienced significant weight gain as outlined by the facility's policy at each weight taken monthly with the only corresponding care plan update 3/4/14. Additionally, the resident continued to gain weight after the nutritional care plan was updated.]</p> <p>The resident's Interdisciplinary Progress Notes (IDPN), Medical Nutrition Therapy Assessment (NTA), and Physician/practitioner progress notes (PPN) included the following: -PPN, "4/29/13, Received a note from nursing staff that patient is having new onset edema to her lower extremities... Bilateral lower extremity edema. We are going to start low-dose Lasix and potassium as well as some compression stockings." -PPD, "5/28/13, The patient had a little edema in between compliance visits... Seems to be resolved at this point." -IDPN, "5/15/13, Res[ident] [with] wt gain of 5</p>	F 325	<p>Operations on or before May 12, 2014 regarding interventions for weight changes and MD involvement</p> <p>Monitoring Corrective Action for sustained corrections: Beginning the week of 5/12/14 members of the Interdisciplinary Team will complete once weekly audits x 4 weeks then once monthly x 2 months on observations related to residents receiving dietary interventions as indicated on meal ticket. Additionally, the Registered Dietician or designee will complete six weekly audits for 4 weeks then six monthly audits for 2 months related to significant weight changes to ensure dietary interventions and family and practitioner notification. The result of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly for three months. The Director of Nursing Services</p>	

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F 325	<p>Continued From page 96</p> <p>[lbs] this month. Med review requested. Labs ordered. Eating 85% of meals. Eating in dining room. Alarms discontinued. No falls in >90 days. Independent with transfers and bed mobility." -IDPN, "6/11/13, Resident noted to have 4 lb weight gain over the past month. Eating 80-90% of each meal." -NTA, "6/11/13, Usual Wt - 120's, Pt [patient] weight is 132 lbs, [up] 15 lbs this quarter. Now at IBW [ideal body weight]. Is on Regular diet, is independent eating in DR [dining room] [with] set up intakes 85/90/85...Attends good relaxed socials as well. Is also on sup [sic] meals and snacks PRN. Will watch for needed intervention on weight gain... Labs (5/6/13: prot[ein] 4.9, alb[umin] 2.9, BUN 41). Plan: Maintain current weight - [no] sig[nificant] changes. Maintain intakes >75%, monitor daily. Monitor labs as available." -IDPN, "6/12/13 at 1000, Family aware of wt gain." NTA, "9/3/13, Usual Wt - 130's, Wt 143 lbs, Pt weight is 143 lbs, up 11 lbs in 90 days. At IBW [ideal body weight]. No oral or swallowing problems noted... Is on regular diet - independent [with] set up in DR [dining room] Intakes: 85/100/85. Will DC [discontinue] sup meals to prevent futher weight gain. Plan: maintain current weight, no significant changes. Maintain intakes >75%, monitor daily. Monitor labs as available. [Note: resident had an 18% weight gain in 180 days. There was no documentation of communication with the resident, LN or MD to address weight changes and no labs were ordered for the resident]. -PPN, "11/15/13, Psychiatric Evaluation...The patient has been gaining weight and it has been unclear why she is gaining weight..." [Note: the physician documented that he was</p>	F 325	<p>will be responsible for monitoring and follow up.</p> <p>Completion date: 5/12/14</p>	

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F 325	Continued From page 97 aware of some weight gain, did not quantify it or address it during his psychiatric evaluation. No physical exam was done or labs drawn to evaluate weight gain for the resident.] -NTA, "12/3/13, Usual Wt - 140's. Pt's weight 148, [up] 5 lbs in 90 days. But largely stopped previous weight gain. At IBW [ideal body weight]... Pt is on a regular/liberalized diet... intakes 100/100/75. Attends socials [with] activities as well... No new labs. Plan: Maintain current weight, no sig[nificant] changes. maintain intakes >75% monitor daily. Monitor labs as available." [Note: 12% weight gain over the last 180 days is identified as a significant change in the facility's policy.] -IDPN, "1/4/14, Res[ident] [with] noted 9 [pound] wt gain in 30 days. Significant amt [amount] of wt gain over last 6 mo[nths]. Cont[inue] on Regular diet eats 100% of meals. Attends all socials. Thyroid levels normal. [Change] to small portions [with] normal proteins" [Note: There was no mention of physician notification; although the author of this note discussed thyroid levels, no other discussion was found to identify cause of weight gain. Additionally, no lab work was found for this time period.] -IDPN, "1/9/14, Family notified of wt gain." -PPN, "2/12/14, ...She has actually gained some weight in the last little while... No edema to lower extremities..." [Note: the nurse practitioner documented that she was aware of 'some weight gain the last little while' but did not quantify it or address it in her assessment and plan.] NTA, "3/4/14, Usual Wt - 150's. Pt's weight 159, [up] 11 lbs in 90 days, >IBW... Pt is on regular liberalized diet. Started on small portions due to persistent weight gain. Independent eater in DR	F 325		

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F 325	<p>Continued From page 98</p> <p>[with] set up. Intakes: 85/100/75. Attends activities and has family that brings [food] items in... No new labs. Plan: maintain current weight, [no] sig[nificant] weight gain. Maintain intakes >75%. Monitor daily. Enc[ourage] dietary compliance. Monitor labs as available.</p> <p>[Note: The resident had 10.2% weight gain over 180 days which is significant. No documentation was found regarding communication between RD, LN or the physician/practitioner. Although the Physician and Nurse Practitioner mentioned the weight gain, it was never addressed as a problem or evaluated for the cause.]</p> <p>On 4/9/14 at 2:15 PM, the facility's RD was interviewed. When asked about Resident #6's weight gain she said, "A few years ago she would stay in her room, she never would get out and didn't eat well. She was underweight with a goal weight of 135 lbs. Then she increased her socialization, eating and gained weight." When asked why the resident's Usual Body Weight increased with each evaluation, the RD responded, "I calculate it quarterly. It is subjective depending on whether it is quarterly, annual or admission weights." When asked what the resident's goal weight was based on, as again it seemed to increase as the resident gained weight. She said, "It's based on height, then age." When asked about the determination of weight gain for the resident, the RD said, "Her family brings in items and activities that contributed to her weight gain. When asked if the family had been observed to bring in unhealthy food items the RD replied, "Within reason." She continued to explain the family and activities staff had been directed to offer and bring in healthier food items. She did not document any of the education provided to family and staff regarding weight gain</p>	F 325			

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F 325	<p>Continued From page 99</p> <p>for the resident. When asked if her weight gain was entirely calorie related, she reported the resident has been on Lasix and her edema fluctuates and said, "she could gain 3-5 lbs in a day. When asked how the facility would know this with monthly weight checks she reported, "Nursing would know, staff is only required to document meals and [bedtime] snacks." The RD attributed weight gain to calories (brought in by the resident's family and provided during activities) or edema, or something not identified. When asked about physician notification, she said, "[Resident #6 physician] was notified in November of 2013. The Doc reviewed meds, she was on Celexa." She said the notification of providers has recently changed related to weight changes. When asked how the RD concluded the snacks from family and activities caused the resident's weight gain and how it was assessed, she replied, "Nurses notes, CARES meetings." When asked what the resident's weight goal was, she replied, "She doesn't have a goal. She likes her Oreos, she likes her snacks, she likes the stuff her family brings." When asked where this documentation could be found she said, "I may not have documented that." When asked how she updates the care plans she said, "Should be done by nursing."</p> <p>On 4/10/14 at 9:30 AM, the DON was interviewed regarding resident #6's weight gain. When asked about her weight gain the DON said, "She was admitted for failure to thrive. She lost weight. She has been socializing more." When asked how notification occurs between staff and the physician or practitioner, the DON said, "Things have recently changed related to weight changes... When the nurse takes the weight they also notify the MD and the family if it is</p>	F 325			

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F 325	<p>Continued From page 100</p> <p>significant... We send notes to the MD to review medications related to weight changes." When asked where the documentation of the communication was, she said that the communication may not have been documented formally. The DON said, "The MD's have documented it [weight gain]. The consulting pharmacist has seen it 5/24/13. She was a woman that was severely below her BMI. There has been documentation regarding her weight gain by [the resident's physician]." When asked how the activity staff would know about resident #6's weight gain and interventions, the DON verbalized that there was no care plan in place that would direct them in activities.</p> <p>Note: The facility did not provide documentation demonstrating the physician had been notified of significant weight changes, and no subsequent evaluation was done to determine the cause. Labs were drawn in May of 2013 but none following the resident's continued weight gain. Additionally, no counseling or care conferences were documented around the issue of the resident's weight gain. The single intervention the RD put in place, "small portions" at meals was initiated on 3/4/14 and was after the resident had already gained 40 lbs and was approximately 24 lbs above her goal weight.</p> <p>2. Resident #3 was admitted to the facility on 11/19/13 with multiple diagnoses including advanced dementia and acute on chronic systolic heart failure.</p> <p>Resident #3's admission MDS assessment, dated 11/26/13, coded her weight as 122 pounds. Her quarterly MDS assessment, dated 1/31/14, coded</p>	F 325			

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F 325	<p>Continued From page 101 her weight as 108 pounds.</p> <p>On 11/26/13, Resident #3's Medical Nutrition Therapy Assessment form documented her swallowing ability as adequate, with speech therapy to evaluate and treat. Her weight was documented as 122 pounds, with her usual weight in the 110 pound range, and her desired body weight in the 130 pound range. The space to document her Body Mass Index, was blank. The back of the form documented, "...Plan: Maintain current weight [no significant] changes. Maintain intakes [greater than] 50%..."</p> <p>Resident #3's weights documented: *12/2/13, 121 pounds. *12/6/13, 118 pounds.</p> <p>On 12/11/13, an NP progress note documented, "...[Resident #3] feels like her appetite had been excellent. She is actually being followed by dietary secondary to some poor appetite and weight loss. She is on comfort management..." [NOTE: The NP did not document the facility was no longer to implement interventions in an effort to minimize weight loss, nor that the resident's weight loss was unavoidable.]</p> <p>Resident #3's weights documented: *12/13/13, 114 pounds. 6.6 % (percent) decrease in 30 days. [NOTE: Although the NP had documented 2 days prior to this weight the resident was being followed by dietary due to poor appetite and weight loss, no new interventions were noted.] *12/27/14, 117 pounds. *1/1/14, 108 pounds. 10.7 % decrease in 30 days. [NOTE: Again, no new interventions documented with this weight loss. At this point, the facility</p>	F 325		

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F 325	<p>Continued From page 102 reduced the frequency with which they were weighing the resident.]</p> <p>On 1/6/14, a physician order for Resident #3 documented, "OT to eval[uate] and treat [related to complaints of] not being able to see food on plate."</p> <p>On 1/29/14, an Interdisciplinary Progress Note from the facility RD documented, "[Patient's weight 11/19/[13] 122 lbs [pounds]/121 lbs. 1/2/[14] 108 lbs - had PICC line while in hospital [and anti-biotic treatment]. Pt is on comfort measures...ST working [with] resident [with] yogurt [and] ice cream added to [lunch and dinner]..."</p> <p>*On 1/31/14, Resident #3's weight was documented as 108 pounds, an 11.5 % decrease in 90 days. An Interdisciplinary Progress Note from the resident's Nurse's Notes that date documented, "Resident [weight] obtained following GI-like flu symptoms...was working with ST [and] was[downgraded] to puree [with extra] gravy, yogurt [and] ice cream [with] meals...Intake varies 35-50% of meals..."</p> <p>On 2/4/14, Resident #3's Medical Nutrition Therapy Assessment form documented her usual weight was in the 110 pound range, with a goal weight of 130 pounds. The space to document the resident's Body Mass Index (BMI), was blank. The back of the form documented, "Plan: Maintain current weight [no significant] weight loss. Maintain intakes [greater than] 50 %..." [NOTE: At this point in time the resident's weight had decreased from 122 pounds at the time of her admission on 11/19/13, to 108 pounds on 1/31/14.]</p>	F 325		

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F 325	<p>Continued From page 103</p> <p>Resident #3's weights further documented: *2/5/14, 118 pounds. (9.3 % increase in 30 days). [NOTE: No explanation was offered as to a 10 pound weight gain for this resident in the 6 days which had elapsed since her previous weight]. *3/3/14, 109 pounds. (10.7 % decrease in 30 days.)</p> <p>On 3/5/14, an Interdisciplinary Progress Note from the facility RD documented, "...Will [change] to small portions as resident gets overwhelmed [with] amount of food on the plate. Intakes: 50/50/50 [fifty percent of each meal]. Resident is dependent on staff for meals. Comfort measures. Will follow for needed interventions."</p> <p>No further weights were documented in the resident's chart at the time of the survey, and no futher interventions were documented as implemented.</p> <p>On 4/8/14 between 12:05 PM and 12:25 PM, Resident #3 was observed at the lunch meal. The resident was assisted by LN #4 to consume her meal. Neither ice cream nor yogurt were provided for the resident. The resident consumed approximately 45-50 % of the meal. No supplement was offered.</p> <p>On 4/9/14 at 2:15 PM, the RD was asked about the facility's process for monitoring weight changes. The RD stated the facility nurses were primarily responsible for monitoring resident weights, and would only notify the RD if there was a problem. The RD stated residents were weighed weekly after admission for the first month, until it could be established the resident's weight was stable.</p>	F 325	

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F 325	<p>Continued From page 104</p> <p>On 4/10/14 at 10:35 AM, the DNS and CMO were asked about the weight changes for Resident #3. The DNS stated the facility first noted a weight change for this resident in February 2014. [NOTE: The resident had been noted with weight loss of 6.6 % as early as 12/13/13.] The DNS stated she would have to research further regarding this resident's weight loss. The DNS confirmed the RD statement the facility normally weighed a resident weekly after admission until their weight was known to be stable. The DNS was asked if the resident's weight was considered stable after the 1/1/14 weight, when the facility stopped weighing her weekly. The DNS reviewed the weights and stated, "No, but I will have to look into it a little more." The DNS stated if the resident consumed less than 50% of her meal, she would be offered a supplement. The DNS was informed of the surveyor's observation of neither yogurt nor ice cream being provided for the resident, nor a supplement being offered when the resident had only consumed approximately 50% of her meal.</p> <p>On 4/11/14 at 9:00 AM, the DNS reported that following the resident's weight decline noted on 1/1/14, the OT had become involved on 1/8/14, because the resident couldn't see her food. The DNS was unable to identify any interventions implemented between 1/1/14 and 1/18/14. The DNS was unable to explain how the effectiveness of OT interventions was monitored in the absence of more frequent weights. The DNS re-iterated the resident was on comfort care only. The DNS could not explain how continuing to assess, implement, and monitor oral nutritional interventions was inconsistent with comfort care.</p>	F 325		

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F 325	Continued From page 105 On 4/11/14 at 6:00 PM, the Administrator, DNS, and CMO were informed of the surveyor's findings. The facility offered no further information.	F 325	F327 SUFFICIENT FLUID TO MAINTAIN HYDRATION	
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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure residents' water pitchers were in reach to maintain adequate hydration. This was true for 2 of 4 sampled residents (#s 3 and 8) reviewed for hydration. This failure had the potential to cause physical harm from dehydration. Findings included: 1. Resident #8 was admitted to the facility on 3/6/13 with multiple diagnoses which included dementia and muscle weakness. The most recent significant change MDS assessment for Resident #8, dated 2/5/14, documented in part: * Severely impaired cognition with a BIMS of 2; * Extensive assistance required with 1 person for bed mobility, transfers, ambulation in corridor, dressing, personal hygiene, toilet use and bathing; and, * Range of motion impairment on one side of the upper extremities.	F 327	Corrective Actions for Residents Affected; Resident #3 was assessed for indications of hydration status and fluids were within reach on 4/14/14 by RN unit manager. Resident #3 had a renal function panel drawn on 4/17/14 that indicated good hydration status and were reviewed by facility NP. Resident #8 was assessed for indications of hydration status and fluids were within reach on 4/14/14 by RN unit manager. Resident #8 had a renal function panel drawn on 4/15/14 that indicated good hydration status and were reviewed by facility NP. Identifying other residents having the potential to be affected, and what corrective action will be taken; Center rounds were conducted by resident ambassadors on or	5/12/14

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F 327	Continued From page 106 Resident #8's Care Plan documented in part: * Focus - "Risk for falls related to: advanced age with need for staff assist with ADLS [activities of daily living] to level indicated and Hx [history] of noncompliance with medical tx [treatment], fall 1/25/14 with Dx [diagnosis] of left humerus Fx [fracture]." Date initiated: 3/11/13 and revision on 2/7/14; * Interventions - "When resident is in bed, place all necessary [sic] personal itmes [sic] within reach." Date initiated: 3/11/13; * Focus - "Hypothyroidism: has Dx of hypothyroidism with need for hormone replacement." Date initiated 3/29/13; * Interventions - "Encourage fluid and fiber intake." Date initiated 3/29/13; * Focus - "HYDRATION CARE PLAN: Risk for dehydration characterized by fluid volume deficit; dry skin and mucous membranes, poor skin turgor and integrity related to: cognitive state, laxative/enema use, DM [Diabetes Mellitus], hypothyroidism, dementia." Date initiated 3/11/13 and revision on 2/7/14; and, * Interventions - "Offer water/fluids throughout the day." Date initiated 3/11/13 and revision on 11/1/13. On 4/8/14 the surveyor made the following observations of Resident #8: * 8:04 a.m., the resident was sitting in her wheelchair in her room wearing a pink top with short sleeves. The resident's bilateral arms were dry and flaky; * 12:03 p.m., the resident was lying on top of her bed resting wearing a pink top with short sleeves. The resident's water pitcher was on the bedside table which was across the room next to the bathroom door, and the resident's bilateral arms	F 327	before 4/25/14 to ensure fluids were within reach. Corrections made as indicated at time of rounds. Measures and systemic changes to prevent reoccurrence; Staff were re-educated on or before 5/2/14 by the facility's nurse practice educator on ensuring resident's access to fluids and to ensure residents that are mobile in their rooms have fluids accessible when out of bed Monitoring Corrective Actions for sustained corrections; Members of the IDT with Director of Nursing oversight will complete daily audits for 2 weeks, 3 audits weekly for 2 weeks then once weekly for 8 weeks to assure fluids of choice are within residents' reach beginning the week of 5/12/14. The results of these audits will be reviewed in the center's quality assurance and performance		

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F 327	<p>Continued From page 107</p> <p>were dry and flaky.</p> <p>* 12:30 p.m., the resident was still lying on top of her bed resting. The resident's water pitcher remained on the bedside table which was across the room next to the bathroom door; and,</p> <p>* 1:48 p.m., the resident was lying in bed with blankets over her. The resident's water pitcher was on the bedside table which was across the room next to the television and small dresser.</p> <p>On 4/10/14 at 9:08 a.m., the DON was asked if she would expect the water pitchers to be in reach of residents. She stated, "Water should be in reach, or be offered fluids." The DON was informed of the observations with Resident #8's water pitcher out of reach while the resident was lying in bed. No further information was provided.</p> <p>2. Resident #3 was admitted to the facility on 11/19/13 with multiple diagnoses which included advanced dementia.</p> <p>Resident #3's most recent quarterly MDS dated 1/31/14, coded:</p> <p>*Severely impaired cognitive skills;</p> <p>*Extensive assistance of one person for eating; and</p> <p>*Extensive assistance of two persons for bed mobility;</p> <p>Resident #3's care plan documented:</p> <p>*Focus area of hydration with an intervention of offering water and fluids throughout the day, dated 11/26/13.</p> <p>*Focus area for potential for urinary tract infection with an intervention to encourage to fluids dated 3/19/14; and</p> <p>Resident #3 was observed without water in reach:</p> <p>* On 4/7/14 at 1:25 PM and 2:10 PM, the resident</p>	F 327	<p>improvement committee monthly for three months. The Director of Nursing Services will be responsible for monitoring and follow up.</p> <p>Completion date: 5/12/14</p>	

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F 327	Continued From page 108 was laying in her bed. Her water mug was on the nightstand which was approximately 18 inches to her right and 18 inches behind her head. *On 4/8/14 at 8:25 AM, sitting in the television room near the west nurse's station, with no access to fluids. * On 4/8/14 at 10:10 AM, the resident was in her bed and her water mug was on her over bed table. The table was located approximately 10 feet across the room. *In the television room across from the west nurse's station with no access to fluids on 4/9/14 between 8:00 and 9:00, and again on 4/10/14 between 8:00 to 9:15 AM. [NOTE: During these times, the surveyors were observing the resident approximately every 5 minutes.] On 4/10/14 at 10:35 AM the DNS and CMO were asked about water for Resident #3. The DNS stated, "She loves it when I go in and give her a drink of water. She says 'Oooo, that's good.'" The DNS confirmed water should be available within the residents reach. The surveyors informed the DNS and CMO of the observations and the water not being within reach. The facility offered no further information.	F 327		
F 329 SS=D	483.25(l) 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.	F 329		5/12/14

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F 329	<p>Continued From page 109</p> <p>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.</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 residents who received psychopharmacological medications had adequate indications for its use, had specific target behaviors and adequate monitoring. This was true for 2 of 6 sampled residents (#s 1 and 10) reviewed for psychopharmacological medication use. These failures created the potential for harm should the medication regimen result in an unanticipated decline or newly emerging or worsening symptoms. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 9/10/13 with multiple diagnoses which included dementia with behavioral disturbance and depressive disorder.</p> <p>The most recent quarterly MDS assessment for Resident #1, dated 1/28/14, documented in part:</p>	F 329	<p>F329 UNNECESSARY MEDICATIONS Corrective actions for residents affected: Resident #1 behavior flow sheets and care plan were updated by Licensed Social Worker on 5/9/14 for resident specific behaviors related to her antidepressant medication ensuring staff were aware of what behaviors to monitor for. Resident #1 was reviewed by facility psychiatrist on 4/17/14 related to use of antidepressant. Resident #10 behavior flow sheets and care plan were updated by Licensed Social Worker on or before 5/8/14 for resident specific behaviors related to her psychopharmacological medication ensuring staff were aware of what behaviors to monitor for. Resident #10 was reviewed by facility psychiatrist on 4/17/14 related to use of mind-altering medication.</p>

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F 329	<p>Continued From page 110</p> <ul style="list-style-type: none"> * Severely impaired cognition with a BIMS of 4; * Depression score of 0, * No verbal or physical behaviors directed at self or others; and, * No hallucinations. <p>April 2014 recapitulated Physician's Orders for Resident #1, documented, "CeleXA (Citalopram Hydrobromide) 15 MG tablet by mouth (Oral) - daily Everyday: Give 15mg PO QD [my mouth every day] depression."</p> <p>Resident #1's MAR for March and April 2014 (Medication Administration Record) documented the depression medication was administered per Physician Orders.</p> <p>Resident #1's Care Plan documented in part:</p> <ul style="list-style-type: none"> * Focus - "I am currently utilizing drugs that have an altering effect on the mind related to Depressive Disorder." Date initiated 9/10/13 and revision on 2/23/14; * Interventions - "My mood and behaviors will be monitored." Date initiated 9/10/13. <p>A Psychotropic Medication Evaluation form for Resident #1 documented quarterly assessments for 4 quarters, 3 of which were filled out for the resident and were as follows:</p> <p>First Quarter, dated 9/13/13:</p> <ul style="list-style-type: none"> * Drug - "Celexa 20mg;" * Diagnosis - "Depression;" * Behavior warranting use of medication - "Depression." <p>Second Quarter, dated 12/19/13:</p> <ul style="list-style-type: none"> * Drug - "Celexa 20 mg q [every] day;" * Diagnosis - "depression;" * Behavior warranting use of medication - "neg[ative] statements, agitation." 	F 329	<p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:</p> <p>Residents with antipsychotic and antidepressant medications were reviewed by LSW or designee on or before 4/29/14 to ensure that resident behavior monitors were in place with specified behaviors and care plans reflected resident's specific behaviors.</p> <p>Measures and systemic changes to prevent recurrence:</p> <p>Staff were re-educated by Nurse Practice Educator or designee on or before 5/2/14 related to ensuring behavior monitors are in place and resident specific. Newly ordered psychotherapeutic medications will be reviewed in morning clinical meeting with interdisciplinary team to ensure that behavior monitors are in place.</p>	

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F 329	<p>Continued From page 111</p> <p>Third Quarter, dated 2/19/14: * Drug - "Celexa 15 mg q day;" * Diagnosis - "depression;" * Behavior warranting use of medication - "neg statements, tearfulness."</p> <p>Behavior Monthly Flow Sheets for February and March 2014 documented Resident #1 was being monitored for "Angry" and "Hallucinations/paranoia/delusion." The resident had 3 episodes of "Angry" on 2/1/14. No behaviors occurred since 2/1/14.</p> <p>The Behavior Monitoring and Interventions Flow Record for April 2014 documented the behavior symptom "Anger." No episodes of anger had occurred.</p> <p>On 4/9/14 at 9:09 a.m., the DON was shown Resident #1's Care Plan regarding mood and behavior monitoring. When asked which behaviors were being monitored, the DON stated, "I will have to get that for you," and said the nurses document on the behavior flow sheets. When asked how the CNA's would know which behaviors to look for, the DON stated, "I will look into that." Note: No further information was provided on how the CNA's would know which behaviors to look for.</p> <p>On 4/10/14 at 9:10 a.m., the DON was asked which target behaviors were treated with the Celexa for Resident #1. She stated, "Negative statements and tearfulness." When asked what negative statements meant for the resident, the DON said, "Expressing frustration and anger" and described the frustration as, "Situational frustration." The DON was asked if the resident</p>	F 329	<p>Monitoring Corrective Action for sustained corrections: Beginning the week of 5/12/14 members of the nurse management team will complete once weekly audits for 4 weeks then once monthly for 2 months to ensure that resident behavior monitors were in place with specified behaviors and care plans reflected resident's specific behaviors. The result of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly for three months. The Director of Nursing will be responsible for monitoring and follow up.</p> <p>Completion date: 5/12/14</p>	

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F 329	<p>Continued From page 112</p> <p>had hallucinations, paranoia or delusions at which she said the resident had previously displayed hallucinations such as making statements about seeing or hearing things. When asked what the resident was stating to see or hear, the DON stated, "I can't speak specifically to that." The DON described the resident as stable since the resident had been there.</p> <p>On 4/10/14 at 5:40 p.m., the Administrator and DON were informed of the medication issue. No further information was provided.</p> <p>2. Resident # 10 was readmitted to the facility on 3/24/14 from the hospital with diagnoses that included depressive disorder, and psychosis unspecified.</p> <p>The resident's Significant change MDS dated 3/31/14 documented in part: *BIMS score: 12- Cognition moderately impaired. *Signs and Symptoms of delirium: Disorganized thinking- Behavior present, fluctuates. *Potential indicators of Psychosis: Delusions. *Active diagnosis: Unspecified paranoid state. *Medication received: Antipsychotic- Given 7 out of 7 days. *Care Area Assessment Summary triggered: Psychotropic drug use- Care planning decision was marked to be completed.</p> <p>The resident's Physician orders dated 3/24/14 documented in part: **"Risperidone 0.5 mg [milligrams] tablet by mouth (oral) - at bedtime Everyday: 1 TAB PO Q HS."</p> <p>The resident's MAR dated March 2014, documented:</p>	F 329			

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F 329	<p>Continued From page 113</p> <p>*The resident received the Risperidone 3/25 through 3/31, except on 3/26, which documented the resident refused the medication.</p> <p>*Is the resident exhibiting side effects from the medication?: "N" [No] was documented for day and night shift from 3/24/ through 3/31. The April 2014 MAR documented "N" from 4/1 through day shift 4/10.</p> <p>*NOTE: The document did not describe the side effects of the medication to be monitored.</p> <p>The resident's Behavior Monthly Flow sheet dated March 2014 documented in part: *Drug/Dose: "Sertraline HCL, 50 mg." *NOTE: The document had 3 behaviors to be monitored. The documentation was started on 3/2/13 and documented through 3/20/13, which was prior to the resident being admitted to the hospital. A monitor sheet for Risperdal was not provided.</p> <p>The resident's Care Plan documented in part: *Focus: "I am currently utilizing drugs that have an altering effect on the mind related to my history of depression and anxiety." Date Initiated: 8/1/13 Revision on: 8/1/13 *Interventions: -"My medications will be evaluated for their effectiveness and side effects for possible decrease/elimination of psychotropic drugs." Date initiated: 8/1/13 -"My mood and behaviors will be observed and monitored for my medications effectiveness." Date Initiated: 8/1/13. *Focus: "Risk for falls related to: use of psychotropic medications, impaired balance, pain, generalized weakness." Date Initiated: 7/31/13. *Interventions:</p>	F 329		

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F 329	<p>Continued From page 114</p> <p>- "Evaluate effectiveness and monitor for side effects of psychotropic drugs." Date Initiated: 7/31/13</p> <p>NOTE: The care plan did not address the behaviors, or side effects that were to be monitored, pertinent to the resident.</p> <p>The Psychotropic Medication Evaluation completed by a LN, dated 3/24/14, documented in part:</p> <p>*Drug, dosage, frequency: "Risperidone 0.5 mg po [by mouth] BID [twice daily]."</p> <p>*Behavior warranting use of medication: "Delirium."</p> <p>*NOTE: The assessment did not describe the delirium symptoms that were to be monitored.</p> <p>The resident's Skilled Charting Guidelines Tool, which was not dated, documented in part:</p> <p>*Nursing: Document on circled / highlighted items daily in nurse notes: "Agitation," "Delusional thoughts," and "Hallucinations."</p> <p>The resident's IDT notes documented entries on 3/24, 3/26, 3/27, 3/28, 3/29, 4/5, and 4/7. The entries on 3/26, 3/27, 3/29, 4/5 and 4/7 documented on the items from the skilled charting guidelines tool.</p> <p>*NOTE: The IDT notes had days which there was no documentation on the listed items to document on daily. There was no documentation on the resident's condition from 3/29 to 4/5, a period of 6 days.</p> <p>The Physician Progress note dated 3/28/14 documented in part:</p> <p>*History: "The patient a week ago was in severe delirium, psychotic symptoms. The patient was sent to the emergency room. The patient was</p>	F 329		

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F 329	<p>Continued From page 115</p> <p>given Risperdal. The patient has been stabilized. They did not find any specific cause for her delirium."</p> <p>*Assessment and Plan: "The patient with a diagnosis of psychotic disorder, unspecified, depressive disorder. Is currently on sertraline 75 mg and Risperdal 0.5 mg at bedtime daily. Benefits outweigh the risks. The patient's psychotic symptoms are quite severe and involve visual hallucinations, persecutory delusions, I suspect the patient has underlying advanced dementia also and follow up as needed. Staff is to use nondrug strategies to manage the patient's agitation."</p> <p>NOTE: The resident's care plan did not document 'non drug strategies to manage the patient's agitation'.</p> <p>On 4/9/14 at 9:13 am, the surveyor asked the DON and MCO, why and when the resident was started on the Risperdal, the DON stated, "She was having an increase in hallucinations and agitation. Then she went to the hospital and they may have done another adjustment." The surveyor asked for a specific diagnosis other than delirium, and the DON stated, "OK." The surveyor asked for a description of the behaviors that were to be monitored, the DON did not respond. The surveyor asked for the resident's care plan for nondrug interventions, and behaviors that were to be monitored, the DON stated, "Ok."</p> <p>On 4/9/14 at 12:20 pm, the DON provided the orders for the Risperidone and stated, "She was started on 2/28/14. [Psychiatrist's name] saw her while she was in the hospital and adjusted the Risperidone. I did not find a diagnosis of dementia on the order it is for psychosis." The</p>	F 329			

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F 329	Continued From page 116 surveyor asked the DON to describe what that would be for the resident, the DON did not respond. On 4/9/14 at 1:15 pm, the DON and MR [Medical Records] were asked if there were behavior monitoring sheets for the resident, the DON stated, "We are still looking into that." On 4/10/14 at 3:30 pm, the surveyor asked the DON and Administrator for the care plan on behaviors for the resident, the DON stated, "It's not on there," and she asked, "Is there a delirium care plan?" On 4/11/14 at 9:00 am, the DON provided documentation for benefits outweigh the risk and nurse notes. The surveyor asked for the documentation that monitored the behaviors and the behavior care plan and she stated, "The only care plan there is, is on delirium and not on behaviors, so I am not going there." The surveyor asked who implemented the behavior sheets the facility used to monitor specific behaviors for the residents, the DON stated, "[SW name] puts the behavior monitor sheet in place and she changes the behaviors we are monitoring month to month. There are no behavior sheets. We are watching for documented behaviors since she returned in March." On 4/10/14 at 6:00 pm , the Administrator, DON and the MCO were informed of the findings. No additional information was provided.	F 329			
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364		5/12/14	

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F 364	<p>Continued From page 117</p> <p>food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident group interview and test tray results, it was determined the facility failed to prepare and serve palatable food. This was true for 15 of 15 residents in the resident group. The deficient practice had the potential to cause more than minimal harm if residents did not enjoy good quality of life and have their nutritional needs met because of unpalatable food. Findings included:</p> <p>On 4/8/14 at 10:40 AM, when asked about the palatability of the food served in the facility, all 15 of the residents began to make sounds of displeasure, many of them audibly booing. When asked, the residents identified, specifically: *The flavor and appearance of the food was such that at times they were not even sure what they were eating. *Many times the residents had been served foods they disliked, repeatedly, even after they had told the staff they disliked an item. *Usually the food served in the dining rooms was of a palatable temperature, but when the residents chose to dine in their rooms the food served was consistently cold. *It was not uncommon for the meals to start 15 to 20 minutes late. *One resident stated the Resident Council had tried to address this issue with the facility in the past, and was told the facility was breaking in a new cook. But, the resident said, "That's what they've been saying for years."</p>	F 364	<p>F364 PALATABILITY No specific residents were identified.</p> <p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: On or before May 12, 2014 Residents have been interviewed using the "Food Satisfaction Surveys" related to taste and temperature by the facility's Dietary Manager. Facility's activity assistant reviewed the findings and improvements to improve meal temperature and palatability on 4/22/14 in resident council.</p> <p>Measures and systemic changes to prevent recurrence:</p>	

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F 364	Continued From page 118 *One resident stated, "While you're here, you should try the food and see what you think. But God bless you if you do, honey." On 4/9/14 at 1:00 PM, the surveyors and the facility Dietary Manager (DM) tasted both the main and alternate lunch together: *The pork ragu over noodles was cool when tasted. The temperature was 131 degrees Fahrenheit (F) when served. The DM stated, "It does need more seasoning." *The turkey with gravy was also cool when tasted, served at 128 degrees F. The DM stated she thought it was warm enough to eat, although agreed if she were served a meal at that temperature in a restaurant, she would send it back to be reheated. The surveyors all stated the temperature was too cool for a hot meal. *The sliced carrots were served at 122 degrees F. The DM described the texture as, "soggy, but palatable." The DM further stated, "The taste would keep me from eating any more. And the residents did complain they were soggy." *When asked to summarize her thoughts on the meal shared by the surveyors and DM, the DM stated, "It was a little cold, and could have used some more flavor. But in a restaurant, there wouldn't be 12 other people's trays put on the cart before mine." On 4/11/14 at 6:00 PM, the Administrator, DNS, and CMO were informed of the surveyor's findings. The facility offered no further information.	F 364	Staff were re-educated on or before 5/2/14 by Nurse Practice Educator or designee related to assuring food provided to residents is correct temperature and is palatable. Resident recommendations from "Food Satisfaction Surveys" have been implemented as appropriate by the IDT with oversight by the Dietary Manager. Monitoring Corrective Action for sustained corrections: Beginning the week of 5/12/14 members of the interdisciplinary team will complete 3 weekly audits/test trays for 4 weeks then 9 monthly for 2 months on assuring food served to residents is palatable and at the correct temperature. The results of these audits will be reviewed with Quality Assurance Performance Improvement Committee monthly for three months. The Dietary Manager will be responsible for monitoring and		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		5/12/14	

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F 371	<p>Continued From page 119</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was stored, prepared and maintained under sanitary conditions. This had the potential to affect 14 of 15 sampled residents (#s 1-10 and 12-15) and any resident who dined in the facility. This practice created the potential for contamination of food and exposed residents to potential sources of disease causing pathogens. Findings included:</p> <p>On 4/7/14 at 8:15 a.m., the Food Services Supervisor (FSS) accompanied the surveyor during the initial tour of the facility's kitchen. The following was observed by the surveyor:</p> <p>1. A large industrial mixer was located near the slicer and microwave and was covered with a black plastic bag. The surveyor requested to observe the mixer for cleanliness. The FSS removed the plastic cover. The mixer had visible white and tan debris on the mixer frame which was rough to the touch. The area directly above where the mixing bowl would be placed when in use, had a white and tan substance which was rough to the touch. The FSS stated, "Looks like we have some things on there, some spots."</p>	F 371	<p>follow up.</p> <p>Completion date: 5/12/14</p> <p>F371 KITCHEN SANITATION Corrective actions for residents affected: Residents 1, 2, 3, 4, 5, 6, 7, 8, 10, 13, 14, 15 were evaluated on or before May 12, 2014 and no outcomes were identified regarding this finding. Residents 9 and 12 no longer reside in this center. The Assistant Director of Nursing Services removed unlabeled and/or outdated food items from the 600 hall fridge on 4/7/14. Noted items in the kitchen were cleaned on or before 4/10/14 by facility's Dietary Manager.</p>

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F 371	<p>Continued From page 120</p> <p>2. The overhead hood which was above the grill and stove had dark brown, dusty debris. The FSS stated, "It needs cleaned. I'll say that right off."</p> <p>3. The top surface of the convection oven had a layer of dark brown, dusty debris build-up which was rough to the touch.</p> <p>4. A standing and rotating white fan was placed near the warewashing room and the kitchen entrance which blew into the kitchen and warewashing room. The surveyor requested the FSS to stop the fan to observe for cleanliness. The cage had dark gray, hairy debris stuck onto it and the edges of the fan blades had a layer of dark gray debris build-up. The FSS stated, "We need to clean it."</p> <p>5. A rack of 9 Dynex mugs were observed with the assistance of the FSS and 3 of 9 Dynex mugs had a gray dusty residue on the inside surfaces.</p> <p>6. The walk-in refrigerator had a rack containing four trays of peaches in dishes. Three of the trays were not covered. The fourth tray was covered with a plastic see-through sheet which was not dated or labeled. A large plastic bag was crumpled up and setting on top of the rack. The FSS stated they, "Usually put the bag over it."</p> <p>On 4/8/14 at 1:40 p.m., the white standing fan was observed by the surveyor to still have the dark gray, hairy debris on the cage, as well as the dark gray debris build-up on the fan blades. When asked if the fan had been cleaned, the FSS stated, "No, but I'm going to get to that."</p> <p>The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart</p>	F 371	<p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: Regional Vice President completed a food safety and sanitation audit on 4/16/14. All pantry fridges were audited on or before 5/12/14 by the Dietary Manager for sanitation, expired or undated food items. Any concerns were corrected at the time of audit.</p> <p>Measures and systemic changes to prevent recurrence: Staff were re-educated by Nurse Practice Educator or designee on or before 5/2/14 related to fridge sanitation and food storage as well as kitchen sanitation.</p> <p>Monitoring Corrective Action for sustained corrections:</p>		

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F 371	<p>Continued From page 121</p> <p>601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated:</p> <p>"(C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris...(5) At any time during the operation when contamination may have occurred." Subpart 602.13, Nonfood-Contact Surfaces, indicated, "Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues;" "Equipment food-contact surfaces and utensils shall be clean to sight and touch." Subpart 4-602.11 indicates, "(A) Equipment food-contact surfaces and utensils shall be cleaned:...(5) At any time during the operation when contamination may have occurred."</p> <p>On 4/8/14 at 4:25 p.m., the Administrator and DON were informed of the kitchen observations. No further information was provided.</p> <p>2. On 4/7/14 at 8:15 AM, during the initial tour of the facility, a small storage room was noted at the entrance to the 600 hall, with the door propped open. A white refrigerator/freezer was inside. A sign on the front of the refrigerator stated, "No employee food in fridge."</p>	F 371	<p>Beginning the week of 5/12/14 members of the Interdisciplinary Team will complete weekly audits for 4 weeks then monthly for 2 months on observations related to kitchen sanitation and pantry refrigerators. The result of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly for three months. The Dietary Manager will be responsible for monitoring and follow up.</p> <p>Completion date:</p>	5/12/14

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F 371	Continued From page 122 The following items were found inside: *In the freezer portion, there were approximately 20 packages labeled, "Lemon Glycerine Swabs." There were also 2 wrapped bean and cheese burritos. *1 small Styrofoam container, approximately 8 ounces, with cooked pasta inside. The container was not labeled with either a name or a date. *A plastic bag with 4 oranges, dated 3/4/14, no name. *A container of fresh blueberries, dated 3/31/14, no name. *A plastic tub of heart shaped cookies, which appeared to be homemade. The container was dated 3/6/14. No name was noted. *A plastic bag with 2 limes, not labeled with either a name or a date. *A covered pink mug with a small amount of liquid inside. There was a hole in the cover to allow a straw to be inserted. It was not labeled with a name, date, or contents. *An opened pouch of Australian licorice, not labeled with a name or a date. *The produce drawer on the bottom left hand side had approximately 1 inch deep of gelatinous goo solidified on the inside, covering the first 2" of the drawer. At 8:25 AM, LSW #15 confirmed the door to the room should have been secured, and the refrigerator was designated as a storage area for resident food. On 4/7/14 at 4:30 PM, the Administrator and DNS were informed of the surveyor's observations. The facility offered no further information.	F 371			
F 406	483.45(a) PROVIDE/OBTAIN SPECIALIZED	F 406		5/12/14	

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F 406 SS=D	<p>Continued From page 123 REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility failed to provide Specialized Rehabilitation services to 1(#16) of 1 resident sampled for Specialized Rehabilitation services. The deficient practice had the potential to cause more than minimal harm when Resident #16 was admitted on 5/3/13 with a primary diagnosis of specified Rehabilitation procedure and the facility failed to provide the resident with an evaluation for Physical therapy. Findings include:</p> <p>The resident was admitted on 5/3/13 with diagnoses that included a primary diagnosis of specified Rehabilitation procedure, secondary diagnoses of abnormality of gait, and muscle weakness.</p> <p>The resident's MD note dated 5/7/13 documented: *Assessment and Plan: -2). "Chronic lower extremity weakness, could be partly due to neuropathy. Continue to have</p>	F 406	<p>F406 PROVISION OF SERVICES Corrective actions for residents affected: Resident #16 was discharged from facility on 5/28/13.</p> <p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: A review of the last 30 days of MD orders for skilled therapies were reviewed by the Director of Nursing Services on 5/2/14 to ensure therapy evaluations were completed per MD order. No outstanding evaluations were noted at time of review.</p> <p>Measures and systemic changes to prevent recurrence: Staff were re-educated on or before 5/2/14 by Nurse Practice Educator or designee related to ensuring that the therapy department receives</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/11/2014
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F 406	<p>Continued From page 124 therapy work with him."</p> <p>The resident's IDT (Interdisciplinary Note) dated 5/7/13 documented in part: "Resident would also like to work on balance and strength, he was informed that the nurse had put in a request for therapy."</p> <p>The resident's Physician order dated 5/15/13, and signed by the Physician 5/17/13, documented: *Change in patient status/purpose of fax: "PT [Physical therapy] eval[uate] and treat." *Physician order/response: "OK." *NOTE: The resquest for the Physician order was faxed to the physician 12 days after the resident was admitted to the facility.</p> <p>On 4/11/14 at 8:55 am, the UM[Unit Manager] for the unit the resident resided on while in the facility was asked, if a resident is admitted with a diagnosis for Rehabilitation, what does that usually mean, she stated, "The main goal is to come in for rehab to go to another facility that is a lesser level of care." The UM was shown the order for PT and the date of 5/15/13, and stated, "That is odd, that it took that long."</p> <p>On 4/11/14 at 9:20 am, the surveyor asked PT Aide #23 and PT Aide #24, what would the program specified rehabilitation be, and PT aide #23 stated, "If they come for rehab they will come with orders sometimes, or through the 24 hour report we will find out about the need. I don't really know much else, you will have to ask the manager."</p> <p>On 4/11/14 at 11:15 am, the surveyor asked the DON if the resident was in the facility for rehab, and she stated, "Yes, and dialysis." The surveyor</p>	F 406	<p>therapy orders at time of receiving for evaluations to be completed.</p> <p>Monitoring Corrective Action for sustained corrections: Beginning the week of 5/12/14 the Director of Nursing Services or designee will complete once weekly audits for 4 weeks then once monthly audits for 2 months related and the implementation of therapy orders. The results of these audits will be reviewed with Quality Assurance Performance Improvement Committee monthly for three months. The Director of Nursing Services will be responsible for monitoring and follow up.</p> <p>Completion date: 5/12/14</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 406	<p>Continued From page 125</p> <p>asked the DON how long after a resident was admitted for rehab would it be before PT would know about the resident, and the DON stated, "Our admissions coordinator, coordinates that to all departments, including therapy on the day he arrives." The surveyor asked if she thought 5/15 was a long time to wait to get an order for PT for a resident who entered the facility for rehab, she replied, "If they don't come in with therapy orders we have to request them. Sometimes we have to wait for approval from insurance." The DON was asked if they were waiting for the insurance approval, would there have been a notification of this to the resident, and she stated, "There should be a notification or something that he was aware we were waiting for it."</p> <p>On 4/11/14 at 11:25 am, the surveyor asked the Administrator for the initial evaluation for the resident, and he stated, "We do not have an evaluation for PT for him. We did not do it, but reviewing his ADL's [Activity of Daily living] and he was independent we did not cause him harm. We did not get a discontinue the order for the evaluation either. This citation should be a level 1 not more than minimal harm."</p> <p>On 4/1/14 at 12:00 pm, the Administrator was notified of the findings.</p> <p>On 4/14/14 at 3:46 pm, a fax was received from the facility. The additional information did not resolve the issue.</p>	F 406			
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system</p>	F 431		5/12/14	

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F 431	<p>Continued From page 126</p> <p>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> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and Policy and Procedure review, it was determined the facility failed to ensure expired medications, Calcium and Docusate Sodium, were not available for administration to residents. This was</p>	F 431	<p>F431 STORAGE OF DRUGS AND BIOLOGICALS</p> <p>Corrective actions for residents affected:</p> <p>No residents identified or noted to be effected. The medications identified calcium and stool softeners were destroyed by the Assistant Director of Nursing Services on 4/9/14 per safe recommendations.</p> <p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:</p> <p>Medication rooms and medication carts were reviewed for expired medications on or before 5/10/14 by members of the nurse management team. No other expired medications found at the time of review.</p> <p>Measures and systemic changes to prevent recurrence:</p>		

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F 431	<p>Continued From page 127</p> <p>true for 1 of 5 medication carts and 1 of 2 medication storage rooms. This created the potential for sub-optimal efficacy by any resident who could have received the expired medication. Findings included:</p> <p>The Storage and expiration Dating of Dugs, Biologicals, Syringes, and Needles Policy and Procedure, dated 08/01/02 and revised on 05/16/11, documented in part: * Process - "3. Drugs and biologicals that have an expired date on the label or are after manufacturer/suppler guidelines/recommendations, or if contaminated or deteriorated, are stored separately, away from use, until destroyed or returned to the provider."</p> <p>On 4/9/14 at 2:18 p.m., during inspection of the 600 hall medication cart with LN #1 in attendance, 1 bottle of Calcium 500 mg [milligrams] was observed as expired in March 2014.</p> <p>On 4/9/14 at 2:19 p.m., the ADON was informed of the expired medication and she acknowledged it had been expired, "By a few days."</p> <p>On 4/9/14 at 2:20 p.m., during inspection of the 500 and 600 hall medication storage room with LN #2 in attendance, 2 bottles of stool softener Docusate Sodium 250 mg were observed as expired in February 2014. LN #2 read the expiration dates, "2/14, 2/14."</p> <p>On 4/9/14 at 2:22 p.m., the ADON walked towards the nurses station and asked the surveyor what else had been found. The ADON acknowledge the 2 bottles of medication were expired.</p>	F 431	<p>Monitoring Corrective Action for sustained corrections: Beginning the week of 5/12/14 members of the nurse management team will complete once weekly audits for 4 weeks then once monthly audits for 2 months on observations related to ensure that medication carts and medication rooms are free of expired medications. The result of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly for three months. The Director of Nursing Services will be responsible for monitoring and follow up.</p> <p>Completion date:</p>	5/12/14	

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F 431	Continued From page 128	F 431			
F 441 SS=D	<p>On 4/9/14 at 6:00 p.m., the Administrator and DON were informed of the expired medication.</p> <p>On 4/11/14 at 9:00 a.m., the DON was asked who was in charge of the medication storage rooms. She said Central Supply was in charge during the week and the Nurse Manager was in charge on the weekends. The DON added the Nurse Manager will sometimes do audits on the weekends.</p> <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</p>	F 441	<p>F441 INFECTION CONTROL Corrective actions for residents affected: Resident #11 was reviewed by the facility's Infection Control Nurse on 4/16/14 for signs or symptoms of infection with none noted at time of review. Resident #11's catheter bag was observed off the ground on 4/20/14 by weekend RN charge nurse. Resident #23 was reviewed by the facility's Infection Control Nurse on 4/16/14 for signs or symptoms of infection with none noted at time of review. Resident #23 was observed with catheter bag in a privacy bag off the ground on 4/14/14 by the RN unit manager. Resident #24's mattress was replaced on 4/9/14 by the facility's Housekeeping Director.</p> <p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective</p>	5/12/14	

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F 441	<p>Continued From page 129</p> <p>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> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure the implementation of proper infection control measures related to: *Providing clean equipment/mattresses for residents to use; and *Preventing foley bags from lying and dragging on the floor. This was true for 1 random resident (#24), and 2 of 5 residents (#s 11 and 23) observed with foley catheters. These practices created the potential for illness by increasing the risk for the development and spread of infection. Findings include:</p> <p>1. On 4/7/14 at 8:20 AM, during initial tour, resident #24's mattress was observed without linens and had a large stain in the center of the mattress approximately 12 in by 12 in. Housekeeping staff #9 approached the surveyor, looked at the mattress and said, "The material is starting to rot. I keep telling them to replace it."</p> <p>On 4/9/14 at 5:10 PM, LN #6 was shown the</p>	F 441	<p>action will be taken: Residents with catheters were observed having catheter bags covered and off the ground on 4/20/14 by the RN weekend manager and again on 4/21/14 by facility's Infection Control Nurse. Housekeeping Director or designee completed an audit of mattresses to assure that mattresses were not rotted on or before 4/23/14. Findings corrected at time of review.</p> <p>Measures and systemic changes to prevent recurrence: Staff were re-educated on or before 5/2/14 by Nurse Practice Educator or designee related to ensuring catheter bags are not touching the ground. Residents in low beds will have bags placed in basins while in bed and residents with tilt wheel chairs will have shortened strings to ensure not touching the floor.</p> <p>Monitoring Corrective Action for sustained corrections:</p>		

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F 441	<p>Continued From page 130</p> <p>rotted mattress and said, "Oh dear, I'll get housekeeping to replace that. Thank you for bringing it to my attention."</p> <p>2. Resident #1 was admitted to the facility on 3/31/14 following a CVA with left sided weakness, and with a foley catheter in place.</p> <p>Resident #1 was observed in bed, with his catheter drain bag and privacy bag in contact with the floor on 4/8/14 at 7:45 AM, 8:10 AM, 10:05 AM, and 2:45 PM.</p> <p>On 4/9/14 at 3:50 PM, the DNS and CMO were informed of the surveyor's observations. The CMO stated, "When we were in there (the resident's room) on Monday (4/7/14), it wasn't on the floor." The facility offered no further information.</p> <p>3. Resident # 23 was admitted to the facility on 10/27/04 with diagnoses that included, infantile cerebral palsy, and spinocerebellar disease.</p> <p>On 4/9/14 at 4:47 pm, the surveyor observed the resident seated in his w/c[wheelchair] by the nurse station. The resident's foley catheter bag was hooked under his w/c, the bag was dragging on the floor, the protective covering was off the bag, and urine was visible in the bag.</p> <p>On 4/9/14 at 4:54 pm, the surveyor observed the resident seated in his w/c at the dining room table. The protective cover was on the catheter bag, the bag dragged on the floor. The surveyor observed the 400 hall UM pull the resident's w/c back from the table and begun to wheel the resident down the hall towards the nurse station. The foley catheter bag drug on the floor, as the resident was wheeled down the hall. The surveyor asked the UM if the foley bag always</p>	F 441	<p>Beginning the week of 5/12/14 members of the nurse management team will complete once weekly audits for 4 weeks then once monthly audits for 2 months to ensure that catheter bags are covered and not in contact with the ground. Additionally, the housekeeping director or designee will complete once weekly audits for 4 weeks then once monthly for 2 months to ensure mattresses in use are in proper condition. The results of these audits will be reviewed with Quality Assurance Performance Improvement Committee monthly for three months. The Infection Control Nurse will be responsible for monitoring and follow up.</p> <p>Completion date: 5/12/14</p>		

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F 441	Continued From page 131 drug on the floor, and the UM stated, "Yes," and continued down the hall.	F 441			
F 468 SS=E	<p>On 4/10/14 at 6:00 pm, the Administrator, DON and CMO was notified of the findings. No additional information was provided.</p> <p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</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 interviews, it was determined the facility failed to ensure all corridors were equipped with handrails. This affected 4 of 15 (#s 4, 6, 7, and 10) sampled residents, and random resident #20. This had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents to not have handrail for stability when needed. Findings included:</p> <p>On 4/7/14 at 1:25 PM, approximately 95 feet of handrails were observed to be missing on the north side of the hallway connecting the East and West Wings of the facility.</p> <p>On 4/7/14 at 1:30 PM, approximately 140 feet of handrails were observed to be missing on the right and left side of the hallway labeled "The Growing Place."</p> <p>On 4/8/14 at 9:30 AM, Resident #20 was observed leaving the room at the end of the</p>	F 468	<p>F468 LIFE SAFETY Corrective actions for residents affected: Residents 4, 6, 7 and 10 were evaluated on or before May 12, 2014 regarding negative outcomes related to this finding. None were noted. Handrails have been ordered and will be installed in these areas as soon as they are manufactured and delivered.</p> <p>Identifying other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken: Areas of the facility have been evaluated by facilities maintenance to ensure that hand rails are in place as required by this regulation to ensure resident safety.</p> <p>Monitoring Corrective Action for sustained corrections:</p>	6/5/14	

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F 468	<p>Continued From page 132</p> <p>hallway, "The Growing Place" propelling himself in his wheelchair going towards the nurses station.</p> <p>On 4/8/14 at 10:30 AM, Activity Aid #17 was interviewed in the activity room located on the right side at the end of the hallway labeled, "The Growing Place." When asked how many residents come down the hallway and participate in the activity at that location, she reported, "We do cooking activities weekly, and in the evenings we do connections, a social activity. We get 10-15 residents usually who come here, but sometimes only 3."</p> <p>On 4/8/14 at 2:55 PM, the Maintenance Director was shown the missing handrails and stated, "The hallway [The Growing Place] used to be only administrative and the adult day care wing. Now they have opened it up to residents. This is why it had no handrails." No information was given about handrails in the walkway between the East and West Wings.</p> <p>On 4/8/14 at 4:00 PM, the Administrator and DON were informed of the issue. No further information was provided by the facility.</p>	F 468	<p>Beginning May 2014 for three months, the Maintenance Supervisor will provide the Safety Excellence Committee of the Facility's Quality Assurance and Performance Improvement (QAPI) Program, with any audits which identify missing, or problems with, handrails in this center.</p> <p>Completion date:</p>	6/5/14

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER
APEX CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
**8211 USTICK ROAD
BOISE, ID 83704**

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C 000 16.03.02 INITIAL COMMENTS

The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.

The following deficiencies were cited during the annual licensure and complaint survey of your facility.

The surveyors conducting the survey were:
Amy Jensen, RN, BSN, Team Coordinator
Nina Sanderson, BSW, LSW
Susan Gollobit, RN
Lauren Hoard, RN, BSN
Jana Duncan, RN, MSN
Noel Mathews, MSW

The survey team entered the facility on 4/7/14, and exited the facility on 4/11/14.

C 000

C 121 02.100.03,c,v Encouraged/Assisted to Exercise Rights

v. Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient/resident and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

This Rule is not met as evidenced by: Please see F 165 as it pertains to resident grievances.

C 121

Please refer to F165

RECEIVED

AUG - 6 2014

FACILITY STANDARDS

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

TITLE

(X6) DATE

[Handwritten Signature]

Administrative

81214

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER APEX CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 123	Continued From page 1	C 123		
C 123	02.100,03,c,vii Free from Abuse or Restraints vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to himself or to others; This Rule is not met as evidenced by: Please see F 221 as it pertains to physical restraints.	C 123	Please refer to F221	
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please see F 164 as it pertains to resident privacy.	C 125	Please refer to F164	
C 127	02.100,03,c,xi Private Association/Communication xi. May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record); This Rule is not met as evidenced by: Please see F 172 as it pertains to surveyor access to residents.	C 127	Please refer to F172	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/11/2014
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

APEX CENTER

**8211 USTICK ROAD
BOISE, ID 83704**

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C 147	<p>02.100,05,g Prohibited Uses of Chemical Restraints</p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician.</p> <p>This Rule is not met as evidenced by: Refer to F329 regarding clinical indications for use and unnecessary medication issues.</p>	C 147	Please refer to F329	
C 311	<p>02.107,07 FOOD PREPARATION AND SERVICE</p> <p>07. Food Preparation and Service. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance, and shall be attractively served at proper temperatures.</p> <p>This Rule is not met as evidenced by: Please see F 364 as it pertains to food palatability.</p>	C 311	Please refer to F364	
C 325	<p>02.107,08 FOOD SANITATION</p> <p>08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)."</p> <p>This Rule is not met as evidenced by:</p>	C 325	Please refer to F371	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER APEX CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704
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C 325	Continued From page 3 Refer to F371 as it relates to sanitary conditions in the kitchen.	C 325		
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: Please refer to F468 regarding handrails.	C 389	Please refer to F468	
C 392	02.120,04,a RESIDENT/STAFF COMMUNICATION 04. Resident/Staff Communication. Requirements governing communication are as follows: a. Each building shall have a telephone for resident use so located as to provide wheelchair access for personal, private telephone communications. A telephone with amplifying equipment shall be available for the hearing impaired. This Rule is not met as evidenced by: Please refer to F174 regarding accessible phones and private conversations.	C 392	Please refer to F174	
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 F315 as it relates to catheters.	C 650	Please refer to F315	

Bureau of Facility Standards

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BOISE, ID 83704

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C 671	02.150,03,b Handling Dressings, Linens, Food b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Please refer to F 441 regarding foley bags and equipment.	C 671	Please refer to F441	
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 for revision of care plans	C 782	Please refer to F280	
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Refer to F327 as it relates to hydration. Please refer to F325 regarding resident weight gain and weight loss.	C 787	Please refer to F325 & F327	
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F314 as it relates to pressure.	C 789	Please refer to F314	

Bureau of Facility Standards

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C 790	Continued From page 5	C 790		
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F323 as it relates to accidents	C 790	Please refer to F323	
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Refer to F431 as it relates to expired medications.	C 821	Please refer to F431	
C 950	02.302 SPECIALIZED REHABILITATION SERVICES 302. SPECIALIZED REHABILITATIVE SERVICES. In addition to rehabilitative nursing, the facility provides for or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (i.e., physical therapy, occupational therapy, speech pathology, and audiology) as needed by patients to improve and maintain functioning. This Rule is not met as evidenced by: Refer to F406, the resident did not receive Physical Therapy as ordered by the Physician.	C 950	Please refer to F406	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
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3232 Elder Street
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May 12, 2014

FILE COPY

Joseph B. Rudd, Administrator
Apex Center
8211 Ustick Road,
Boise, ID 83704-5756

Provider #: 135079

Dear Mr. Rudd:

On **April 11, 2014**, a Complaint Investigation survey was conducted at Apex Center. Amy Barkley, R.N., Nina Sanderson, L.S.W., Susan Gollobit, R.N., Q.M.R.P., Lauren Hoard, R.N., Jana Duncan, R.N. and Noel Mathews, L.S.W. conducted the complaint investigation. This complaint investigation was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on April 7 through April 11, 2014.

The following observations were conducted:

- Safety interventions for nine residents.

The following documents were reviewed:

- The facility's grievance logs from January 2014 to April 2014;
- Resident Council meeting minutes from January 2014 to April 2014;
- The facility's Incident and Accident Reports from July 2013 to April 2014;
- The entire medical records of the three identified residents (referred to as residents A, B and C in this letter);
- The medical records of ten residents for falls; and,
- The medical records of two residents for end-of-life care.

Joseph B. Rudd, Administrator
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The following interviews were conducted:

- Fifteen residents were interviewed at a group interview regarding nursing services;
- Four residents were interviewed individually regarding nursing services; and,
- The facility's Director of Nursing (DoN) regarding end-of-life care and resident falls.

The Resident A and Resident B were no longer residing in the facility.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006243

ALLEGATION #1:

The complainant stated Resident A did not receive appropriate nursing care at the end of life.

FINDINGS:

Resident A's closed record was reviewed. Progress notes and communication notes documented the providers were aware of the resident's deteriorating condition and that nursing services assessed and treated him.

The resident was assessed when his medical condition changed, and his comorbid conditions were managed appropriately prior to his death.

The DoN was interviewed regarding the Resident A. She reported the resident had multiple serious medical conditions. The resident's wishes regarding medical interventions and poor health contributed to his decline. She stated that the resident declined a few days before his death and that the nurses communicated regularly with the resident's medical doctor about his condition. The resident was seen by the provider the day before his death.

Based on records reviewed and staff interviews, it was determined the facility was in compliance with Federal guidelines.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated Resident B fell and was not assessed and later died from injuries

Joseph B. Rudd, Administrator
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sustained during the fall.

FINDINGS:

Resident B's chart documented she had three falls in the facility prior to her death. For the first fall, progress notes and Incident and Accident Reports documented the resident miscalculated the distance she needed to travel and slid herself to the floor with no reported injuries. The second fall was 11 days later and was an assisted fall. This fall was witnessed and no injury was sustained. The third fall was approximately three weeks later and was unwitnessed. The resident reported shoulder pain but no injuries were found. Resident B was transferred to hospice a week later with unrelated medical problems. The resident's falls were appropriately assessed, and although the facility did not implement interventions for the resident's safety after the second fall, this did not contribute to her death.

The DoN was interviewed regarding Resident B, and she reported the root cause of the fall was found after the resident's second fall but acknowledged that no additional safety interventions were implemented at that time. She reported that the resident was not injured when she fell and that the falls did not contribute to her death.

Based on records reviewed and staff interviewed, it was determined the allegation was substantiated because the facility did not implement safety interventions to prevent falls for Resident B. However, the resident's fall did not contribute to her death. The facility was cited at F323 for noncompliance.

CONCLUSIONS:

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

ALLEGATION #3:

The complainant stated that Resident C fell, hit her head at an unknown time and was not assessed by staff.

FINDINGS:

Resident C was interviewed and during the interview, the resident reported that she had a fall "a couple of months ago," where she fell off the bed, hit her head and got a bruise on the back of her head. The resident was unable to give details about the fall or who was involved. The resident reports that after the fall, nothing was done. She said, "I can't remember what they did exactly. They just scooped me up and put me back into bed." The resident denies being assessed by staff. The resident's chart and the facility's Incidents and Accidents Reports were reviewed for

Joseph B. Rudd, Administrator
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Page 4 of 4

over 10 months and no notes or incident reports were found documenting a fall or any unexplained injuries for the resident.

The DoN was interviewed regarding the resident's falls. She stated that Resident C's most recent fall was eight months ago and she did not hit her head when she fell. The resident had not had a fall for 14 months prior to that. When asked what the facility would have done if the resident reported that she fell but was not witnessed after the incident, she stated the facility would follow the same procedure as an unwitnessed fall and initiate the assessments and notifications. The DoN said, "If she fell and hit her head and no one witnessed it, we would still assess her and do neuro checks, just in case."

Although this allegation cannot be substantiated for Resident C, the facility was cited at F323 for noncompliance regarding falls for another resident.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



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

LKK/dmj



IDAHO DEPARTMENT OF
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May 12, 2014

Joseph B. Rudd, Administrator
Apex Center
8211 Ustick Road,
Boise, ID 83704-5756

Provider #: 135079

Dear Mr. Rudd:

On **April 11, 2014**, a Complaint Investigation survey was conducted at Apex Center. Amy Barkley, R.N., Nina Sanderson, L.S.W., Susan Gollobit, R.N., Q.M.R.P., Lauren Hoard, R.N., Jana Duncan, R.N. and Noel Mathews, L.S.W. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006300

ALLEGATION #1:

The complainant stated the resident was supposed to have physical therapy during the stay in the facility that never happened. The resident had not even received a physical therapy evaluation.

FINDINGS:

During the investigation the Director of Nursing, Administrator and Unit Manager were interviewed, and the record was reviewed.

The resident was admitted with a primary diagnosis of specified rehabilitation procedure. The physician's admission note dated May 7, 2013, documented that the plan for the resident was to continue to have therapy work with the resident.

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A physician's order was faxed to the physician, by the facility, on May 15, 2013, which documented, PT (physical therapy) evaluate and treat. On May 17, 2013, the physician faxed back "Ok."

The chart did not have a documented Physical Therapy evaluation.

On April 11, 2014, the Sol-Oasis Unit Manager was shown the order for the PT evaluate and treat dated May 15, 2013. The Unit Manager agreed it was an order for PT and that it was odd it took so long to obtain the order after the resident's admission.

On April 11, 2014, the Director of Nursing stated if the resident does not come in with therapy orders, they have to request them and sometimes they have to wait for insurance approvals. The Director of Nursing agreed that the resident should be notified when waiting for approval and was unable to verify that the resident had been notified, if in fact this was the reason the facility did not request the order for PT until May 15, 2013.

On April 11, 2014, the Administrator confirmed an evaluation for PT was not performed.

The facility was cited at F406 for failure to provide Specialized Rehabilitation Services.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated the resident was on dialysis three times a week while in the facility. The complainant stated the resident was told to find his own transportation, or he could use the facility van for \$15.00 per day.

FINDINGS:

During the investigation, the van driver's log was reviewed; the Director of Nursing, the Unit manager, Admission Coordinator and van driver were interviewed.

On April 11, 2014, the Director of Nursing verified that residents who needed a ride to dialysis, had rides set up by the van driver.

On April 11, 2013, the Sol- Oasis Unit manager verified that residents on the unit who needed rides to dialysis used the facility's van, unless the resident's wheelchair was too wide, if their family wanted to take them or the resident had to be transported by a stretcher. The Unit

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manager stated it was set up by the van driver.

On April 11, 2013, the van driver's log for the month of May 2013 was reviewed, and it verified the facility's van did not transport the resident. The resident was transported by another company.

On April 11, 2013, the Admissions coordinator and the van driver confirmed the resident was not provided rides to dialysis by the facility's van. The van driver stated the resident's rides were provided by an identified company, and he had made those arrangements for the resident. The Admission Coordinator, who oversees the van driver, stated the facility has a contract with three companies to transport residents if the facility is unable to do so, and at no cost to the resident.

The allegation was not substantiated due to lack of evidence that the facility told the resident to find his own transportation. The facility is required to assist the resident in arranging transportation but is not required to pay for the transportation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the resident was not provided enough food related to the resident's diabetes and dialysis needs.

FINDINGS:

During the investigation, the resident's chart was reviewed which included:

- Physician orders;
- Interdisciplinary Communication to Nutrition Services;
- Dialysis Communication Records; and
- Registered Dietitian (RD) assessments and notes.

The physician had ordered a regular renal diet with snacks and a fluid restriction of 960 milliliters per day for the resident. The resident had an order for the facility to send a sack lunch to dialysis with the resident.

The Resident's Interdisciplinary Communication to Nutrition Service form, dated May 6, 2013, documented the facility had provided a sack lunch of two sandwiches that were peanut butter and jelly, per the resident's preference. This sack lunch was to be provided on Monday, Wednesday

Joseph B. Rudd, Administrator
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Page 4 of 7

and Friday, to go with the resident on the days of dialysis. On May 9, 2013, a Communication to Nutrition Service form was provided to dietary for the patient's request of two deli sandwiches with lunch on dialysis days; Monday, Wednesday and Friday.

The resident's Dialysis Communication records, which were documented by the dialysis center, indicated the resident had eaten a sandwich and at another time had eaten lunch. On the communication forms, the resident had been given a meal prior to leaving the facility for dialysis.

The resident's RD progress note dated May 22, 2013, documented the resident's weight had increased since admit. The resident's meal intakes were 85% at breakfast, 75% at lunch and 100% at dinner. The facility provided an increase of food at night and when going to dialysis. The RD had performed a food preference interview on May 21, 2013, to document the resident's likes and dislikes of food.

This allegation was not substantiated due to lack of evidence that the facility had not provided enough food for the resident. The physician had ordered a regular renal diet and fluid restrictions related to the resident's dialysis. The record documented the facility had made changes in the resident's food preferences per the nutrition communication forms. The dialysis facility documented the resident ate either lunch or a sandwich while at dialysis. The RD documented the resident had gained weight while in the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the resident had to share a room with another resident and could not use the shower in the room. The resident turned on the water and no water came out of it.

FINDINGS:

During the investigation, the number of bathing facilities per licensed bed and the resident's Interdisciplinary Progress Notes (IDT) were reviewed.

The resident's IDT note dated May 7, 2013, documented a 72-hour care meeting with the resident. The issue of bathing was not documented as a concern during this meeting. On May 10, 2013, three of the facility's staff, the resident and the resident's Power of Attorney met to discuss concerns the resident and the POA had pertaining to the resident's stay. The bathing issue was not documented as a concern during this meeting.

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On April 11, 2014, the maintenance employee provided a diagram of the building with each room marked that had shower capabilities. The facility has seven bathing rooms and 18 resident rooms with showerheads that can be utilized as needed.

The facility had a sufficient amount of bathing facilities required for full occupancy of the building. The facility is not required to utilize showers in the rooms as long as they are able to provide the required amount of bathing facilities per licensed bed. The record did not document a shower concern during the stay in the facility.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated the resident received a bill for his stay when the stay was less than 30 days. The facility told the resident he would have to start paying only if he was in the building longer than 30 days.

FINDINGS:

Billing concerns were not investigated, as the Bureau does not have authority to investigate billing problems. The discharge planning of the resident was investigated.

The resident's Interdisciplinary notes, Social Service Progress notes and the Recapitulation of the stay were reviewed.

The resident's Social Service note dated May 21, 2013, documented the Licensed Social Worker (LSW) had told the resident he would need to discharge from the facility. The LSW told the resident the LSW could assist the resident with this.

The IDT note dated May 23, 2013, documented the resident wanted to discharge at the end of the month. The resident's desire was to look for placement in the community.

The LSW documented on May 27, 2013, the resident had requested to leave Against Medical Advice. The LSW educated the resident on the concerns the LSW had for the resident should the resident leave without medications or any services being set up. On May 28, 2013, the LSW talked with the resident who agreed to stay one more day so the necessary arrangements could be made.

The Recapitulation of the resident's stay dated May 28, 2013, documented, the resident's

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medications had been called to the pharmacy; orders for home health and transportation had been obtained and dialysis on Monday, Wednesday and Friday had been arranged.

The facility documented it had provided services at discharge of the resident to ensure continuity of care.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated the resident was required to attend groups and because the resident did not attend the groups on the days the resident was out to dialysis the facility was going to notify his physician.

FINDINGS:

During the investigation the resident's IDT (Interdisciplinary) notes, Social Service notes, Sol-Oasis assessments and physicians' faxes were reviewed.

On May 3, 2013, the resident was admitted to the Sol-Oasis unit of the facility.

On May 7, 2013, the resident with three staff members present identified the goals the resident had for while in the facility and when he discharged from the facility.

On May 8, 2013, the resident completed a Sol-Oasis assessment.

On May 10, 2013, the IDT notes documented a meeting with three staff members, the resident and the resident's Power of Attorney. During this meeting, the resident worked with staff to set up the skill groups the resident would attend.

On May 10, 2013, a Sol-Oasis Initial Group Program assessment was initiated that documented: resident's needs, resident's strength and the resident's goals. Part of this assessment was to attend groups to attain the goals the resident had desired.

The IDT notes, Social Service notes and physicians' faxes did not document that the resident's physician was notified that the resident had not attended groups.

The resident was admitted to the Sol-Oasis unit in the facility. The Sol-Oasis unit utilized groups to accomplish the resident's goals. The resident was made aware of this when the resident was

Joseph B. Rudd, Administrator
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admitted to the facility. The resident had been a part of setting the goals and planning which groups the resident would attend to accomplish the goals the resident had set. The facility had not documented in the record that the physician was notified when the resident did not attend the groups.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



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

LT/dmj