



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 1680

May 6, 2014

Joseph Frasure, Administrator
Aspen Transitional Rehabilitation
2867 East Copper Point Drive
Meridian, ID 83642

Provider #: 135130

Dear Mr. Frasure:

On **April 24, 2014**, a Recertification and State Licensure survey was conducted at Aspen Transitional Rehabilitation 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form

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CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 19, 2014**. Failure to submit an acceptable PoC by **May 19, 2014**, may result in the imposition of civil monetary penalties by **June 9, 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 29, 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 29, 2014**. A change in the seriousness of the deficiencies on **May 29, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 29, 2014** includes the following:

Denial of payment for new admissions effective **July 24, 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 24, 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 24, 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 19, 2014**. If your request for informal dispute resolution is received after **May 19, 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: 05/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during your annual Federal recertification survey.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Nina Sanderson, BSW, LSW Noel Mathews, MSW</p> <p>The survey team entered the facility on 4/21/14, and exited the facility on 4/24/14.</p> <p>Survey definitions: ADL/Adl's = Activities of Daily Living AST (SGOT) = Aspartate Aminotranferase (Serum Glutamic Oxaleacetic Transaminase) BIMS = Brief Interview Mental Status BUN = Blood Urea Nitrogen CBC = Complete Blood Count CMP = Complete Metabolic Panel CNM = Clinical Nurse Manager CRP = C-Reactive Protein DNS = Director of Nursing Services ESR = Erythrocyte Sedimentation Rate LPM = Liters Per Minute LN = Licensed Nurse L4-L5 = Lumbar 4 and 5 MAR = Medical Administration Record MCV = Mean Corpuscular Volume MD = Medical Doctor mg = milligrams O2 = Oxygen OT = Occupational Therapy PICC = Peripherally Inserted Central Catheter PT = Physical Therapy pt = patient RBC = Red Blood Count RDW = Red Cell Distribution Width</p>	F 000	<p>"This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <p style="text-align: right;">RECEIVED MAY 15 2014 FACILITY STANDARDS</p>		

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

TITLE

(X6) DATE

 Administrator 5-16-14

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

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F 000	Continued From page 1 RUC = Resource Utilization Coordinator sats. = Saturation s/s = signs and symptoms TAR = Treatment Administration Record	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F 157 Patient Specific: Patient number 1 has been discharged. Other Patients: All current patients charts have been reviewed to ensure that physicians are aware of abnormal lab results as outlined in F 157 and in the documentation the physician's name is present. Systemic Changes: Licensed staff have been inserviced in regards to notifying physicians of abnormal lab results as outlined in F 157 and documenting said notifications with the physician's name, <i>And physician's response</i>		

per conversation with DNS at 4/15/15 at 1:00 PM
Nancy Sanderson

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

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F 157	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure a resident's physician was aware of laboratory test results. This was true for 1 of 6 residents (Resident #1) sampled for physician notification. The deficient practice had the potential to cause more than minimal harm if the physician was unaware of abnormal laboratory values. Findings included:</p> <p>Resident #1 was admitted to the facility on 3/13/14 with multiple diagnoses which included L 4-L 5 diskitis/osteomyelitis, acute-on-chronic hyponatremia, chronic urinary retention with recent urinary tract infection, chronic systolic congestive heart failure, and hypothyroidism.</p> <p>Resident #1's Interagency/Interfacility Physician Orders, identified by the facility as the admission orders for this resident, documented the resident was to have laboratory work each Tuesday, including a CBC with differential, CMP, ESR, and CRP. The orders documented the results were to be faxed to a specific telephone number each week, although did not document which physician correlated with that number. Three physician names and a physician's assistant name were documented in various areas of the form.</p> <p>Completed laboratory reports in Resident #1's record documented abnormal values as follows: *3/18/14: -Sodium 131, normal range 132-143; -AST (SGOT) 10, normal range 13-39; -Alkaline Phosphate 137, normal range 30-128; -Protein 5.5, normal range 6.0-8.0;</p>	F 157	<p>Monitors:</p> <p>The D.O.N. or her designee will review 20% of patients charts weekly times 4 then monthly times 5 to ensure that physicians have been notified of abnormal lab results as outlined in F157 and documentation of said notification is in place with the physician's name.</p> <p>She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed.</p> <p>Date Audits will start: 05/19/14</p> <p>Date of Compliance: 5/29/14</p>		

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F 157	Continued From page 3 -Albumin 3.0, normal range 3.5-5.0; -C-Reactive Protein 44.5, normal range 0-5; -RBC 3.63, normal range 4.3-5.7; -Hemoglobin 9.7, normal range 13.5-18.0 -Hematocrit 28.9, normal range 41-50; -MCV 79.7, normal range 81-99; -RDW 18.2, normal range 10.5-15 -Lymphocytes 10, normal range 24-44. *3/25/14 -Potassium 5.2, normal range 3.6-5.1; -Alkaline Phosphate 131; -Protein 5.7; -Albumin 3.2; -RBC 3.38; -Hemoglobin 9.1; -Hematocrit 27.2; -Platelet count 561, normal range 140-440; -Lymphocytes 7.4; -ESR 40, normal range 0-15. *4/1/14 -Albumin 3.4; -RBC 3.51; -Hemoglobin 9.4; -Hematocrit 28.0; - MCV 79.8; -RDW 19.5; -Lymphocytes 16; -Monocytes 22, normal range 0-12; -ESR 54. *4/8/14 -BUN/Creatinine ratio 28.8; normal range 6.0-28.6; -AST (SGOT) 12; -RBC 3.56; -Hemoglobin 9.6; -Hematocrit 28.9;	F 157			

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F 157	<p>Continued From page 4</p> <ul style="list-style-type: none"> -RDW 20; -Platelet Count 508; -Lymphocytes 20; -ESR 55. <p>*4/15/14</p> <ul style="list-style-type: none"> -BUN/Creatinine Ratio 32.9; -AST (SGOT) 10; -RBC 3.62; -Hemoglobin 9.7; -Hematocrit 29.5; -RDW 20.3; -Lymphocytes 12; -Monocytes 18; -Eosinophils 7, normal range 0-6; -ESR 54. <p>The lower left hand corner of each of the above reports documented, "Notified [Infectious Disease Physician's Name]." However, it was not clear if this was the physician identified in the admission orders as the person to be notified of the laboratory results, nor was any acknowledgement or response from the physician documented. It was also not clear how the physician had been notified (fax, telephone, in person, etc).</p> <p>On 4/22/14 at 2:20 PM, the DNS and CNM were interviewed about the laboratory results for Resident #1. The CNM stated the results were called weekly to the Infectious Disease physician. However, when reviewing the resident's facility record, the CNM could not determine whether or not the physician had actually reviewed the information on the laboratory reports, or what the physician's response was regarding the abnormal values. The CNM stated, "Maybe they have it at [the physician's] office."</p>	F 157		

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F 157	Continued From page 5 On 4/24/14 at 1:30 PM, the Administrator and DNS were informed of the surveyor's concerns. On 4/28/14, the facility faxed additional information, which included a progress note from the Infectious Disease MD, dated 3/20/14, which had a check box marked for "Weekly Labs Reviewed." However, since this information was not available in the facility at the time of the survey, it did not resolve the surveyor's concerns of the facility ensuring physician notification.	F 157			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record	F 279	F 279 Patient Specific: Patient number 5 has been discharged. Other Patients: All current patient charts have been reviewed to ensure that an appropriate personalized care plan is in place for depression (if applicable) Systemic Changes: Licensed staff have been inserviced in regards to completing appropriate personalized care plans for patients with depression. Monitors:		

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F 279	<p>Continued From page 6</p> <p>review, it was determined the facility failed to develop a resident-specific care plan for a resident with a diagnosis of depression, on multiple anti-depressant medications, and with an MDS mood severity score indicating the presence of depression. This was true for 1 of 6 residents (Resident #5) sampled for care plan development. The deficient practice had the potential to cause more than minimal harm if the resident experienced continued depression or a deterioration in his mood state, because the facility did not implement a care plan appropriate for the resident's mental health needs. Findings included:</p> <p>Resident #5 was admitted to the facility on 4/5/14 with multiple diagnoses including Alzheimer's dementia and depression.</p> <p>Resident #5's Physician Order Report documented, beginning 4/5/14: *Paxil 40 mg daily for depression; *Abilify 5 mg daily for depression; and *Bupropion Hcl 150 mg twice daily for depression.</p> <p>[NOTE: Please see F329 as it pertains to the use of Abilify for Resident #5.]</p> <p>Resident #5's initial MDS assessment, dated 4/12/14, coded a mood severity score of 10, indicating moderate depression. Amongst the items triggered, the resident identified he felt down or depressed almost daily.</p> <p>Resident #5's care plan for "Alteration in Mood Status" contained pre-printed columns for "Problem," "Short Term Goal," and "Approach." Each column had pre-printed options, with a check box next to them. On 4/18/14, Resident</p>	F 279	<p>The Director of Nursing or her designee will review 20% of the patients' care plans weekly times four then monthly times 5 to ensure that appropriate personalized care plans are in place for patient's with depression. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed.</p> <p>Date Audits will start: 05/19/14</p> <p>Date of Compliance: 5/29/14</p>		

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F 279	<p>Continued From page 7</p> <p>#5's care plan was checked for:</p> <p>*Problem: "Depression related to:" and "Anxiety related to:". Each of these options had lines to add specific information regarding the resident. For each of these options, the lines were blank.</p> <p>*Short Term Goal: All boxes were checked, with the form documenting goals of, "Altered Mood Status will not Interfere with daily functions on an ongoing basis," "Episodes of anxiety will not Interfere in activities of daily living throughout his/her stay," and, "Patient's Mood Status will remain stable and positive without increased [signs and symptoms] of depression throughout his/her stay."</p> <p>*Approaches: All boxes were checked, with the form documenting approaches of, "Administer Medication per MD order," "Teach relaxation techniques," "Provide support and reassurance; validate concerns," "Monitor for adverse side effects of medications," "Monitor for [signs and symptoms] of withdrawal or increased depression," "Encourage family to visit regularly," and, "Encourage patient to express current feelings and needs."</p> <p>On 4/22/14, during a resident interview, Resident #5 stated he had been admitted to the facility following the removal of a previously replaced knee due to infection. The resident stated he currently had an antibiotic implant where the knee once was, and in a few more weeks would have the knee replaced again. The resident stated he was pushing to have the procedure done as soon as possible, because his wife was living on her own while he was in the facility, and he usually served as her caregiver. He had a number of brochures on the table in his room from home health agencies. The resident stated he usually used his time between therapies making calls,</p>	F 279			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	Continued From page 8 trying to hire someone to help him care for his wife until he could be discharged. On 4/23/14 at 9:00 AM, the DNS and CNM were asked about the care plan for Resident #5 in terms of the medications he was on, his MDS mood score, and the surveyor interview with the resident. The DNS and CNM were unable to describe the resident's history of depression, or what the staff should watch for in terms of understanding what was normal for the resident and what would be concerning. After reviewing the care plan for his mood state, the CNM agreed the care plan was insufficiently personalized for the resident. The facility offered no further information.	F 279			
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, resident and staff interview, and record review, it was determined the facility failed to ensure a resident had been assessed for his ability to intermittently catheterize himself correctly, or that physician's	F 315	F 315 Patient Specific: Patient number 1 has been discharged. Other Patients: All current patient charts have been audited to ensure that anyone that self catheterizes has been assessed and that appropriate orders are in place and documentation of said assessment and results of self catheterization are in place. Systemic Changes: Licensed staff have been inserviced in regards to performing and documenting assessments of patients who self catheterize and ensuring that appropriate orders and results of self-catheterization are in place.		

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F 315	<p>Continued From page 9</p> <p>orders were in place for the resident to self-catheterize. This was true for 1 of 2 residents (Resident #1) sampled for catheter use. The deficient practice had the potential to cause more than minimal harm if the resident developed a urinary tract infection or experienced urinary retention. Findings included:</p> <p>Resident #1 was admitted to the facility on 3/13/14 with multiple diagnoses which included L 4-L 5 diskitis/osteomyelitis, acute-on-chronic hyponatremia, chronic urinary retention with recent urinary tract infection, chronic systolic congestive heart failure, and hypothyroidism.</p> <p>Resident #1's re-admission MDS assessment, dated 3/20/14, coded: *BIMS of 15, indicating the resident was cognitively intact; *Extensive assistance of 1 person for toileting; *Impaired range of motion in one of his upper extremities; and *Required intermittent catheterization (cath).</p> <p>Resident #1's Physician Order Report (Recapitulation Orders) for April 2014 documented, "Straight Cath [every] 8 hours [as needed] for urinary retention." Date initiated 3/13/14.</p> <p>[NOTE: There was no information on the order regarding the type of supplies or equipment to be used, nor indicating the resident was to catheterize himself].</p> <p>There were spaces available on the Resident's TAR three times per day, with specific information regarding the time the catheter was utilized, and the amount of cc's (cubic centimeters) of urine</p>	F 315	<p>Monitors:</p> <p>The Director of Nursing or her designee will perform weekly audits times 4 then monthly times 5 to ensure that any patient who self catheterizes has had an assessment performed and documented and that appropriate physician orders are in place as well as documentation of results. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed.</p> <p>Date Audits will start: 05/19/14</p> <p>Date of Compliance: 5/29/14</p>	

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F 315	<p>Continued From page 10</p> <p>obtained via the catheter. There was also a space on the TAR for the initials of the nurse performing the treatment.</p> <p>The resident's TARs and Resident Progress Notes (PNs) were reviewed, as follows: *PN 3/14/14 at 11:02 PM, "...Straight caths self PRN..." *TAR 3/14/14 at 11:30 PM, 400 CCs urine obtained. *TAR 3/14/14 at 5:00 AM, 400 CCs urine obtained. [NOTE: The 5:00 AM catheterization was documented after the 11:30 PM one.] *PN 3/15/14 at 6:37 AM, "...self cathed x 2 for 400 cc each, last at [5:00 AM]..." *TAR 3/15/14 at 9:30 AM, 400 CCs urine obtained. *TAR 3/15/14 at 6:00 PM, 380 CCs urine obtained. *TAR 3/15/14 at 8:00 PM, 420 CCs urine obtained. *PN 3/16/14 at 5:24 PM, "...Voiding clear amber urine and self straight caths PRN..." [NOTE: The resident's TAR for 3/16/14 was blank, indicating the resident had not required catheterization that day.] *TAR 3/17/14 at 7:00 AM, 925 CCs urine obtained. *TAR 3/17/14 at 11:00 AM [four hours from the last catheterization], 80 CCs urine obtained. *TAR 3/17/14 at 7:20 PM, initialed as performed, but no CCs documented. *PN 3/17/14 at 10:38 PM, "...Voids and self straight caths PRN. Cathed for 306 cc this evening..." *PN 3/18/14 at 12:54 AM, "...straight caths himself, has adequate amounts of clear yellow urine..." [NOTE: It is unclear what constituted "adequate" amounts of urine.]</p>	F 315		
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F 315	<p>Continued From page 11</p> <p>*TAR 3/18/14 at 11:00 AM 500 CCs urine obtained.</p> <p>*PN 3/19/14 at 4:51 AM, "...last cath...[at 4:00 AM]..."</p> <p>*TAR 3/19/14 at 10:00 AM, 400 CCs urine obtained.</p> <p>*PN 3/20/14 at 3:18 AM, "...continues to self cath. This evening at [11:00 PM]hours, he cathed had 500 cc output. At [3:00 AM], he had 900 cc. [Patient] is very concerned about this much output..." [NOTE: This information was not recorded on the resident's TAR.]</p> <p>*TAR 3/20/14 at 10:00 AM, 600 CCs urine obtained.</p> <p>*TAR 3/21/14 at 4:00 AM, 575 CCs urine obtained.</p> <p>*PN 3/21/14 at 4:06 AM, "...does self cath at this time also. Able to void on his own approx. 100 mls [milliliters] once this shift..."</p> <p>*PN 3/22/14 at 1:56 AM, "...straight cathed himself for 600 cc clear yellow urine..."</p> <p>*TAR 3/22/14 at 6:00 AM, 1100 CCs urine obtained.</p> <p>*PN 3/23/14 at 1:29 AM, "...[patient] self caths for 600 cc this shift..."</p> <p>*TAR on 3/23/14 at 5:00 AM 80 CCs urine obtained. There was a subsequent procedure documented on 3/23/14, with the space for time reading, "475", and the space for the "CC's" containing initials.</p> <p>*PN 3/25/14 at 2:54 AM, "...cathed self for 300 cc at [midnight]..."</p> <p>*The TAR on 3/25/14 documented a nurse's initials, along with the number "350" in the "Time" area of the form. No further information was documented.</p> <p>*PN 3/26/14 at 2:57 AM, "...self cath twice last night..."</p> <p>*PN 3/27/14 at 4:40 AM, "...patient able to self</p>	F 315			

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F 315	Continued From page 12 cath..." *PN 3/28/14 at 4:46 AM, "...self cathes with no issues..." *PN 3/29/14 at 4:27 AM, "...cathed himself for 225 CCs at [midnight], and 300 CCs at [4:15 AM]..." *The TAR on 3/29/14 documented a nurse's initials, along with the number "600" in the "Time" area of the form. No further information was documented. *The TAR on 3/31/14 documented a nurse's initials, along with the number "300" in the "Time" area of the form. No further information was documented. [NOTE: The resident's TAR for April 2014, in the area to document the straight cath being performed, the time, and cc's obtained, was blank for the entire month.] *PN 4/3/14 at 4:12 AM, "...self cathes with no issues..." *PN 4/7/14 at 3:01 AM, "...Continues to self-cath and has adequate urinary output..." [NOTE: It was unclear what an "adequate" amount of urinary output was. It was also unclear from this entry if the urinary output was from the resident voiding on his own, or if he had been catheterized.] *PN 4/8/14 at 1:28 AM, "...self cathed for 225 CCs at [midnight]..." *4/11/14 at 3:33 AM, "...self cathes [every 4 hours]..." [NOTE: The physician's order for catheterization was once every 8 hours as needed, not every 4.] *PN 4/11/14 at 6:09 PM, "...Self straight cathes PRN and cathed this afternoon for 200 cc at [2:00 PM]..." *PN 4/14/14 at 3:16 AM, "...Continues to self-cath..." *PN 4/15/14 at 4:31 AM, "...cathes himself..." *PN 4/16/14 at 4:34 AM, "...self cathes..." [NOTE:	F 315		

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F 315	<p>Continued From page 13</p> <p>No further notations of the resident performing self-catheterization were documented in the PN's between 4/16/14 and the time of the survey on 4/21/14.]</p> <p>On 4/22/14 at approximately 8:30 AM, during a resident interview, Resident #1 stated, "I have to use a catheter on myself sometimes. I have done that for years. It gets a little dicey sometimes with this thing in my arm (gesturing to the PICC line in his left arm)."</p> <p>On 4/22/14 at 2:20 PM, the DNS and CNM were asked about the process for using the straight cath with Resident #1:</p> <p>*The DNS stated the facility did not have specific orders for specific supplies, but when the resident came to her and asked for more supplies, he would tell her what he needed and she would order them.</p> <p>*When asked if the facility had ever assessed the resident's ability to catheterize himself, the DNS stated, "At first the nurses had to help him because of his arm. Then they must have observed him at some point, but there would be no formalized assessment. He had been doing it for years." The DNS stated the documentation in the PN's should address the resident's competency at self-catheterization.</p> <p>*The DNS was asked how the frequency of the resident's need to catheterize himself, or the amount of urine obtained, was documented. The DNS stated, "I don't know."</p> <p>*The DNS was asked how often the resident was voiding. The DNS stated, "I don't know. We should be tracking [input and output], but we're not."</p> <p>*The DNS stated post-void residuals would not necessarily be checked by the facility, but the</p>	F 315		

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F 315	<p>Continued From page 14 facility would count on the resident to report them.</p> <p>On 4/23/14 at 8:45 AM, the DNS returned with additional information: *CNAs tracked how often the resident was voiding, absent the use of the catheter. It was unclear if that information was provided to/reviewed by the charge nurse. *Regarding the TAR, the DNS stated if there was no documentation on the TAR, then the catheterization had not happened. [NOTE: Even though the resident reported he had self cathed for years, and continued to do so in the facility, the resident's TAR for straight cath during April 2014, was blank.] *The DNS stated the facility did not have specific policies on self catheterization, but used the Lippincott Manual of Nursing Practice, Fifth Edition. The DNS provided pages 724 -726 as the facility's policy, which documented: "...Self-catheterization requires thorough and careful teaching by the nurse. The patient will probably use clean technique at home, but he must use sterile technique in the hospital because of the increased risk of infection...Record the date and times of catheterization, character of the urine...amount of the urine...and any problems encountered during the procedure. Note whether the patient has difficulty performing a return demonstration." [NOTE: A nursing handbook does not constitute a policy and procedure on the facility's part.] The facility failed to ensure the resident had an order from the physician to specify the resident could self-cath; did not assess the resident to ensure he employed appropriate technique, especially in light of the fact he had been very ill</p>	F 315			

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F 315	Continued From page 15 and now had a PICC line in his left arm; provide any teaching as may have been indicated by such an assessment; consistently document when the straight cath needed to be used, or the results; or identify when the resident might need assistance to identify when it was too soon or too late to use the cath (the documentation of the amount of urine collected from the catheter varied from as little as 80 CCs to more than 1000 CCs.) On 4/24/14 at 1:30 PM, the Administrator and DNS were informed of the surveyor's findings. The facility did not offer any 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 medical record review, review of the facility's policy and procedure and staff and resident interview it was determined the facility failed to implement interventions including adequate supervision and/or assistive devices to reduce the risk of falls for 1 of 9 (#4) sampled residents. This deficient practice had the potential for more than minimal harm if the resident's fell and sustained serious injury and/or decline in physical functioning. Findings include:	F 323	Patient Specific: Patient number 4 has been discharged. Other Patients: All current patients charts have been reviewed to ensure that appropriate interventions are in place to decrease the risk of falls. Systemic Changes: Licensed staff have been inserviced in regards to implementing appropriate interventions to decrease the risk of falling. Monitors:		

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F 323	<p>Continued From page 16</p> <p>Resident #4 was admitted to the facility with multiple diagnoses including, left rib fractures with left-sided atelectasis and pleural effusion.</p> <p>The resident's Admission Assessment, dated 4/10/14, documented the following:</p> <ul style="list-style-type: none"> - Cognitively intact with a BIMS of 15; - Extensive Assist of one person for bed mobility, transfers, dressing, toilet use, and bathing; - Had a fall the previous month with fractures. <p>The facility's Fall Prevention Policy and Procedure, dated 7/10/13, documented the following:</p> <ul style="list-style-type: none"> - The Admitting Nurse/Nurse Manager would be responsible for ensuring that interventions were initiated and communicated to appropriate staff for follow-up. - Staff would be notified of patients as risk for falls and interventions by shift-to-shift reporting, care plans and written communication book. <p>The resident's Fall Risk Assessment, dated 4/3/14, documented a score of "13," which indicated "the patient should be considered at RISK for falls."</p> <p>The Fall Risk Protocol and Care Plan, dated 4/3/14, documented:</p> <p>Problem: s/p L rib fx (status-post left rib fractures);</p> <p>Interventions: Moderate Risk, Occupational Therapy (OT)/Physical Therapy (PT) consult;</p> <p>Additional Interventions: pt (patient) ambulatory, mats [sic] not placed.</p> <p>The resident's Occupational Therapy Weekly Evaluation, dated 4/9/14, documented the following:</p> <ul style="list-style-type: none"> - "Pt (patient) focused on being independent with 	F 323	<p>The Director of Nursing will perform weekly audits times 4 then monthly times 5 of 20% of current patients' charts to ensure that appropriate interventions are in place to decrease the risk of falling.</p> <p>She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed.</p> <p>Date Audits will start: 05/19/14</p> <p>Date of Compliance: 5/29/14</p>		

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F 323	<p>Continued From page 17</p> <p>Adl's (Activities of Daily Living) however lacks insight into safety and requires skilled OT to give clear and precise steps to begin and complete tasks of Adl's. Pt. is impulsive and requires v/c's (voice commands) to slow down and pace herself; specifically with transfers and performing showering and dressing..."</p> <p>The resident's Physical Therapy Patient Evaluation & Plan of Care, dated 4/10/14, documented the following: - "Pt (patient) is at risk of falls/injury with recent musculoskeletal and/or neurologic impairment; skilled gait and balance training by a physical therapist are necessary for safe mobility."</p> <p>The resident's Fall Care Plan, dated 4/14/14, documented the following: - Assist with transfers and ambulation as needed; - Encourage patient to call for assistance with transfers and ambulation; - Encourage patient to keep room door open when not engaged in personal cares; - Educate patient and/or family regarding fall risks and safety needs; -PT/OT to address functional deficits; -Monitor for adverse side effects of medication regimen; consult MD as needed.</p> <p>An Incident Report, dated 4/17/14, at 8:05 PM, documented, "Patient found on the bathroom floor by the CNA. Patient unresponsive...Lying on the floor on her right side..." The resident was transported and admitted to a local hospital for further evaluation on 4/17/14.</p> <p>The Resident's Facility Progress Note, dated 4/18/14, at 6:37 AM, documented, "...Pt has been admitted to Neuro[logical] floor for hemothorax."</p>	F 323		

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F 323	Continued From page 18 Note: The resident was re-admitted to the facility on 4/20/14, after spending two days in the hospital. On 4/24/14, at 9:30 AM, the DNS, Admissions Nurse, and the RUC (Resource Utilization Coordinator) were interviewed. The surveyor asked how a resident's Fall Care Plan was created. The RUC stated the facility has a Fall Risk policy which directs staff to use a Fall Risk Assessment form. Page one of that form determined the resident's fall risk score. Page two of the form, "Fall Risk Protocol and Care Plan" determined the interventions to be implemented based on the score from page one. The surveyor then asked the RUC to explain how the form was individualized into a care plan with resident-specific interventions. The RUC provided no explanation. The surveyor asked how the facility provided increased supervision. The RUC stated the facility has high staffing ratios, which in itself was increased supervision. The surveyor then asked how often a resident identified at risk for falls would be observed and would that information be documented. The RUC stated there were no set time checks and staff would not have time to document more frequent checks. No further information was provided to resolve this concern. On 4/28/14, at 4:53 PM the Bureau of Facility Standards received additional information from the facility. The additional information provided by the facility did not resolve concerns related to the resident's fall.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328			

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F 328	<p>Continued From page 19</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to develop policies and procedures to ensure residents received appropriate care with the use of their CPAP machines. This was true for 2 of 2 residents (Resident #s 3 and 5) sampled for CPAP use. The deficient practice had the potential to cause more than minimal harm if residents experienced respiratory distress from the misuse of their equipment, had malfunctioning equipment, or developed infections from improper use or cleaning of their CPAPs. Findings included:</p> <p>The facility was asked for, but did not provide, a policy and procedure for CPAP management. Instead, the facility referred to Lippincott's Manual on Nursing, Fifth Edition.</p> <p>1. Resident # 5 was admitted to the facility on 4/4/14 with multiple medical diagnoses, including dementia and obstructive sleep apnea, on CPAP. The resident also had a mobility restriction of toe</p>	F 328	<p>F 328 Patient Specific:</p> <p>Patients numbers 3 and 5 have been discharged</p> <p>Other Patients:</p> <p>All current patients who utilize CPAP's have been assessed for ability to utilize independently (if able), that there is documentation of above assessment and that there are specific orders for settings and cleaning of the CPAP as well as documentation of utilization.</p> <p>Systemic Changes: Licensed staff have been inserviced in regards to:</p> <ol style="list-style-type: none"> 1. Assessing and documentation of a patient to self utilize a CPAP. 2. Specific orders for settings of said CPAP as well as cleaning schedule. 		

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F 328	<p>Continued From page 20 touch weight bearing to his right leg, and a PICC line in his left arm.</p> <p>A "Consultation Report" in Resident #5's record, from the acute care hospital, dated 4/2/14, documented, "...history of Alzheimer's dementia...Overall, the patient has difficulties giving a good history due to his underlying dementia..."</p> <p>Resident #5's Physician Order Report for April 2014 documented, "CPAP at [night] per home settings [every night]." Date initiated was 4/4/14. The area on the resident's TAR to document CPAP use was blank except for 4/8/14, 4/15/14, 4/16/14, and 4/21/14. On the dates where documentation was present, it consisted only of the nurse's initials. No settings or cleaning of the machine were documented.</p> <p>[NOTE: There was no documentation as to what the resident's home settings were. There was no oxygen liter flow specified. There were no instructions to ensure machine was kept clean and in good working order. There was no indication the resident was able to use the machine on his own.]</p> <p>Resident #5's initial MDS assessment, dated 4/12/14, coded: *BIMS of 15, indicating the resident was able to correctly answer simple orientation questions at that time; *Extensive assistance of 2 for bed mobility and transfers; and *Extensive assistance of 1 for ambulation or wheelchair mobility.</p> <p>Resident #5's Resident Progress Notes</p>	F 328	<p>3. Documentation of utilization, cleaning and settings of CPAPs.</p> <p>Monitors: The Director of Nursing or her designee will perform weekly audits times 4 then monthly times 5 of any patient who utilizes a CPAP for:</p> <ol style="list-style-type: none"> 1. Assessing and documentation of a patient to self utilize a CPAP. 2. Specific orders for settings of said CPAP as well as cleaning schedule. 3. Documentation of utilization, cleaning and settings of CPAPs. <p>She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed.</p> <p>Date Audits will start: 05/19/14</p> <p>Date of Compliance: 5/29/14</p>		

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F 328	<p>Continued From page 21</p> <p>documented:</p> <p>*4/5/14 at 11:02 PM. "Patient stated feeling [short of breath] at [bedtime]. O2 [oxygen] sats [saturation] 89-90% on RA [room air]. States his C-pap is not working correctly, 'mask is broke.' Applied O2 [at 2 liters per nasal cannula] per patient request and patient states that he already feels like he is breathing better..."</p> <p>[NOTE: There was no documentation on 4/6/14 regarding the CPAP, or whether or not the broken mask had been fixed.]</p> <p>*4/7/14 at 7:52 AM, "...NP into (sic) see patient...Uses a CPAP at night. States it is not working right. Will contact [Name of Medical Equipment (DME) Company] to evaluate his machine..."</p> <p>[NOTE: There was no documentation as to whether or not the company was ever contacted, or what the outcome of that contact was. There was no documentation the company contacted was the company where the resident had originally obtained his machine.]</p> <p>*4/8/14 at 2:49 AM, "...has CPAP at night..."</p> <p>*4/12/14 at 4:28 AM, "...CPAP used at night..."</p> <p>*4/14/14 at 3:41 AM, "...Wears CPAP at night..."</p> <p>*4/19/14 at 4:12 AM, "...CPAP in use at bedtime..."</p> <p>*4/20/14 at 3:32 AM, "...CPAP on at night..."</p> <p>*4/21/14 at 3:39 AM, "...Wears a CPAP at night..."</p> <p>On 4/22/14 at 7:40 AM, 9:30 AM, and 9:45 AM, a CPAP machine was observed on the nightstand in the resident's room.</p> <p>On 4/22/14 at 9:45 AM, the resident was asked</p>	F 328			

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F 328	<p>Continued From page 22</p> <p>about his CPAP machine. The resident stated since the machine was his from home, he used it and took care of it himself in the facility. The resident was asked how often he rinsed out the mask and tubing. The resident chuckled and stated, "Oh, now and again, I guess."</p> <p>2. Resident # 3 was admitted to the facility on 4/4/14, with multiple diagnoses including obstructive sleep apnea.</p> <p>Resident #3's initial MDS assessment, dated 4/11/14, coded: *BIMS of 12, indicating moderate cognitive impairment; *Extensive assistance of 2 for bed mobility; and *Extensive assistance of 1 for personal hygiene.</p> <p>Resident #3's Physician Order Report for April 2014 documented, "CPAP at [night] per home settings." Date initiated was 4/4/14.</p> <p>On 4/21/14, Resident #3 was observed in his room. A CPAP machine was on his nightstand. The resident indicated he managed and cleaned the machine himself. He was not able to elaborate on how he was able to manage the process.</p> <p>On 4/23/14 at 8:45 AM, the DNS and CNM were asked about CPAP use in the facility. The CNM stated since the residents in the facility using CPAPs had usually been using them at home, the facility just asked them to bring in their own machines for use. The CNM stated the facility did not get further orders as to what, specifically, the settings should be, or have a protocol for staff to ensure the masks and tubing were cleaned, because it was presumed the residents were</p>	F 328			

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F 328	<p>Continued From page 23</p> <p>managing that themselves and were doing so effectively. She stated the facility did not feel the need to assess residents for independence with the use of the machines, or the residents' competency at cleaning the machines.</p> <p>During the interview, when asked about Resident #5's CPAP, specifically the resident's complaints that the machine had not been working properly. The CNM stated if the resident had complained about his CPAP not working properly, she would call [name of DME company] and have them come and check on it. The CNM was unable to explain why there had been a delay of at least one night between the time Resident #5 had complained of his machine not working, and the DME company being contacted. The CNM was not sure if the company contacted was the same company the resident used for his machine. After reviewing the documentation in the resident's PNs, the CNM stated, "Well, that was me. I contacted them when he told the NP about it." The CNM was asked if there was documentation the issue had ever been resolved for the resident. The CNM reviewed the resident's chart, then stated, "I don't know."</p> <p>On 4/24/14 at approximately 12:30 PM, the Administrator attempted to clarify the facility's CPAP management. The Administrator stated the facility had never received clarification beyond home settings for CPAP use, citing the facility residents were generally alert and oriented, and managed those type of responsibilities independently. The Administrator stated the facility was "not like a regular nursing home," and felt the assessment process for such concerns would be a violation of the dignity and privacy of their residents. The Administrator stated, "We are</p>	F 328			

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F 328	<p>Continued From page 24</p> <p>very customer-service oriented. Our patients would rather have, and we would rather have, our nurses talking with the patients rather than violating their privacy."</p> <p>The facility failed to have a policy and/or written procedure for the use and care of CPAP machines; did not request clear physician's orders on how each individual machine was to be used; and did not assess residents individually to ensure their functional and cognitive abilities were appropriate to manage their CPAP machines.</p> <p>On 4/24/14 at approximately 2:15 PM, the Administrator and DNS were informed of the surveyor's concerns.</p> <p>On 4/28/14, the facility faxed additional information regarding F 328. However, this information did not resolve the surveyor's concern.</p>	F 328		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</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</p>	F 329	<p>F 329 Patient Specific:</p> <p>Patients numbers 1 and 5 have been discharged.</p> <p>Other Patients: All current patients charts have been reviewed to ensure that:</p> <ol style="list-style-type: none"> Any Psychopharmacological Medication Review forms are completed accurately, including but not limited to 	

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F 329	<p>Continued From page 25</p> <p>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 observation, interview, and record review, it was determined the facility failed to ensure adequate indication for the use of anti-psychotic medication or the use of duplicate anti-depressant therapy. The facility further failed to identify target mood and behavioral symptoms so as to monitor for the efficacy of these medications. Additionally, the facility did not monitor a resident's blood pressure as ordered before the administration of an anti-hypertensive medication. This was true for 2 of 6 residents (Resident #s 1 and 5) sampled for appropriateness of medications. The deficient practice had the potential to cause more than minimal harm should the resident experience adverse effects from medications, or mood state changes. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 4/5/14 with multiple diagnoses including Alzheimer's dementia and depression.</p> <p>On 4/2/14, a Consultation Report from the acute care hospital documented, "...history of Alzheimer's Dementia...Overall, the patient has</p>	F 329	<p>appropriate drug classification, AIMS in place, duplicate therapy, initiation of behavior monitors, appropriate diagnosis and completion of the form in its entirety.</p> <p>2. Documentation of blood pressures for medication with physician ordered parameters.</p> <p>Systemic Changes:</p> <p>Licensed staff have been inserviced in regards to:</p> <p>1. Any Psychopharmacological Medication Review forms are completed accurately, including but not limited to appropriate drug classification, AIMS in place, duplicate therapy, initiation of behavior monitors, appropriate diagnosis and completion of the form in its entirety.</p> <p>2. Documentation of blood pressures for medication with physician ordered parameters</p>		

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F 329	<p>Continued From page 26</p> <p>difficulties giving a good history due to his underlying dementia. The patient's wife, very unfortunately, has worse dimension (sic) than he does and he is actually her primary caregiver..."</p> <p>Resident #5's Physician Order Report, for 4/5/14, documented: *Paxil (anti-depressant) 40 mg daily for depression; *Bupropion HCl (anti-depressant) 150 mg twice daily for depression; *Abilify (anti-psychotic with a black box warning for elderly dementia patients) 5 mg daily for depression; *Propranolol (antihypertensive which can be used to treat tremors) 20 mg twice daily for tremors; and *Olanzapine (anti-psychotic) was listed as a medication allergy.</p> <p>On 4/10/14, Psychopharmacological Medication Review forms for Resident #5 documented: *Bupropion. -Therapy start date was documented as greater than 5 years. -The question, "Is there indication of duplicate therapy?" was answered, "No." -The question, "Is a Behavior Monitor in place?" was answered, "n/a (not applicable)." -The question, "Have changes in functional status occurred since the initiation of medication?" was answered, "yes." The space to describe the functional changes was blank. *Paxil -Therapy start date was documented as greater than 5 years. -The question, "Is there indication of duplicate therapy?" was answered, "No," -The question, "Is a Behavior Monitor in place?"</p>	F 329	<p>Monitors:</p> <p>The Director of Nursing or her designee will perform audits of 20% of the current patients charts weekly times 4 then monthly times 5 to ensure that:</p> <ol style="list-style-type: none"> Any Psychopharmacological Medication Review forms are completed accurately, including but not limited to appropriate drug classification, AIMS in place, duplicate therapy, initiation of behavior monitors, appropriate diagnosis and completion of the form in its entirety. Documentation of blood pressures for medication with physician ordered parameters. <p>She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed.</p> <p>Date Audits will start: 05/19/14</p>		

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F 329	<p>Continued From page 27 was answered, "n/a." *Abilify -Therapy start date was documented as 1 year. -The question, "Is this medication appropriate for use in Geriatric patients" was answered, "Yes." -The question, "Is the diagnosis appropriate for the prescribed medication?" was answered, "yes." -The question, "Is there an indication of duplicate therapy?" was answered, "No." -The question, "Has an AIMS (Abnormal Involuntary Movement Scale) been completed?" was answered, "n/a." -The question, "Is a Behavior Monitor in place?" was answered, "n/a." -The questions, "Have changes in behavior occurred since the initiation of medication?", "Have changes in mood status occurred since initiation of medication?" and, "Have changes in functional status occurred since initiation of medication?" were all answered, "Yes." However, the spaces to describe these changes were all blank.</p> <p>Resident # 5's initial MDS assessment, dated 4/12/14, coded: *BIMS score of 15, indicating the resident could answer concrete orientation questions; *Mood severity score of 10, indicating moderate depression; and *No hallucinations or delusions.</p> <p>Resident #5's care plan for "Alteration in Mood Status", dated 4/18/14, did not specify how the resident's depression presented, or individualized approaches which may have been helpful to the resident.</p> <p>[NOTE: Please see F 279 as it pertains to care</p>	F 329		

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F 329	<p>Continued From page 28 plan development.]</p> <p>On 4/22/14 at 9:45 AM, during a resident interview, Resident #5 readily interacted with the surveyor, stating he was the primary caregiver to his wife in the community, and was worried about how she was managing while he was in the facility recovering from knee surgery and an infection. The resident was sitting at a table in his room, with numerous brochures for home care agencies in front of him. The resident stated he was trying to use his time between therapies to hire someone to care for his wife while he recovered from his illness and awaited another surgical procedure.</p> <p>On 4/23/14 at 9:00 AM, the DNS and CNM were interviewed about the psychotropic medications for Resident #5. They stated: *Regardless of the pharmacological classification of the Abilify, if the physician's order documented it was for depression, that's how the facility monitored it. It would not be customary for the facility to question the physician as to why a medication such as Abilify had been ordered for a resident with a diagnosis of dementia. *Even with the black box warning for the Abilify, the facility felt if the physician had ordered the medication, it was appropriate for use in the geriatric population. It would not be customary for the facility to question the physician regarding this matter. *Even though the facility would normally conduct an AIMS on a resident receiving an anti-psychotic medication, they did not feel the need to do one in this case because the physician had ordered the medication for depression, not psychosis. *When asked if the facility had assessed the potential that the Abilify was causing or</p>	F 329		

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F 329	<p>Continued From page 29</p> <p>contributing to the resident's tremors, for which he was receiving yet another medication, the CNM stated, "I don't know."</p> <p>*When asked how the allergy to Olanzapine presented, or if the facility would monitor for a similar reaction to the Abilify, the CNM stated, "I don't know."</p> <p>*The facility was unable to describe why the resident required duplicate anti-depressant therapy, in addition to the use of an anti-psychotic. The CNM stated the facility had not obtained information regarding the resident's mood state history.</p> <p>*The facility reported they did not typically initiate any kind of mood or behavior monitoring for a resident receiving anti-depressant therapy, because they had not been trained to do so. The CNM stated, "It's not required in the regs (regulations)."</p> <p>NOTE: The State Operations Manual, Appendix PP, under the guidance for F 329, documented for anti-psychotic and anti-depressant use: "Extrapyramidal symptoms (EPS)' are neurological side effects that can occur at any time from the first few days of treatment to years later. EPS includes various syndromes such as...Parkinson-like symptoms including tremors..."</p> <p>**Examples of information to be considered and evaluated may include, but are not limited to...A history of prior and current medications and non-pharmacological interventions (including therapeutic effectiveness and any adverse consequences)..."</p> <p>**Admission...some residents may be admitted on medications for an undocumented chronic condition without a clear indication as to why a medication was begun or should be continued. It</p>	F 329			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 30</p> <p>is expected that the attending physician, pharmacist, and staff subsequently determine if continuing the medication is justified by evaluating the resident's clinical condition risks existing medication regimen, and related factors. If the indications for continuing the medication are unclear, or if the resident's symptoms could represent a clinically significant adverse consequence, additional consideration of the rationale for the medication(s) is warranted." **"Monitoring for Efficacy and Adverse Consequences...Use of two or more antidepressants simultaneously may increase the risk of side effects; in such cases, there should be documentation of expected benefits that outweigh risks and monitoring for any increase in side effects..." **"...All residents being treated for depression with any antidepressant should be monitored closely for worsening depression and/or suicidal behavior or thinking..."</p> <p>On 4/24/14 at approximately 12:30 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.</p> <p>2. Resident #1 was admitted to the facility on 3/13/14 with multiple diagnoses which included hypertension.</p> <p>Resident #1's Physician Order Report documented an order for Losartan 25 mg twice per day, with special instructions to hold for a blood pressure (BP) reading of less than 130/65.</p> <p>Resident #1's MAR for April 2014 documented the resident received the dose of Losartan scheduled for the evening of 4/7/14. There were</p>	F 329			

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F 329	Continued From page 31 also spaces on the resident's MAR to document his BP twice daily. However, no BP reading was documented on the evening of 4/7/14. On 4/24/14, at 1:30 PM the DNS stated even if the MAR did not have the BP documented, the CNAs would have documented the BP on the MatrixCare form, which could be printed from the computer. However, when printed, there was no documentation on that form correlating with the timing of the medication given on 4/7/14. The facility offered no further information.	F 329			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked,	F 431	F 431 Patient Specific: Patients in rooms 104, 117 and 125 have been discharged. Patient in room number 115 no longer has medications stored in room. Other Patients: No patients have medications stored in their room unless they have appropriate evaluations in place and the medications are stored in a locked box. Systemic Changes: Licensed and certified staff have been inserviced on appropriate		

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F 431	<p>Continued From page 32</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility failed to ensure resident medications were stored in a secure manner. This was true for 4 of 30 resident rooms (#s 104, 115, 117, and 125.) The deficient practice had the potential for more than minimal harm if residents administered their own medications in a manner inconsistent to physician's orders and without nursing knowledge that medications had been administered. Findings included:</p> <p>On 4/21/14 at 8:15 AM, during the initial tour of the facility, the following observations were made: *Room 104 - A packet of Bio Freeze (topical pain treatment) and a tube of Bacitracin (antibiotic) ointment were in the resident's room, on the counter by the sink. *Room 115 - A box of Advair Diskus (antiasthmatic inhaler, also classified as a corticosteroid) was on the over bed table, next to the bed, within reach of Random Resident #11. The resident was lying in bed. The resident stated she had broken her hip "at the first of the month. But I don't know what month. What month is it?" The resident then reported she had to "walk with</p>	F 431	<p>storage of medications in patients rooms as well as completion of appropriate assessments before storage may be allowed.</p> <p>Monitors:</p> <p>The Director of Nursing or her designee will perform walking rounds of 20% of patients room weekly times 4 then monthly times 5 to ensure that no medications are in patient rooms unless stored appropriately and that proper assessments have been performed and documented. She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed. Date Audits will start: 05/19/14</p> <p>Date of Compliance: 5/29/14</p>		

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F 431	Continued From page 33 that iron thing over there (pointing to her walker, which was located across the room)." Regarding the Advair Dikcus, the resident stated, "The nurse forgot to give it to me last night, so I gave it to myself this morning." The resident stated she did not think the facility usually kept that medication at her bedside. [NOTE: According to the 2014 Nursing Drug Handbook, Advair Diskus requires the user to rinse their mouth without swallowing after administration.] *Room 117 - 3 vials of Heparin Lock Flush Solution, 5 ml (anticoagulant), were on the counter in the room, near the sink. 4 more vials were on the over bed table next to the resident's bed. Resident #5, who had a diagnosis of dementia, resided in that room. *Room 125 - A bottle of Nystatin powder (antifungal) and a packet of Bio Freeze were in the room, on the counter next to the sink. On 4/21/14 at 9:15 AM, the CNM was asked if those items should be at bedside for the residents. The CNM stated, "I doubt it." On 4/24/14 at approximately 12:30 PM, the Administrator and DNS were informed of the surveyor's observations. The facility offered no further information.	F 431			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514			

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F 514	<p>Continued From page 34</p> <p>accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain accurate, complete and organized clinical records on each resident. This was true for 3 of 10 sampled residents (#'s 1, 3, & 4) reviewed for clinical records. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care and/or interventions. Findings included:</p> <p>1. Resident #4 was admitted to the facility with multiple diagnoses to include, left rib fractures with left-sided atelectasis and pleural effusion.</p> <p>A Physician's Order, dated 4/5/14, documented the following, "O2 (oxygen) to keep sats (saturation) [greater than] 90%. May titrate 1-3 LPM (Liters per Minute) as needed. Monitor LPM, O2 Sats at QHS (hours of sleep)."</p> <p>The resident's Respiratory Care Plan, dated 4/14/14, documented the following: * Problem - Chronic Atelectasis * Approach - Schedule cares and activities to</p>	F 514	<p>F 514</p> <p>Patient Specific:</p> <p>Patients' numbers 1,3 and 4 have been discharged.</p> <p>Other Patients:</p> <p>All current patients' medical records have been reviewed to ensure completeness of documentation of:</p> <ol style="list-style-type: none"> 1. Oxygen utilization and monitoring, 2. Reasons for Fluid Restrictions. <p>Systemic Changes: Licensed staff have been inserviced on documentation of:</p> <ol style="list-style-type: none"> 1. Oxygen utilization and monitoring, 2. Reasons for Fluid Restrictions. <p>Monitors: The Director of Nursing will perform audits of 20% of current patient charts weekly times 4 then monthly times 5 to ensure that appropriate documentation is in place for:</p> <ol style="list-style-type: none"> 1. Oxygen utilization and monitoring, 2. Reasons for Fluid Restrictions. 		

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F 514	<p>Continued From page 35</p> <p>allow for adequate rest. Observe for flushed face, headache, dizziness, confusion, dyspnea, cyanosis, and/or temperature; report changes to LN/MD. Assess lungs and monitor vital signs, oxygen saturations at least daily and PRN s/s (signs and symptoms) of respiratory distress. Oxygen per MD order, elevate head of bed to maximize air exchange.</p> <p>The resident's TAR, dated 4/5/14, documented the following, "O2 to keep sat[urations] greater than 90%. May titrate 1-3 LPM as needed. Monitor LPM, O2 sats. QS (every shift)." On the night shift for 4/9 - 4/12/14, and on 4/16/14 there was nothing documented on the TAR related to the resident's oxygen saturation, or if the resident was even using oxygen during that shift. On the PM (evening) shift for 4/7/14, 4/9 - 4/12/14, and 4/14 - 4/16/14 there was nothing documented on the TAR related to the resident's oxygen saturation, or if the resident was even using oxygen during that shift.</p> <p>The DNS was interviewed on 4/24/14 at 9:00 AM. The surveyor asked the DNS about the missing documentation on the resident's TAR related to the resident's O2 saturations and use of oxygen. The DNS offered no explanation. The surveyor asked who audited the TAR for accuracy, to which the DNS stated she did the auditing, and noted " Exactly, that was a good question, why were there holes on the TAR." No additional information was provided to resolve this issue.</p> <p>2. Resident #1 was admitted to the facility from an acute care hospital on 3/13/14 with multiple diagnoses which included L 4-L 5 diskitis/osteomyelitis, acute-on-chronic hyponatremia, chronic urinary retention with</p>	F 514	<p>She will report her findings at the Q.A. meetings and will make changes to the above plan of correction as needed.</p> <p>Date Audits will start: 05/19/14</p> <p>Date of Compliance: 5/29/14</p>		

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F 514	<p>Continued From page 36</p> <p>recent urinary tract infection, chronic systolic congestive heart failure, and hypothyroidism.</p> <p>Resident #1's Physician Order Report for April 2014 documented the resident had a 2 liter per day fluid restriction, starting 3/13/14 when the resident was admitted.</p> <p>On 4/22/14 at 2:20 PM, the DNS and CNM were asked about the reason for the fluid restriction. The CNM stated she thought the resident had been on the fluid restriction for "some time", and that the restriction would be ongoing. The CNM stated the fluid restriction was managed by the resident's cardiologist, and details could be found in the resident's H&P. When asked to review the H&P section of Resident #1's record, it was found to contain only 3 pages of "Doctor's Orders and Progress Notes" from the acute care hospital, dated 3/12/14. The notes documented some of the issues being addressed in the acute care hospital the day prior to his transfer to the facility, but did not include comprehensive information regarding the resident's medical history. The forms were signed by a Physician's Assistant. Regarding the fluid restriction, the form documented, ""HYPONATREMIA (stable/monitoring)...on fluid restriction and diuretics)." However, there was no further information regarding the history of the fluid restriction, nor how long the fluid restriction would continue.</p> <p>On 4/24/14 at 8:15 AM, the surveyor was given an H&P dated 3/7/14, a Consultation Report dated 3/9/14, and a Discharge Summary dated 3/13/14. The DNS stated the facility had contacted the acute care hospital and obtained the information the previous evening, but did not</p>	F 514			

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F 514	<p>Continued From page 37</p> <p>have the document prior to that time. The Discharge Summary documented the resident was to be on a 2 liter per day fluid restriction due to his diagnosis of hyponatremia, which would need continued monitoring.</p> <p>On 4/24/14 at 8:15 AM, the DNS was informed of the surveyor's concerns with the lack of pertinent medical information readily available in the resident's record. The facility offered no further information.</p>	F 514		

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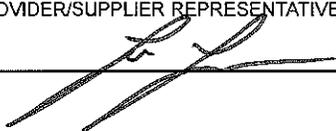
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Amy Jensen, RN, BSN, Team Coordinator Nina Sanderson, BSW, LSW Noel Mathews, MSW</p> <p>The survey team entered the facility on 4/21/14, and exited the facility on 4/24/14.</p>	C 000		
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: Please see F 329 as it pertains to indications and monitoring of medications.</p>	C 147	<p>C 147 See POC for F329</p>	<p>RECEIVED MAY 19 2014 FACILITY STANDARDS</p>
C 173	<p>02.100.12,d Immediate Notification of Physician of Injury</p> <p>d. The physician shall be immediately notified regarding any</p>	C 173	<p>C173 See POC for F157</p>	

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



TITLE
Administrator

(X6) DATE
5-16-14

Bureau of Facility Standards

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C 173	Continued From page 1 patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Please see F 157 as it pertains to physician notification.	C 173		
C 778	02.200,03,a PATIENT/RESIDENT CARE 03. Patient/Resident Care. a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Please see F 279 as it pertains to care plan development.	C 778	C778 See POC for F 279	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please see F 315 as it pertains to self catheterization. Please see F 328 as it pertains to CPAP management.	C 784	C784 See POCs for F315 and F328	
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	C790 NS See POCs for F232 and F431	

per telephone call with DHS 6/16/14 at 1:50PM, F232 for C790 should read F323.

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C 838	<p>02.201,02,I Secure Storage of Medications</p> <p>I. All medications in the facility shall be maintained in a locked cabinet located at, or convenient to, the nurses' station. Such cabinet shall be of adequate size, and locked when not in use. The key for the lock of this cabinet shall be carried only by licensed nursing personnel and/or the pharmacist.</p> <p>This Rule is not met as evidenced by: Please see F 431 as it pertains to medication storage.</p>	C 838	<p>C838 See POC for F431</p>	
C 881	<p>02.203,02 INDIVIDUAL MEDICAL RECORD</p> <p>02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F514 as it relates to having a complete medical records.</p>	C 881	<p>C881 See POC for F514</p>	