



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: 7007 3020 0001 4044 7205

May 9, 2013

Stephen Farnsworth, Administrator
Pocatello Care & Rehabilitation Center
527 Memorial Drive
Pocatello, ID 83201

Provider #: 135011

Dear Mr. Farnsworth:

On **April 26, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Pocatello Care & Rehabilitation Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 22, 2013**. Failure to submit an acceptable PoC by **May 22, 2013**, may result in the imposition of civil monetary penalties by **June 11, 2013**.

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 you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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

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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 31, 2013 (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 31, 2013**. A change in the seriousness of the deficiencies on **May 31, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 31, 2013** includes the following:

Denial of payment for new admissions effective **July 26, 2013**. [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 26, 2013**, if substantial compliance is not achieved by that time.

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

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

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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 26, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **May 22, 2013**. If your request for informal dispute resolution is received after **May 22, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LKK/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135011	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/26/2013
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NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 204	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to account for personal belongings and provide an organized discharge for 1 of 2 sampled residents (#15) reviewed for transfer and discharge. Findings include:</p> <p>Resident #15 was admitted on 6/21/12 for respite care and discharged on 6/24/12. The resident's Inventory of Personal Effects list was not dated or signed upon admission by the resident, responsible party, or a facility representative. The list contained a section titled, "On Discharge", which was not dated, but was signed by a responsible party and by the facility Housekeeping Supervisor.</p> <p>The resident's Progress Notes on 6/24/12 at 4:10 PM documented, "Daughter given pt.s (patients) personal belongings and pt.s meds; Daughter notified nursing staff that a few of the pt.s clothing were not in the items to be sent home ...Daughter will be back in the morning to obtain missing clothing."</p> <p>On 4/25/13 at 11:25 AM, the Admission Coordinator/SSD was interviewed. She said the admission person from June was no longer employed at the facility. She said the process upon admission would be to include all items on the personal belongings list, have the list signed and dated by the resident, POA or family member; and facility staff.</p> <p>On 4/25/13 at 4:35 PM, the Housekeeping Supervisor was interviewed and shown Resident #15's inventory list. She said she does not remember when she signed the discharge portion of the form and stated, "Whoever admits them fills them (Inventory list) out...somebody should have signed it on admission."</p> <p>On 4/25/13 at 6:00 PM, the Administrator, DON, ADON, Director of Social Services, and Clinical Resources Representative were informed of the issue. No other information was provided by the facility.</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2013
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NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Bradley Perry, BSW, LSW Team Coordinator Linda Kelly, RN Karen Marshall, MS, RD, LD</p> <p>Survey Definitions: ADL = Activities of Daily Living ADON= Assistant Director of Nursing APAP = Acetaminophen BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CM = Centimeters CNA = Certified Nurse Aide DM = Dietary Manager DON = Director of Nursing ET = And LN = Licensed Nurse RN = Registered Nurse MAR = Medication Administration Record MAD = Moisture Associated Dermatitis MD = Medical Doctor MDS = Minimum Data Set assessment PRN = As Needed RD = Registered Dietitian QD = Every Day QOD = Every Other Day NS = Normal Saline ROM = Range of Motion</p>	F 000		
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical</p>	F 164		

RECEIVED
MAY 22 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 5-20-13
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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 164	<p>Continued From page 1 records.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure window blinds were closed or privacy curtains were drawn when personal care was provided to residents. This was true for 1 of 13 sample residents (#4). This failure created the potential for a negative effect on the resident's psychosocial well-being. Findings included: Resident #4 was admitted to the facility on 2/9/12</p>	F 164			

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F 164	<p>Continued From page 2</p> <p>with multiple diagnoses which included dementia and depression. On 3/21/13, hospice care started for unspecified debility.</p> <p>Resident #4's significant change MDS, dated 4/4/13, coding included impaired cognition, with a BIMS score of 9; extensive assistance of 1 person for bed mobility and toileting; frequent bowel incontinence; and, occasional urinary incontinence.</p> <p>On 4/25/13 at 11:55 a.m., the window blind was open and the privacy curtain was not used when CNA #9 and CNA #10 were observed as they provided incontinence care for Resident #4. The CNAs pulled down the top bed covers which exposed the resident's incontinence brief and lower extremities. The CNAs turned the resident side to side as they provided peri-care and changed the incontinence brief. When the resident's bare buttock area was turned toward the open blind, the CNAs were asked what was outside the window. CNA #9, stated, "A parking lot." At that point, CNA #9 pulled the privacy curtain and the 2 CNAs completed the cares.</p> <p>Note: A parking lot, approximately 20 feet away, was visible through the open blind. Several vehicles were in the parking lot and one person was observed getting in and out of a vehicle parked directly in front of, and facing, the resident's window.</p> <p>Immediately afterward, when asked about privacy during the provision of care, CNA #9 acknowledged the blind was open and the privacy curtain was not used initially.</p> <p>On 4/25/13 at about 6:30 p.m., the Administrator, DON, ADON, and Clinical Resource Representative were informed of the observation. No other information was received from the facility.</p>	F 164			

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F 167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of the survey reports in the facility survey binder, and staff interview, it was determined the facility failed to ensure the most current survey results were available for residents to review. This affected 13 of 13 (#s 1-13) sampled residents and had the potential to affect all residents who resided in the facility. Findings included:</p> <p>On 4/23/13 at 11:29 a.m., the surveyor informed the Administrator and the DON the facility's designated survey binder did not include the last complaint investigation and did not include the most recent Life Safety Code survey report. The Administrator reviewed the survey binder and stated, "I will take care of that."</p>	F 167			
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, it was determined the facility failed to ensure an</p>	F 225			

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F 225	Continued From page 5 investigation of injuries was completed when a resident was found with multiple open skin areas and SDTIs (Suspected Deep Tissue Injuries). This was true for 1 of 13 (#6) sampled residents. This failed practice had the potential to place the resident at further risk of potential neglect. Findings included: Resident #6 was originally admitted to the facility on 8/18/06, and readmitted on 12/15/11, with multiple diagnoses including generalized muscle weakness and pain in lower leg, shoulder regions, upper arm and hand joints. Resident #6's annual 1/22/13 MDS coded: -Minimum of one person physical assistance for ADLs, -At risk for PUs, One of more unhealed PUs (Pressure Ulcers) at Stage I or higher, -No Unhealed Stage I PU, -Stage I or greater, scar over bony prominence, or a non-removable dressing/device -two Stage II PUs, date of oldest Stage II PU 12/15/12, -No Stage III, Stage IV, or Unstageable- Slough and/or eschar, -No SDTIs, -No worsening PUs since prior assessment, Stage II, III, IV -Healed PUs present on the prior assessment -Number of current PUs not present on prior assessment, None -No moisture associated skin damage (MASD) -Treatments: pressure reducing device for chair and bed and ulcer care, -Indwelling catheter, -Hospice, -Moderate pain, received scheduled pain	F 225			

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F 225	<p>Continued From page 6</p> <p>medication, no prn medication, and no non-medication interventions.</p> <p>Note: Resident #6's most recent quarterly MDS was in progress at the time of the survey.</p> <p>Resident #6's Physician Orders "All Active Orders for March 2013" (most recent recapitulation orders) contained, in part, the following.</p> <p>-3/17/13, Apply zinc based barrier cream to bilateral buttocks and lower back M.A.D. (Moisture Associated Dermatitis) area then dust entire area with powder prn with cares daily until resolved.</p> <p>-3/17/13, Cleanse Right medial knee SDTI site with NS, pat dry, apply skin prep (preparation), apply adapic, cover with protective dressing. Change QOD et (every other day and) prn until resolved.</p> <p>-3/17/13, Cleanse SDTI site to right medial cuneiform (bone just proximal to the first metatarsal bone) with NS, pat dry, apply skin prep and monitor QD for change in condition until resolved - QD Everyday, 8:00 a.m.</p> <p>-3/17/13, Cleanse stage two blistered areas with NS, pat dry, apply adapic and ag+ (silver) alginate to open areas then cover with protective dressing. Apply skin prep to intact blisters then cover with protective dressing. Change QOD et prn until resolved.</p> <p>-3/17/13, Monitor red blanchable areas QD - left lateral ankle, right medial shin, right lateral ankle, left lateral hip, right 4th toe, and right 5th toe.</p> <p>-3/17/13, Monitor SDTI areas and apply skin prep QD and monitor QD until resolved, left lateral shin, right superiolateral shin, right inferiolateral shin, left lateral hip, and left lower lateral pinna (ear area).</p>	F 225			

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F 225	Continued From page 7 Resident #6's Care Plan (CP) included, in part, PU Focus area, Resident #6 has history of PUs and potential for PU development related to immobility. "Resident with stage I to right medial knee. Stage II area to left medial knee, left trunk x2, left armpit x3. SDTI to left lateral lower leg, right medial cuneiform, right inferior lateral shin, right superior lateral shin, left lateral hip, left lateral distal pinna as of 3/17/13." Date initiated: 2/10/12 NOTE: Resident #6's PU CP Focus area identified a total of thirteen different pressure ulcer and SDTI areas on Resident #6's body as of 3/17/13. The CP did was not individualized with the onset dates for each of the above identified areas. The documentation provided evidence the onset date was 3/17/13 for all thirteen different open skin areas and SDTI areas on Resident #6's body. On 4/24/13 at 10:15 a.m., the surveyor informed the DON, ADON, Clinical Resource Representative (CRR), and Administrator the survey team had concerns about the number of open areas (thirteen) on Resident #6's skin after reviewing Resident #6's medical record, specifically what occurred on 3/17/13. On 4/24/13 at 2:30 p.m., two surveyors observed LN #8 and a medical doctor (MD) providing wound care for Resident #6. The MD said he received a call from the facility to help the facility treat Resident #6's wounds, this was his second visit to the facility, he worked at a local wound care center, and treated patients with wounds on a daily basis. The surveyors asked the MD what could have	F 225			

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F 225	<p>Continued From page 8</p> <p>caused all these skin issues. The MD stated, "I think one night someone did not move her and her skin blew up [broke open]."</p> <p>-At 3:10 p.m., LN #8 stated, "I received a phone call on 3/17/13 from the weekend wound nurse. I came in and found these open areas to her skin."</p> <p>On 4/24/13 at approximately 3:00 p.m., the facility provided additional information that included, in part,</p> <p>-"Late Entry 3/18/13 13:59 [1:59 p.m.]" The entry did not specify the original date for the late entry.</p> <p>"Wound nurse assessed patient while checking on protective dressing. Several new wounds were found during this assessment. These wounds include Left lateral ankle is red blanchable areas that measure 3.9cm x 1.8cm. 0cm.</p> <p>Right medial cuneiform area SDTI site measures 1.9cm x 1.8cm x utd [unable to determine].</p> <p>Right medial shin red blanchable site measures 2.5cm x 2.0cm x 0cm.</p> <p>Right lateral ankle red blanchable site measures 0.6cm x 1.7cm x 0cm.</p> <p>Right inferior lateral shin SDTI site measures 3.0cm x 2.8cm x utd.</p> <p>Right superior lateral shin SDTI site measures 1.5cm x 2.5cm x utd.</p> <p>Right medial knee stage I pressure site measures 5.3cm x 2.0cm x 0cm.</p> <p>Left medial knee stage II pressure site measures 4.8cm x 2.0cm x <0.1cm [less than 0.1 cm].</p> <p>Left lateral hip red blanchable area measures 6.0 cm x 10.0cm x 0cm With SDTI site in center that measures 4.5cm x 4.3cm x utd.</p> <p>Bilateral medial buttocks and lower back moisture associated dermatitis site measures 27.5cm x 15.8 cm x 0cm.</p> <p>Left lateral trunk inferior stage II pressure clear</p>	F 225			

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F 225	<p>Continued From page 9</p> <p>fluid filled blister site measures 4.8cm x 3.0 cm x <0.1cm. Left lateral trunk superior stage II pressure clear fluid filled blister site measures 1.0cm x 1.1cm x <0.1cm. Left armpit superior stage II pressure clear filled blister site measures 4.9cm x 1.7cm x <0.1cm. Left armpit middle stage II pressure clear fluid filled blister site measures 7.4cm x 3.0cm x <0.1cm. Left armpit inferior stage II pressure clear filled blister site measures 5.8cm x 2.4cm x <0.1cm. Left lateral distal pinna SDTI site measures 1.5cm x 1.3cm x utd. Right 5th toe anteriolateral aspect red blanchable area measures 0.5cm x 0.5cm x 0cm. Right 4th toe anteriolateral aspect red blanchable areas measures 0.4cm x 0.6cm x 0cm..." Electronically signed by LN #8.</p> <p>-March 2013 Incident Report Tracking form dated 3/3/13 through 3/29/13. Highlighted in green on the first page was, "3/17/13, Resident #6...Day Sunday, Shift 1200, Type Skin, Injury Pressure areas; M.A.D. [Moisture Associated Dermatitis]..." The second page identified, Resident #6, reason Left hip amd {sic} left knee with sites. MAD to bottom..." The surveyor asked if there was an incident report generated and also to review the incident report. Later the same day, the Administrator and the DON said the incident report was done but they were unable to locate the report.</p> <p>Resident #6 developed multiple open skin areas and SDTIs on 3/17/13 as evidenced by the resident's Physician Orders, Care Plan, PNs, and Incident Report Tracking form. However, the</p>	F 225			

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F 225	Continued From page 10 facility was not able to provide evidence the cause of the open skin areas and SDTIs was investigated to rule out the possibility of neglect. On 4/26/13 at 11:30 a.m., the Administrator, the DON, and the ADON were informed Resident #6 had multiple open areas and SDTI areas develop on her skin. The source of the injuries was not explained in LN #8's 3/18/13 progress note and the number of injuries observed at one particular point in time, 3/17/13, was suspicious of possible neglect. The facility did not provide additional information.	F 225			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident's call light was within reach and accessible to the resident. This affected 1 of 13 (#6) sampled residents. This practice created the potential for emotional distress or possibly harm for residents whose call light was not available when needed. Findings included: Resident #6 was originally admitted to the facility on 8/18/06, and readmitted on 12/15/11, with	F 246			

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F 246	Continued From page 11 multiple diagnoses including generalized muscle weakness and pain in lower leg, shoulder regions, upper arm and hand joints. Resident #6's annual 1/22/13 MDS coded a minimum of one person physical assistance for ADLs and Hospice. Note: Resident #6's most recent quarterly MDS was in progress at the time of the survey. On 4/23/13 at 7:05 a.m., the resident appeared to be asleep in her bed. A type of metal clip was attached to the call light cord and the clip was attached to the cord at the call light receptacle on the wall. The call light was located approximately three to four feet from where the resident was laying in bed. The resident made a slight sound. - At 7:06 a.m., the ADON walked past. The surveyor informed the ADON the resident may need some assistance. The ADON entered the room to assist the resident. - At 7:15 a.m., the call light was observed attached to the resident's bedding within reach of the resident. - At 7:30 a.m., the ADON stated, "The resident's call light was on the wall." The surveyor thanked the ADON for his honesty. On 4/26/13 at 11:30 a.m., the Administrator and the DON were informed of the observation.	F 246			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure resident's rinsed their mouths without swallowing after administration of an inhaled steroid medication. This was true for 2 of 2 residents (#9 and #19) who received Advair, a corticosteroid medication, during medication pass observations. Failure to have residents rinse their mouth without swallowing after steroid inhalation created the potential for them to develop an oral fungal infection. Findings included: Note: Regarding Advair, the Nursing 2013 Drug Handbook by Lippincott, Williams, and Wilkins, stated, in part, " ADMINISTRATION Inhalation ...After administration, have the patient rinse his mouth without swallowing. " And, in " PATIENT TEACHING ...Instruct patient to rinse mouth after inhalation to prevent oral candidiasis [a fungal infection]. " 1. On 4/23/13 at 7:35 a.m., during a medication pass observation, LN #2 administered 1 puff of Advair 500/50 to Resident #9. The LN did not encourage, instruct, or offer to assist the resident to rinse her mouth before she left the resident's room. Immediately upon return to the medication cart in the hallway, LN #2 was informed of the observation. The LN stated, "I didn't think Advair was a steroid. I'll have to look it up and get back with you." LN #2 stated she would have the resident rinse her mouth and right away she went into the resident's room. However, the LN returned a moment later and stated, "I have to get another cup. I threw that one away." With a new cup in hand, the LN returned to the resident's room and assisted the resident to rinse her mouth	F 281			

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F 281	Continued From page 13 and spit out the rinse water. On 4/25/13 at approximately 6:30 p.m., the Administrator, DON, ADON, and Clinical Specialist were informed of the observation. No other information or documentation was received from the facility. 2. On 4/24/13 at 7:55 p.m., during a medication pass observation, LN #1 administered 1 puff of Advair 100/50 to Resident #19. The LN did not encourage, instruct, or offer to assist the resident to rinse her mouth before he left the resident's room. Immediately upon return to the medication cart in the hallway, LN #1 was informed of the observation. The LN stated, "Oh yeah. I'll go have her do it now." On 4/25/13 at approximately 6:30 p.m., the Administrator, DON, ADON, and Clinical Resource Representative were informed of the observation. No other information or documentation was received from the facility.	F 281			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, facility and hospice staff interviews, review of hospice and dialysis provider contracts,	F 309			

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F 309	Continued From page 14 and review of Accident/Incident reports, it was determined the facility failed to: 1. Ensure an integrated and coordinated plan of care with hospice providers for 3 of 3 residents (#s 1, 4, and 6) reviewed for hospice services. This failure placed Residents #s 1, 4, and 6 at risk for unmet needs. 2. Ensure dialysis communication forms were completed and communication with a dialysis provider was consistent for 1 of 1 residents (#12) reviewed for dialysis services. This failure placed Resident #12 at risk for complications related to dialysis. 3. Ensure care plans regarding pain were individualized and comprehensive for 2 of 7 sample residents (#s 2 and 9) reviewed for pain. This failure placed Resident #2 and #9 at risk for complications related to implanted pain pumps. 4. Perform two person transfers as care planned and complete physician ordered laboratory (lab) tests for 1 of 9 sample residents (#8). Resident #8 sustained a right ankle injury when a staff performed a one person transfer. An A1C, magnesium, and lipid panel lab test was not completed as ordered, which placed Resident #8 at risk for inadequate management of diabetes and hyperlipidemia, and electrolyte imbalance. Findings included: Note: F309 Interpretive Guidelines regarding hospice services stated, "...the hospice and the nursing home must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy and is based on an assessment of the individual's needs and unique living situation in the facility. The plan of care must include directives for managing pain and other uncomfortable	F 309			

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F 309	<p>Continued From page 15</p> <p>symptoms and be revised and updated as necessary to reflect the individual's current status. This coordinated plan of care must identify the care and services which the SNF/NF [skilled nursing facility/nursing facility] and hospice will provide in order to be responsive to the unique needs of the...resident...</p> <p>The SNF/NF and the hospice are responsible for performing each of their respective functions that have been agreed upon and included in the plan of care. The hospice retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions."</p> <p>1. Resident #4 was admitted to the facility on 2/9/12 with multiple diagnoses which included dementia and depression. On 3/21/13, hospice services began for unspecified debility. Resident #4's significant change MDS, dated 4/4/13, coded, in part, impaired cognition, with a BIMS score of 9; extensive 1 person assistance for bed mobility, eating, toileting; hygiene, and bathing; extensive 2 person assistance for dressing; frequent bowel incontinence and occasional urinary incontinence; and hospice. Review of Resident #1's clinical record revealed the facility care plan included the following focus areas and interventions, in part:</p> <p>* "Resident is on hospice...Withdrawal from activities..." Initiated 5/24/12 - None of the 5 interventions involved hospice.</p> <p>* "Declining Health Status R/T [related to] Terminal Prognosis...On Hospice Program..." Initiated 2/22/13 - "Facility staff will co work [sic] [and] closely communicate w/ [with] hospice staff in order to provide comfort care... Observe/report change of condition, increasing pain... Social</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>worker/Chaplain from hospice to visit as necessary, R.N. [registered nurse] from hospice to visit as [sic] 2 times a week for nurse and 2 times a week for CNA."</p> <p>* "Potential for skin breakdown..." Initiated 5/23/12 - "Provide skin care (shower or bed bath at least 2 times a week) Hospice aid [sic] helps two times a week. Nsg [nursing] staff to provide in addition to these times..."</p> <p>Note: None of the resident's other care planned focus areas and interventions mentioned hospice. Review of the resident's clinical record also revealed a Service Plan between the facility and Resident #4's hospice provider. It was dated 3/21/13.</p> <p>This Service Plan outlined the services the facility and the hospice would provide and the frequency of the hospice interdisciplinary team (IDT) visits. The hospice IDT visit frequencies included: Routine CNA = 2-3 times/week, "currently 2 x [times] wk [week]"; Routine Skilled Nursing Visit [SNV] = "2-7 times/week as necessary, "currently daily"; Family Support and Spiritual Well-being by hospice chaplain, SW, RN, CNA, and volunteers = "As necessary or as requested by family and facility"; Bathing/dressing = "Client dependent for all ADL's Hospice Aide 2 x wk."</p> <p>Note: The facility care plan documented hospice SNV were 2 times/week. However, the Service Plan between the facility and hospice documented SNV were "currently daily."</p> <p>No other hospice documents, such as IDT visit notes or the Hospice Certification and Plan of Care were found in Resident #4's clinical record. On 4/24/13 at about 9:00 a.m., upon request, the Administrator provided the facility's contract with Resident #4's hospice provider.</p> <p>This contract documented, "RESPONSIBILITIES</p>	F 309			

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F 309	Continued From page 17 OF HOSPICE," which documented, in part, "4.2.3 Hospice will provide Facility with a copy of the patient's Plan of Care and will coordinate with Facility to revise the Plan of Care when change is indicated;...4.5 ...Hospice will coordinate, supervise, and evaluate the care provided in the following manner: ...4.5.2 By the scheduling of visits to the patient, and communicating the schedule to both the patient and Facility staff. Hospice patients will be visited according to the patient's needs and as specified in the patient's Plan of Care;..." On 4/25/13 at approximately 8:30 a.m., when asked, CNA #9 agreed to notify the surveyor the next time care was to be provided to Resident #4. At 9:30 a.m., the SDC informed the surveyor that the hospice CNA had just provided care to the resident and CNA #9 would provide care again about 11:30 a.m. On 4/25/13 at 9:40 a.m., hospice CNA #11 was interviewed. When asked if hospice IDT visit notes were left at the facility, CNA #11 shook her head "no" and stated, "They can request a print out if they want to and we'll fax them over." On 4/25/13 at 9:50 a.m., the Charge Nurse was asked where one would find hospice documentation regarding Resident #4. The Charge Nurse stated, "I don't know where we keep them." The Charge Nurse said she would ask the DON. On 4/25/13 at about 6:15 p.m., the DON provided a 3/4 inch stack of hospice documents which she stated were IDT visit notes and the hospice plan of care for Resident #4. When asked, the DON indicated she had received the documents from the hospice provider in the evening on 4/24/13. On 4/25/13 at about 6:30 p.m., the Administrator, ADON, and Clinical Resource Representative	F 309			

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F 309	<p>Continued From page 18</p> <p>were also informed of the issue. No other information or documentation was received from the facility that resolved the issue.</p> <p>2. Resident #8 was admitted to the facility on 10/30/08 with multiple diagnoses including obesity.</p> <p>The residents most recent quarterly MDS assessment, dated 2/28/13, coded, in part, Intact cognition, with a BIMS score of 14; and, extensive 2 person assistance with transfers.</p> <p>Resident #8's care plan included the following focus areas and interventions, all of which were initiated 3/8/12:</p> <ul style="list-style-type: none"> * ADL self care performance deficit - "...physical assistance of 2 staff members with transferring." * Limited physical mobility - "[T]ransfers require 2 person extensive assist or use hooyer lift for safety of resident." * Risk for falls - "[T]wo person extensive assist to transfer. May use hooyer lift if necessary." * History of electrolyte imbalance, - "Obtain labs ordered by [physician];" * Diabetes mellitus, - "...medication as ordered by doctor. Monitor/document for...effectiveness." <p>a) During an interview on 4/23/13 at 8:30 a.m., Resident #8 stated, "I have 2 legs but I can't use them. I'm a 2 person transfer." The resident continued, "About 2 weeks ago one girl [CNA] did it [transfer the resident] by herself and I sprained my right leg and ankle. I told everybody. X-rays were done."</p> <p>An Accident/Incident (A&I) report, dated 4/11/13, documented, in part, "TRIGGER FOR INCIDENT (How did it happen?). Res[ident] stated while being transfer [sic] a couple days ago by [CNA #14's name] that she hurt her ankle. ... Tonight Rt</p>	F 309			

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F 309	<p>Continued From page 19</p> <p>[right] outer ankle bruise approx[imately] 9 cm [centimeters] in size, sl[ightly] swollen and warm to touch, C/O [complains of] pain when moved. ... PREVENTION: ... Do not transfer Res alone - 2 person transfer. ..."</p> <p>An Incident Investigation Report attached to the aforementioned A&I report, dated 4/12/13, documented, in part, "Results of Investigation: ...Resident was transferred with one staff...during transfer her foot was bumped on her electric wheelchair. Assessment reveals bruising and swelling... sent for X-ray which resulted negative for fractures... Action/Follow-up: ...care planned for 2 person transfers. The staff member involved...was specifically educated as well as the other staff...resident is always to be a 2 person transfer... Also educated on proper 2 person transfer technique..."</p> <p>b) Resident #8's recapitulation of All Active Orders for March 2013 included orders for A1C, magnesium and lipid panel lab tests yearly in March.</p> <p>Review of the resident's clinical record revealed there were no results for the 3 aforementioned lab tests.</p> <p>On 4/25/13 at 4:50 p.m., the ADON was asked about the missing lab reports for Resident #8. The ADON checked the computer but did not find the reports and said he would continue to look.</p> <p>On 4/25/13 at 6:50 p.m., the ADON stated there were no reports for the 3 lab tests. The Administrator, DON, and Clinical Resource Representative were informed of the issue. No other information or documentation was received from the facility.</p> <p>3. Resident #9 was admitted to the facility on 3/1/09, and readmitted on 10/22/12, with multiple diagnoses including chronic pain.</p>	F 309			

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F 309	<p>Continued From page 20</p> <p>The resident's most recent quarterly MDS assessment, dated 3/28/13, coded, in part, intact cognition, with a BIMS score of 15; extensive assistance of 1-2 staff for all ADL activities, except eating; scheduled and PRN (as needed) pain medications; and pain almost constant at 10 (on a 0-10 scale, with 10 the worst pain). Resident #9's care plan included a focus area for pain, initiated 10/23/13. Interventions for this focus area included, "Administer pain medications as ordered..., F/u [follow up] visits as ordered with [physician's name] at pain clinic [a telephone number] to manage chronic pain and use of pain pump. Next refill date is 04/12/13. Assist with transportation. ... Monitor effectiveness of Dilaudid pump..."</p> <p>Note: The care plan interventions did not include the following information regarding the Dilaudid pump:</p> <ul style="list-style-type: none"> * The location of the pain pump on the resident's body; * Dosages to be delivered by the pump; * Type of alarms and what the alarms meant; * What staff should do if alarms sounded; * Non-critical alarm sounds; * Critical alarm sounds; and * Who to contact in case of emergency. <p>Resident #9's recapitulation (recap) of All Active Orders for March 2013 and the MAR for April 2013 included the following pain medications, all started 10/22/12:</p> <ul style="list-style-type: none"> * Norco 10-325, 1 tablet by mouth (PO) every 4 hours PRN; * Tylenol 500 mg (milligrams), PO every 4 hours PRN; and * Tylenol 325 mg, PO every 4 hours PRN. <p>Note: The recap orders and April 3013 MAR did</p>	F 309			

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F 309	<p>Continued From page 21</p> <p>not include the Dilaudid pump or any information about the Dilaudid pump.</p> <p>The resident's April 2013 MAR contained documentation that Norco was administered 1-4 times/day with positive results and Tylenol was not administered at all.</p> <p>Note: Federal guidance at F309 indicated, "Developing and implementing interventions/approaches to pain management, depending on factors such as whether the pain is episodic, continuous, or both...Identifying and using specific strategies for different levels or sources of pain or pain-related symptoms, including, identifying interventions to address the pain based on the resident-specific assessment...trying to prevent or minimize anticipated pain...in collaboration with the attending physician/prescriber, other health care professionals, and the resident and/or his/her representative, develops, implements, monitors and revises as necessary interventions to prevent or manage each individual resident's pain."</p> <p>On 4/25/13 at 3:50 p.m., the DON was asked what the dose of Resident #9's Dilaudid pain pump was, the location of the implanted pump, and what staff would do in an emergency situation with the pump. The DON stated, "I think we have that in the thinned record. I'll look."</p> <p>On 4/25/13 at about 5:30 p.m., the DON provided 2 pain clinic physician visit notes, one dated 5/1/12, the other dated 4/12/13.</p> <p>The 4/12/13 physician visit note documented Marcaine and Dilaudid were delivered via the implanted pain pump at 1.1569 mg/day and 7.231 mg/day respectively. It also noted the Low</p>	F 309			

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F 309	<p>Continued From page 22</p> <p>Reservoir Alarm volume and alarm date and the Critical and Non-Critical Alarm Intervals.</p> <p>On 4/25/12 at about 6:30 p.m., the Administrator, DON, ADON, and Clinical Resource Representative were informed of the issue regarding Resident #9's implanted pain pump.</p> <p>On 4/26/13 at 11:15 a.m., the DON provided a copy of an Infusion system patient manual which she stated she received from the manufacturer the previous night. The DON indicated Resident #9's care plan and physician orders would be updated to include pertinent information about the implanted pain pump.</p> <p>4. Resident #12 was admitted to the facility on 1/4/13, and readmitted on 3/26/13, with multiple diagnoses including end stage renal disease (ESRD).</p> <p>The resident's care plan included a focus area for ESRD initiated 4/2/13. Interventions included:</p> <ul style="list-style-type: none"> * The name, address, and telephone number of the dialysis provider * "Pick-up time: M-W-F [Monday-Wednesday-Friday]...per facility bus" * "Ensure resident receives dialysis as ordered (makes it to scheduled appointment times)" * "Facility staff will closely co-work and communicate with dialysis center/[physician's name] regarding change of condition" * "Has a new dialysis fistula to left arm. Monitor dressing to site after dialysis for any possible bleeding..." * "Hickman catheter [sic] (dialysis Catheter access) right upper chest to be cared for at dialysis. Licensed [sic] staff to monitor for any 	F 309			

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F 309	<p>Continued From page 23</p> <p>s/s [signs/symptoms] of infection or dressing coming loose. Notify dialysis if noted."</p> <p>Resident #12's recapitulation (recap) of All Active Orders for March 2013 included a 3/27/13 order to, "Change dressing to left arm fistula site PRN [as needed] when saturated until follow up appointment. 1 X [time] for 1 months [sic]..." Note: The resident's Hickman catheter was not included in the recap orders.</p> <p>The resident's April 2013 TAR included the 4/15/13 order, "Dry dressing changes to left arm fistula site if any bleeding from site otherwise open to air. Until resolved or Follow-up appointment on 4-23-13." The TAR documented check marks and/or initials daily in the spaces for 4/15 through 4/22/13. Note: The Hickman catheter was not included in the TAR.</p> <p>The resident's clinical record included Renal Dialysis Communication Forms (RDCF) dated 3/29/13, 4/5/13, 4/8/13, 4/10/13, 4/12/13, and 4/19/13.</p> <p>The RDCF contained 2 sections, one for the facility and one for the dialysis provider to document the resident's name, date, blood pressure (B/P), temperature, pulse (P), respirations (R), "Today's weight" in pounds or kilograms, oxygen saturation levels, and diet. Both sections also asked if the access site was intact, yes or no. However, the facility and/or the dialysis provider did not consistently provide documentation in all of the areas on any of those days.</p>	F 309			

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F 309	<p>Continued From page 24</p> <p>On 4/24/13 at 6:30 p.m., Resident #12 was interviewed. When asked about dialysis, the resident stated his left arm fistula was, "Just installed in March so we're not using it yet. It's not mature." The resident pointed to his right chest and said, "I have a tube in my chest." The resident stated that facility staff did not look at the chest catheter or left arm fistula. He added, "They did put a bandage over it [left arm fistula] one time."</p> <p>On 4/25/13 at 9:15 a.m., LN #3 was asked about the care of Resident #12's dialysis access devices. The LN stated, "I know we can put a light dressing on his arm if needed but otherwise it's open to air." Regarding the Hickman catheter, LN #3 stated, "We don't do anything with it. Dialysis does it. They've asked us not to do anything with the port. Of course, we would monitor it if there was a problem. When asked what facility LNs would do after a dialysis treatment, LN #3 stated, "He just rests and wants to be left alone." The LN said she does not check the resident's vital signs or anything else after dialysis.</p> <p>On 4/25/13 at about 6:30 p.m., the Administrator, DON, ADON, and Clinical Resource Representative were informed of the issue. The DON was asked to provide all facility admission and discharge dates and all RDCF for Resident #12 and the contract with the resident's dialysis provider. The contract was provided immediately.</p> <p>The contract, dated 10/21/09 documented, in part, "Center [dialysis provider] shall provide to Facility information on aspects of the management of the resident's care related to the provision of dialysis services. ... Facility will</p>	F 309			

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F 309	<p>Continued From page 25</p> <p>provide for the interchange of information useful or necessary for the care of the...resident..."</p> <p>On 4/26/13 at 11:15 a.m., the DON provided additional RDCF. The DON said, "He [Resident #12] never missed a dialysis while he was in the facility." She stated while the resident was in the facility the first dialysis occurred on 2/11/13.</p> <p>Review of the addition RDCF revealed there were no RDCF documents for 2/11, 2/13, 2/15, 2/18, 2/27, 3/8, 3/15, 4/1, 4/3, 4/15, or 4/17/13.</p> <p>On 4/30/13 the following information was received "overnight" from the facility: a list of Resident 12's facility admission/discharge dates, and 2 sets of physician orders, dated 1/30/13 and 2/9/13, regarding dialysis. However, none of the information resolved the issue regarding the lack of complete and consistent communication between the facility and dialysis provider.</p> <p>5. Resident #1 was readmitted to the facility on 9/3/10 with multiple diagnoses including cerebral vascular disease, venous insufficiency, and renal failure. The resident expired in the facility on 4/23/13.</p> <p>A physician telephone order dated 4/13/13 documented, "Please consult Hospice agency of family's choice for Hospice care."</p> <p>On 4/23/13 Resident #1's care plan (CP) was reviewed and it did not contain a hospice section with a focus, goals, or interventions for care. On 4/24/13, the facility provided an updated copy of the CP, which included a hospice CP with an initiated date of 4/23/13 and a canceled date of 4/23/13.</p>	F 309			

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F 309	Continued From page 26 On 4/24/13 at 3:48 PM, the facility provided a local Hospice agency document titled, Initial Plan of Care/Physicians Orders for the resident with a fax date of 4/24/13 at 3:21 PM. The orders documented hospice services began on 4/16/13. Note: The Hospice Initial Plan of Care/Physicians Orders document was not in the resident's medical record at the time of review. On 4/25/13 the facility provided a local Hospice agency document titled, Hospice/Contractor Roles/Responsibility for the resident with a fax date of 4/25/13 at 9:13 AM. The document listed the responsibilities of the hospice contractor and for what care the facility was responsible for. The faxed document was signed and dated on 4/16/13 with a facility and hospice representative. Note: The Hospice/Contractor Roles/Responsibility document was not in the residents medical record at the time of review. On 4/24/13 at 2:58 PM the DON was interviewed regarding the resident's hospice CP. She said the medical record did not contain the Hospice Initial Plan of Care/Physicians Orders document and she would ask the hospice agency for a copy. On 4/24/13 at 3:45 PM the DON was asked for a copy of what care the hospice and facility was responsible for and she said she would have to ask the hospice agency to fax the form over, since it was not in the resident's medical record. On 4/25/13 at 8:35 AM the MDS Coordinator was interviewed regarding the resident's hospice CP. When asked why the hospice CP was not completed after admission by the hospice	F 309			

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F 309	<p>Continued From page 27</p> <p>agency, she stated, "We all knew she was on hospice." When asked why the hospice CP was added on 4/23/13 (the day the resident expired), she said she realized it was not in the chart, so she put it in.</p> <p>The facility failed to coordinate with the hospice agency regarding the resident's care needs and provide facility staff with a current hospice CP to provide the resident with the highest practicable care possible.</p> <p>On 4/25/13 at 6:00 PM, the Administrator, DON, ADON, Director of Social Services, and Clinical Resources Representative were informed of the hospice issue. No further information was provided.</p> <p>6. Resident #6 was originally admitted to the facility on 8/18/06, and readmitted on 12/15/11, with multiple diagnoses including generalized muscle weakness and pain in lower leg, shoulder regions, upper arm and hand joints.</p> <p>Resident #6's annual 1/22/13 MDS coded a minimum of one person physical assistance for ADLs, indwelling catheter, Hospice, and moderate pain, received scheduled pain medication, no prn medication, and no non-medication interventions.</p> <p>a. Resident #6's April 2013 MAR documented, place 16 FR 10CC foley cath (16 french 10 cubiccentimeters foley catheter) for urinary retention, change every month and prn. Order Date: 4/30/12. There was a handwritten entry next to this order, "Change by Hospice."</p> <p>b. Resident #6's Care Plan contained one</p>	F 309		

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F 309	<p>Continued From page 28</p> <p>intervention for Hospice under ADL Self Care Performance focus area, "Hospice will provide bath once to twice weekly also."</p> <p>c. A Chaplain Hospice POC (plan of care) was found in the resident's chart in a different area from where the Care Plan was located. There were what appeared to be chaplain visit notes dated 9/26/12 through 3/11/13.</p> <p>d. In this same area of the resident's chart where the Chaplain Hospice POC was found, there were also Hospice Aide Progress Notes for October 2012.</p> <p>The hospice plan of care was not maintained in the medical record in a manner to ensure the hospice plan of care was readily available to the facility staff.</p> <p>The facility provided the surveyor with a copy of the local hospice's Collaborative Plan of Care dated and timed at the top right margin, 4/24/13 11:02 a.m. The date and time provided evidence the Collaborative Plan of Care was faxed to the facility on 4/24/13.</p> <p>Federal guidance at F309 indicated, "This coordinated plan of care must identify the care and services which the SNF/NF and hospice will provide in order to be responsive to the unique needs of the patient/resident and his/her expressed desire for hospice care. For a resident receiving hospice benefit care, evaluate if the plan of care reflects the participation of the hospice, the facility, and the resident or representative to the extent possible, includes directives for managing pain and other</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>uncomfortable symptoms and is revised and updated as necessary to reflect the resident's current status, medications and medical supplies are provided by the hospice as needed for the palliation and management of the terminal illness and related conditions, the hospice and the facility communicate with each other when any changes are indicated to the plan of care, the hospice and the facility are aware of the other's responsibilities in implementing the plan of care, the facility's services are consistent with the plan of care developed in coordination with the hospice."</p> <p>Resident #6's medical record did not include an individualized coordinated hospice plan of care including but not limited to the resident's identified care needs, the different disciplines involved in the resident's care, frequency of visits from the different disciplines, or communication between the different disciplines and the facility.</p> <p>On 4/24/13 at approximately 3:00 p.m., the DON stated, "There was not a coordinated Hospice care plan in Resident #6's chart."</p> <p>7. Resident #2 was originally admitted to the facility on 5/27/12, and readmitted on 10/23/12, with multiple diagnoses including late effect of spinal cord injury, other orthopedic aftercare, aftercare following joint replacement, aftercare for healing traumatic fracture of the hip, and difficulty walking.</p> <p>The resident's 1/31/13 quarterly MDS coded received scheduled and as needed pain medications. Pain present, almost constantly, hard to sleep at night and day to day activities limited due to pain. Pain rated 10 on a numeric</p>	F 309			

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F 309	<p>Continued From page 30</p> <p>scale of 0-10 with 10 being the highest level of pain.</p> <p>Resident #2's physician orders "All Active Orders for March 2013" (most recent recapitulation orders) contained, in part:</p> <ul style="list-style-type: none"> - 10/23/12, Gas-X 80 mg po qid (milligrams by mouth three times a day) for gas pain - 12/10/12, Tylenol 500 mg po prn for pain - 1/1/13, APAP 650 mg po qid for pain - 12/6/12, Kadian (morphine sulfate) 10 mg po every 12 hours for pain in joint pelvic region and thigh - 11/7/12, has an indwelling dilaudid pump right lower abdomen. That is being filled monthly at the (name of the pain clinic and MD). <p>Resident #2's April 2013 MAR provided documentation Gas-X, APAP, and Kadian were administered as ordered. Tylenol was requested, administered, and provided complete relief to the resident.</p> <p>Resident #2's medical record contained a handwritten order form from the local pain clinic, "4/8/13...Dilaudid 12 mg/ml [mg/per milliliter], Baclofen 500 mcg/ml [micrograms/ml] for intra-thecal use..."</p> <p>Resident #2's care plan contained the focus area, has an indwelling dilaudid IV (intravenous) pump. Date Initiated: 6/4/2012. The interventions did not include the following:</p> <ul style="list-style-type: none"> *Telephone number of the pain clinic *Emergency contact *Who would take the resident to the pain clinic *Dosages to be delivered by the pump *Type of alarms 	F 309			

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F 309	Continued From page 31 *What the alarms meant *What staff should do when alarms sounded *What were the sounds of the non-critical alarms *What were the sounds of the critical alarms *The pharmacist's involvement with date and dosages of the intra-theecal pump Federal guidance at F309 indicated, "Developing and implementing interventions/approaches to pain management, depending on factors such as whether the pain is episodic, continuous, or both...Identifying and using specific strategies for different levels or sources of pain or pain-related symptoms, including, identifying interventions to address the pain based on the resident-specific assessment...trying to prevent or minimize anticipated pain...in collaboration with the attending physician/prescriber, other health care professionals, and the resident and/or his/her representative, develops, implements, monitors and revises as necessary interventions to prevent or manage each individual resident's pain." On 4/25/12 at 3:42 p.m., the Administrator, DON, and ADON were informed the pain pump did not include the above identified interventions. The facility did not provide additional information.	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314			

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F 314	<p>Continued From page 32 prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, it was determined the facility failed to ensure a resident with a history of healed pressure ulcers (PUs) did not develop avoidable PUs. This was true for 1 of 5 (#6) residents sampled for hi-risk PUs. Resident #6 was harmed when she developed a Stage III PU to the left lateral hip, the right medial knee, the left medial knee, right inferiolateral shin, and a SDTI (Suspected Deep Tissue Injury) to the right cuneiform (bone just proximal to the first metatarsal [toe] bone). Findings included:</p> <p>Resident #6 was originally admitted to the facility on 8/18/06, and readmitted on 12/15/11, with multiple diagnoses including generalized muscle weakness and pain in lower leg, shoulder regions, upper arm and hand joints.</p> <p>Resident #6's annual 1/22/13 MDS coded: -Minimum of one person physical assistance for ADLs, -At risk for PUs, One or more unhealed PUs at Stage I or higher, -No Unhealed Stage I PU, -Stage I or greater, scar over bony prominence, or a non-removable dressing/device -two Stage II PUs, date of oldest Stage II PU 12/15/12, -No Stage III, Stage IV, or Unstageable- Slough and/or eschar, -No SDTIs,</p>	F 314		

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F 314	<p>Continued From page 33</p> <ul style="list-style-type: none"> -No worsening PUs since prior assessment, Stage II, III, IV -Healed PUs present on the prior assessment -Number of current PUs not present on prior assessment, None -No moisture associated skin damage (MASD) -Treatments: pressure reducing device for chair and bed and ulcer care, -Indwelling catheter, -Hospice, -Moderate pain, received scheduled pain medication, no prn medication, and no non-medication interventions. <p>Note: Resident #6's most recent quarterly MDS was in progress at the time of the survey.</p> <p>Resident #6's 1/23/13 PU Care Area Assessment (CAA) documented, in part:</p> <ul style="list-style-type: none"> "-Analysis of Findings, has current PUs on her ankle and knee...right lateral ankle stage II PU 0.4 by 0.3 by 0.0 Left medial knee stage II PU 0.6 by 0.6 by 0.0 currently at a stage I and has epithelial tissue... -Intrinsic Risk Factors...immobility ... -Conditions that Present Complications or Increase Risk for Pressure Ulcers ...terminal illness...pain... -Treatments and other Factors that Cause Complications or Increase Risk ...history of healed PUs...indwelling catheter tubing... -Care Plan Considerations...dependent upon staff for mobility, ADLs, has contractures, meal percentages are not good and is on medications that can dry skin out and can cause rashes...Will careplan {sic} for this problem to continue resolve {sic} current PUs and prevent any further skin breakdown." 	F 314			

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F 314	Continued From page 34 Resident #6's Physician Orders "All Active Orders for March 2013" (most recent recapitulation orders) contained, in part, the following. -12/15/11, Gabapentin 300 mg po tid (milligrams by mouth three times a day), 8:00 a.m., 12:00 p.m., and 8:00 p.m. for pain -12/28/11, Norco 10-325 mg po bid (two times a day) 6:00 a.m. and 11:00 a.m. for chronic pain -1/16/12, APAP 325 mg po prn for pain -8/24/12, Fentanyl 50 mcg/hr (micrograms per hour) transdermal for pain -2/7/12, Offload bilateral feet and heels with pillows for skin breakdown risk reduction. -2/15/12, Cleanse site to Right (R) outer ankle with NS. Pat dry. Apply skin prep cover with protective dressing change every 3 days (Q3days) and prn until resolved. -8/15/12, Cleanse Left (L) medial knee with NS, pat dry, cut alginate to fit then cover with optiform or equivalent dressing. Change Q3D et. (every 3 days and) prn until resolved. -3/17/13, Apply zinc based barrier cream to bilateral buttocks and lower back M.A.D. (Moisture Associate Dermatitis) area then dust entire area with powder prn with cares daily until resolved. -3/17/13, Cleanse R medial knee SDTI site with NS, pat dry, apply skin preparation, apply adaptic, cover with protective dressing. Change QOD (every other day) et prn until resolved. -3/17/13, Cleanse SDTI site to R medial cuneiform (bone just proximal to the first metatarsal bone) with NS, pat dry, apply skin preparation and monitor QD for change in condition until resolved - QD Everyday, 8:00 a.m. -3/17/13, Cleanse stage two blistered areas with NS, pat dry, apply adaptic and ag+ (silver)	F 314			

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F 314	<p>Continued From page 35</p> <p>alginate to open areas then cover with protective dressing. Apply skin prep to intact blisters then cover with protective dressing. Change QOD et. prn until resolved.</p> <p>-3/17/13, Monitor red blanchable areas QD - left lateral ankle, right medial shin, right lateral ankle, left lateral hip, right 4th toe, and right 5th toe.</p> <p>-3/17/13, Monitor SDTI areas and apply skin prep QD and monitor QD until resolved, left lateral shin, right superiolateral shin, right inferiolateral shin, left lateral hip, and left lower lateral pinna (ear area).</p> <p>Resident #6's 1/21/13 "Braden Scale for Predicting Pressure Sore Risk" form documented a total score of 12.5. The total score scale identified 10-12 as high risk, 13-14 as moderate risk.</p> <p>Resident #6's Care Plan (CP) included, in part, CP PU Focus area, [Resident #6] has history of PUs and potential for PU development related to immobility. "Resident with stage I to right medial knee. Stage II area to left medial knee, left trunk x2, left armpit x3. SDTI to left lateral lower leg, right medial cuneiform, right inferior lateral shin, right superior lateral shin, left lateral hip, left lateral distal pinna as of 3/17/13." Date initiated: 2/10/12</p> <p>NOTE: Resident #6's PU CP Focus area identified a total of thirteen different PU and SDTI areas on Resident #6's body as of 3/17/13. The CP did was not individualized with the onset dates for each of the above identified areas. The documentation provided evidence the onset date was 3/17/13 for all thirteen different PU and SDTI areas on Resident #6's body.</p>	F 314			

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F 314	<p>Continued From page 36</p> <p>PU Focus Interventions included, in part,</p> <ul style="list-style-type: none"> - Assess/record/monitor wound healing daily with care and wound nurse to record weekly for times of wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD for when (resident) has wounds. - "[Resident #6] needs assistance to turn/reposition at least every 2 hours, more often as needed or requested." - Monitor/document/report to MD prn (as needed) changes in skin status: appearance, color, wound healing, s/sx (signs and symptoms) of infection, wound size (length x width x depth), stage. - "Staff will place pillow or thin blanket between [Resident #6's] knees to reduce pressure factor to bony prominences." - "Treat pain as per orders prior to treatment/turning etc. to ensure [Resident #6's] comfort." - "Utilize pillows for positioning et [and] offloading off pressure areas et bony prominence." <p>CP ADL Focus area identified Self Care Performance Deficit related to, in part, limited ROM, osteoarthritis, fibromyalgia, and anemia 2/23/12. Date initiated: 2/10/12. One of the ADL interventions was, "Skin Inspection: Provide frequent skin inspection with cares, showers and weekly skin checks. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse."</p> <p>NOTE: The CP ADL Focus area did not identify the significance between the two dates of 2/23/12 and 2/10/12.</p>	F 314			

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F 314	<p>Continued From page 37</p> <p>CP Comfort Care Focus area, end stage disease process. Admission to Hospice program. Date initiated: 8/2/12. Two of the Comfort Care interventions were, "Turn and reposition in frequent intervals and prn. Evaluate resident's verbal and nonverbal cues to assess the degree and severity of pain."</p> <p>Resident #6's "Weekly Skin Evaluation" (WSE) forms, signed by a LPN, contained handwritten entries as follows: 3/1/13, "dressing" inside of left knee, "wraps" both left and right foot. 3/8/13, "dressing" inside of left knee, "[indistinguishable word]" left foot. 3/15/13, "dressing" inside of left knee, "dressings" both left and right foot. 3/23/13, "dressing" inside of both the left and right knee, "dressing" both the left and right foot, "dressing" outside of left hip. 3/30/13, "dressing" outside of left hip, "dressing" inside of left knee and right knee, "dressing" left and right foot.</p> <p>NOTE: As identified on the PU Care Plan, Resident #6 had a total of thirteen different PU and SDTI areas identified. However, the WSE forms, dated 3/23/13 and 3/30/13, did not identify the different PU and SDTI areas as was on the PU Care Plan.</p> <p>Resident #6's March 2013 Treatment Record contained, in part, "Order dates: 3/17/13; -Cleanse stage two blistered areas with NS, pat dry, apply adaptic and ag+ alginate to open areas then cover with protective dressing. Apply skin prep [preparation] to intact blisters then cover with protective dressing. Change QOD et. prn until resolved.</p>	F 314		

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F 314	<p>Continued From page 38</p> <p>-Cleanse SDTI site to right medial cuneiform with NS, pat dry, apply skin prep and monitor QD for change in condition until resolved.</p> <p>-Monitor red blanchable areas QD for change in condition and apply skin prep QD et prn until resolved.</p> <p>-Monitor SDTI areas and apply skin prep QD and monitor QD until resolved.</p> <p>-Apply zinc based barrier cream to bilateral buttocks and lower back M.A.D. areas then dust entire area with powder prn with cares daily until resolved.</p> <p>-Cleanse Right medial knee SDTI site with NS, pat dry, apply skin prep, apply adaptic, cover with protective dressing. Change QOD et. prn until resolved."</p> <p>On 4/24/13 at 10:15 a.m., the surveyor informed the DON, ADON, Clinical Resource Representative (CRR), and Administrator the survey team had serious concerns about the number of open areas areas (thirteen) on Resident #6's skin on 3/17/13. The surveyor requested information as to Resident #6's current skin issues, when the skin issues began, measurements, assessments completed, and evidence the skin issues (PUs and SDTIs) were unavoidable. The CRR stated the facility had volumes of documentation that would provide evidence the facility repositioned and turned Resident #6 on a regular basis to prevent pressure ulcer recurrence.</p> <p>On 4/24/13 at 2:30 p.m., two surveyors observed LN #8 and a medical doctor (MD) providing wound care for Resident #6. The MD said he received a call from the facility to help the facility treat Resident #6's wounds, this was his second</p>	F 314			

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F 314	<p>Continued From page 39</p> <p>visit to the facility, he worked at a local wound care center, and treated patients with wounds on a daily basis.</p> <p>During the above observation, the survey team observed the treatments given to Resident #6 for the left lateral hip, inside of both the right and the left knee, right lateral shin, and right great toe. Resident #6 had 2 open areas to the inside of the left knee (left superior and inferior medial), one open area to the inside of the right knee (right medial), a scabbed area on the right lower outer leg (right inferior lateral shin), an area on the outside of the left hip (left lateral hip), and an area at the joint of the right great toe (medial aspect at the base of the right great toe, cuneiform). The left superior medial knee had a visible protrusion which the MD said was a bone spur. The MD and LN #8 measured the bone spur site, 0.4 cm (centimeters) length, 0.3 cm width, and 0.4 cm depth. The surveyors asked the MD what could have caused all these skin issues. The MD stated, "I think one night someone did not move her and her skin blew up [broke open]." When the MD said this, LN #8 looked in the direction of the MD, moved her head up and down, nodding, signifying agreement. The MD also stated Resident #6's right medial knee had undermining at one time. As the MD and LN #8 provided wound care, Resident #6 grimaced. The MD made a comment Resident #6 was brave. The surveyors asked LN #8 when Resident #6 was last medicated. The LN stated, "I believe at her last scheduled administration time. I think around 12:00 p.m."</p> <p>-At 3:10 p.m., LN #8 stated, "I received a phone call on 3/17/13 from the weekend wound nurse. I came in and found these open areas to her skin.</p>	F 314			

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F 314	<p>Continued From page 40</p> <p>There was no off-loading device in place between legs and feet while [Resident #6] was lying on her left side and the catheter tubing was over her right lower leg causing pressure to the right lateral shin." The MD and the LN obtained measurements of: Left superior medial knee bone spur site as identified above; Right medial knee, "1.6cm length, 1.4cm width, and 0.7cm depth;" Left inferior medial knee, "2.8cm length, 1.8cm width, and 0.25cm depth;" and the left outside (lateral) hip area was darkened, indented with eschar edges loosening slightly and active bleeding. A dressing was observed at the base of Resident #6's great right toe (cuneiform). The right lateral shin had a raised border with eschar. LN #8 stated, "The left hip progressed to a Stage III. The area [darkened area left lateral hip] was where the PU was. In a month's time it has shrunk considerably."</p> <p>On 4/24/13 at approximately 3:00 p.m., the facility provided additional information that included, in part, -PNs, dated 8/6/12 at 7:00 p.m. through 4/23/13 at 3:25 p.m. The PN's did not provide evidence the resident refused to be repositioned due to discomfort or pain or cried out in pain whenever she was moved or repositioned. The PN's did provide evidence: "11/1/12 11:06 a.m., MDS Careplan meeting results: currently has no open wounds. Has a small scab on right lateral ankle that is mostly healed now..." Electronically signed by the MDS Coordinator. "2/8/13 6:26 p.m. Residents {sic} Right lateral ankle Stage I pressure site is resolved but still considered at risk...Left medial knee stage I pressure site measures 0.6cm x 0.4cm x</p>	F 314			

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F 314	<p>Continued From page 41</p> <p>0.0cm..." Electronically signed by LN #8.</p> <p>"2/14/13 1:57 p.m., Residents {sic} Right lateral ankle Stage I pressure site is resolved but still considered at risk..." Electronically signed by LN #8.</p> <p>"3/7/13 22:28 (at 10:28 p.m.) Note Text: LE [late entry] week of 2/17/13 Residents {sic} right lateral ankle Stage I pressure site is resolved but still considered a risk. Site is covered with a protective dressing. Heels are off-loaded using pillows. Left medial knee stage I pressure site is resolved but still considered at risk. Site is covered with protective dressing. Pillow is placed between legs to keep pressure off of this area to prevent injury." Electronically signed by LN #8.</p> <p>"3/10/13 04:37 (4:37 a.m.)...denies c/o [complaints of] break thru {sic} pain this shift...resident is repositioned q2h [every 2 hours] for comfort and heels elevated..."</p> <p>"3/16/13 10:00 (10:00 a.m.)...Feet and ankles are floated bilaterally at this time. Wraps and bandages in place over sores."</p> <p>NOTE: The PNs provided evidence the resident was routinely repositioned every two hours and no complaints of pain except on 1/23/13 at 3:02 p.m., "...did cry out with some pain with movement being turned side to side but when done she said pain went down."</p> <p>NOTE: The PNs did not include nursing staff entries from 3/16/13 at 10:00 a.m. until 3/18/13 at 13:59 (1:59 p.m.).</p> <p>"Late Entry 3/18/13 13:59 [1:59 p.m.]" The entry did not specify the original date for the late entry.</p> <p>"Wound nurse assessed patient while checking on protective dressing. Several new wounds were found during this assessment. These wounds include Left lateral ankle is red blanchable areas that measure 3.9cm x 1.8cm. 0cm.</p>	F 314			

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F 314	Continued From page 42 Right medial cuneiform area SDTI site measures 1.9cm x 1.8cm x utd [unable to determine]. Right medial shin red blanchable site measures 2.5cm x 2.0cm x 0cm. Right lateral ankle red blanchable site measures 0.6cm x 1.7cm x 0cm. Right inferior lateral shin SDTI site measures 3.0cm x 2.8cm x utd. Right superior lateral shin SDTI site measures 1.5cm x 2.5cm x utd. Right medial knee stage I pressure site measures 5.3cm x 2.0cm x 0cm. Left medial knee stage II pressure site measures 4.8cm x 2.0cm x <0.1cm [less than 0.1 cm]. Left lateral hip red blanchable area measures 6.0 cm x 10.0cm x 0cm With SDTI site in center that measures 4.5cm x 4.3cm x utd. Bilateral medial buttocks and lower back moisture associated dermatitis site measures 27.5cm x 15.8 cm x 0cm. Left lateral trunk inferior stage II pressure clear fluid filled blister site measures 4.8cm x 3.0 cm x <0.1cm. Left lateral trunk superior stage II pressure clear fluid filled blister site measures 1.0cm x 1.1cm x <0.1cm. Left armpit superior stage II pressure clear filled blister site measures 4.9cm x 1.7cm x <0.1cm. Left armpit middle stage II pressure clear fluid filled blister site measures 7.4cm x 3.0cm x <0.1cm. Left armpit inferior stage II pressure clear filled blister site measures 5.8cm x 2.4cm x <0.1cm. Left lateral distal pinna SDTI site measures 1.5cm x 1.3cm x utd. Right 5th toe anteriolateral aspect red blanchable area measures 0.5cm x 0.5cm x 0cm. Right 4th toe anteriolateral aspect red blanchable	F 314		

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F 314	<p>Continued From page 43</p> <p>areas measures 0.4cm x 0.6cm x 0cm..." Electronically signed by LN #8.</p> <p>-March 2013 Incident Report Tracking form dated 3/3/13 through 3/29/13. Highlighted in green on the first page was, "3/17/13, Resident #6...Day Sunday, shift 1200, Type Skin, Injury Pressure areas; M.A.D. [Moisture Associated Dermatitis]..." The second page identified, "Resident #6, reason Left hip amd {sic} left knee with sites. MAD to bottom..." The surveyor asked if there was an incident report generated and also to review the incident report. Later the same day, the Administrator and the DON said the incident report was done but they were unable to locate the report. Please refer to F225 as it related to lack of investigation of injuries.</p> <p>-A one page document titled, "Care Plan History" at the top right that documented in part, "Original Care Plan Item, Description, Staff will place pillow or thin blanket between Resident #6's knees to reduce pressure factor to bony prominences, Created 1/2/2013, Created by LN #8."</p> <p>-A one page document titled, "Dietary" in the top right that provided evidence the resident refused snacks on 3/6, 3/10, 3/12, 3/13, 3/15, 3/16, and 3/17/13.</p> <p>On 4/25/13 at 12:15 p.m., LN #8 stated, "[On 3/17/13] I got a call [from the weekend wound nurse] because she was fresh out of training. She had already started the dressing changes, I arrived at the facility, and we did a full skin assessment. I know she had areas on her leg prior to that catheter tubing laying on her leg. When I came in she had a purple area on her left</p>	F 314			

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F 314	<p>Continued From page 44</p> <p>hip. She has had red areas on either hip depending on which side she was laying on." The LN stated, "I do not remember a conversation when the MD from the wound center said the open areas were caused by someone not turning her. I stepped out of the room and the MD may have said that while I was out of the room. I do not remember saying her left lateral hip progressed to a Stage III. I do not remember saying Resident #6 was laying on her left side and the catheter tubing caused pressure against her lower right leg."</p> <p>On 4/25/13 at 3:45 p.m., the facility provided the surveyors with additional documentation regarding Resident #6's open skin areas. One of the documents was a statement from the resident's primary physician, dated 4/25/13, addressed to the State inspectors that documented in part, "...she cries out when she is moved at all...She has always voiced her wishes that the staff did not have to move or reposition her because of the pain...recurrent skin ulcerations are unavoidable...even the slightest pressure or shear for her results in skin problems because of the skin failure...she will continue to have skin problems despite air mattresses and pillows and cushions and being moved frequently..."</p> <p>On 4/26/13 at 10:45 a.m., the survey team requested additional documentation from the facility: -Evidence the facility addressed, "[Resident #6] cries when she is moved at all, she has always voiced her wishes that the staff did not have to move or reposition her because of pain, and despite air mattress and pillow and cushions and</p>	F 314			

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F 314	<p>Continued From page 45</p> <p>being moved frequently, the resident continues to have skin breakdown." The above information was requested based on Resident #6's physician's statement dated 4/25/13.</p> <p>-All physician progress notes from December 2011 to present.</p> <p>-All wound care MD progress notes.</p> <p>-All wound measurements for any open areas that developed since December 2011 and treatment sheets for those wounds.</p> <p>-All Interdisciplinary Team (IDT) notes from January 2012 to current.</p> <p>-Care plans initiated after December 2011.</p> <p>On 4/26/13 at 11:30 a.m., the Administrator, the DON, and the ADON were informed of the finding.</p> <p>Resident #6's developed pressure areas and SDTIs on 3/17/13 as evidenced by the resident's Care Plan, Treatment Record, Physician Orders, and Incident Report Tracking form.</p> <p>On 4/29/13 at 3:30 p.m., the Administrator contacted the Bureau of Facility Standards and stated the facility had 300 pages of documents for surveyor review. The Administrator was asked to overnight the information to the Bureau. On 4/30/13 at approximately 3:00 p.m., the Bureau received additional documentation from the facility.</p> <p>- Resident #6's physician's progress notes documented, in part, "12/27/11...complains of more pain whenever she is moved whether to turn her or transfer her to wheelchair..." The 12/27/11 progress note documented the physician prescribed medication for Resident #6's pain. "3/29/12...says the chronic pain is</p>	F 314			

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F 314	Continued From page 46 tolerable..." "9/4/12...still hurts with movement but doesn't think she needs a change of pain medication...follow pain...follow skin problems..." "10/9/12...follow closely to be sure no pain or distress..." "10/30/12...due to skin problems with pressure she mostly stays in bed...Stage 2 pressure areas mostly healed again but recurrent problems..." "12/27/12...pain in her left hip when moved but that is chronic. She is comfortable when she can lay still...She has a new pressure areas between her knees...says - hurts to move her..." NOTE: Resident #6's current Care Plan did not include interventions for: Resident #6 cried out when she was moved at all. Resident #6 always voiced her wishes that the staff did not have to move or reposition her because of the pain. Resident #6's Care Plan did not address skin failure as a focus area, or the recurrent skin ulcerations were unavoidable, or even the slightest pressure or shear for Resident #6 resulted in skin problems because of the skin failure. - The wound care MD's 4/17/13 progress note documented, in part, "Stage 2 PU on left medial knee...Stage 3 PU after debridement on right medial knee..." - Weekly Skin Monitoring forms. The facility did not provide Weekly Skin Monitoring forms for the month of March 2013. The 4/14/13 form documented, in part for Resident #6, "Date of onset 3/17/13. R [right] medial cuneiform...Current Stage, SDTI...R inferiolateral shin...Current Stage, III...R medial knee...Tunnel...L [left] medial knee...Current Stage, III...L lateral hip...Current Stage III." -Interdisciplinary (IDT) Skin Review Notes, dated 3/24/12 through 10/19/12, documented Resident	F 314			

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F 314	Continued From page 47 #6 was treated by the facility for open skin areas. The 10/19/12 IDT Skin Review Note documented, in part, the only area of concern was, "...R lateral ankle not open...1.4 length x 0.6 width x 0. Improved..." -The Care Plans provided did not include dates to indicate when the Care Plans were put into place, did not identify when the Care Plans were printed, therefore the survey team was not able to determine when the Care Plans were initiated or revised.	F 314			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by:	F 322			

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F 322	<p>Continued From page 48</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to flush a resident's feeding tube prior to administration of medication. This affected 1 of 5 (#16) random residents. This practice created the potential to clog the resident's feeding tube Findings included:</p> <p>Federal guidelines at F322 direct facility to use universal precautions when flushing and giving medications through a feeding tube. The Center for Medicare & Medicaid Services (CMS) letter, S&C:13-02-NH, directed facilities to flush before and in between each medication administration.</p> <p>Random Resident #16 was originally admitted to the facility on 5/20/99, and readmitted on 12/23/11, with diagnoses including anoxic brain damage and dysphagia.</p> <p>The resident's most recent physician orders "All Active Orders for March 2013" (recapitulation orders) contained, in part, order date 12/23/11, Clonazepam 1 milligram by way of enteral tube - every 8 hours every day, at 6:00 a.m., 2:00 p.m., and 10:00 p.m. diagnosis Myoclonus.</p> <p>On 4/22/12 at 1:50 p.m., LN #12 was observed administering a medication by way of Resident #16's feeding tube. The LN mixed the medication with water, did not flush prior to administering the medication. The LN did flush the tube with water after the administration.</p> <p>On 4/23/13 at 3:06 p.m., the LN stated, I did not flush before administration of the Clonazepam. I did flush with 50 cubiccentimeters of water after the medication was administered. The MAR does</p>	F 322			

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F 322	Continued From page 49 not say to flush before administering the medication." The resident's April 21013 MAR and current care plan were reviewed. Neither of the documents directed nurising staff to flush before or after administration of medications by way of a feeding tube. On 4/26/13 at 11:30 a.m., the Administrator, DON, and ADON were informed of the observation and the CMS letter S&C:13-02-NH.	F 322			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, family and staff interviews, and policy and procedure review, it was determined the facility failed to ensure oxygen was administered per physician orders; and, CPAP/VPAP (continuous positive airway pressure/variable positive airway pressure) were not administered without a physician's order and care plans were revised to	F 328			

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F 328	<p>Continued From page 50</p> <p>reflect residents' current respiratory status and needs. This was true for 3 of 13 sample residents (#s 9, 10, and 12). These failures created the potential for increase in respiratory problems if residents' respiratory needs were not met. Findings included:</p> <p>1. Resident #9 was admitted to the facility on 3/1/09 with multiple diagnoses, which included anemia and asthma.</p> <p>Resident #9's most recent quarterly MDS assessment, dated 3/28/13 coded, in part, oxygen (O2) use.</p> <p>The resident's care plan identified the focus area, "...has Oxygen Therapy r/t [related to] anemia and asthma." One intervention was, "O2 as ordered."</p> <p>A recapitulation (recap) of the resident's All Active Orders for March 2013 included: * O2 at 2 liters per minute (LPM) to keep saturation levels greater than 88% per nasal cannula (NC); and, * Check O2 saturation level every shift 6:30 a.m. - 6:30 p.m. and 6:30 p.m. - 6:30 am. The orders were dated 10/22/12.</p> <p>Resident #9's April 2013 MAR included the aforementioned orders for O2 and saturation level checks. The MAR contained documentation the saturation levels ranged from 90 - 97% on O2 at 2 LPM.</p> <p>Resident #9 was observed with a NC in place and the O2 liter flow rate as follows: * 4/23/13 at 7:22 a.m., 1.5 LPM per O2</p>	F 328		

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F 328	<p>Continued From page 51</p> <p>concentrator; * 4/23/13 at 8:05 a.m., 3 LPM per portable O2 tank; and, * 4/23/13 at 11:00 a.m., 0 LPM per O2 concentrator, the concentrator was turned off.</p> <p>On 4/23/13 at 11:05 a.m., LN #4 accompanied the surveyor to Resident #9's room. The resident was in a recliner with the NC in place. However, the NC was connected to the O2 concentrator which was still off. The LN stated, "It's not on." The LN asked how long she had been in the recliner and who put her there. The resident stated, "A few minutes" and named CNA #10. The LN tried several times to turn on the concentrator but the machine would not work. The LN connected the resident's NC to the portable O2 tank set it to 3 LPM. The LN used her headphone device and called CNA #10 to the resident's room. CNA #10 arrived within seconds. LN #4 said to the CNA, "You didn't turn her concentrator on." The LN instructed the CNA to get another concentrator.</p> <p>At 11:10 a.m., CNA #10 brought another O2 concentrator to Resident #9's room. About then, LN #2 arrived and assisted the CNA to plug in the new concentrator. Then, the LN left the room. However, when the CNA turned on the new concentrator, it alarmed repeatedly and the liter flow rate could not be set. The CNA #10 requested assistance. During this time, the resident's NC was still connected to the portable O2 tank at 3 LPM.</p> <p>At 11:20 a.m., CNA #7 brought another O2 concentrator to the resident's room. CNA #10 turned on the concentrator, connected the</p>	F 328			

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F 328	<p>Continued From page 52</p> <p>resident's NC to it, turned the concentrator to 5 LPM, then left the room.</p> <p>At 11:25 a.m., LN #2 accompanied the surveyor to Resident #9's room. When asked what the liter flow rate on the concentrator was, the LN stated, "Between 4 1/2 and 5." LN #2 then turned the concentrator to 2 LPM.</p> <p>On 4/25/13 at about 6:30 p.m., the Administrator, DON, ADON, and Clinical Resources Representative were informed of the observations regarding Resident #9's O2. When asked if CNAs were allowed to set O2 liter flow rates, the DON said, "No."</p> <p>No other information or documentation was received from the facility that resolved the issue.</p> <p>2. Resident #10 was admitted to the facility on 1/23/13 with multiple diagnoses which included diastolic heart failure with pulmonary hypertension.</p> <p>The resident's care plan included the focus area, "Need Special Care r/t [related to] Oxygen use...Dx [diagnosis] COPD [chronic obstructive pulmonary disease]" on 2/1/13. One intervention was, "Assist with use of CPAP at night and during daytime as needed. Assess for good seal and properly functioning equipment." Note: No other information about CPAP was found in the resident's care plan.</p> <p>There were no orders for CPAP in Resident #10's recapitulation (recap) of the All Active Orders for March 2013 and no orders for CPAP were found in the resident's clinical record. In addition, there</p>	F 328			

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F 328	<p>Continued From page 53</p> <p>were no entries regarding CPAP on the the resident's MARs or TARs for March or April 2013.</p> <p>On 4/24/13 at 7:05 p.m., Resident #10 and her son were observed in the resident's room. A CPAP machine was noted on the resident's bedside table. When asked about the CPAP, the resident said she used the CPAP "every night." The resident's son stated he put the CPAP on the resident every night, except Fridays, and the resident would take it off in the morning. The son stated the facility staff assisted the resident with the CPAP on Friday nights when he was not available.</p> <p>On 4/25/13 at 9:00 a.m., Resident #10 was observed in her room. The resident stated she had used CPAP during the night and had taken it off herself that morning.</p> <p>On 4/25/13 at 10:25 a.m., the ADON confirmed Resident #10 had CPAP equipment and used CPAP at night. The ADON was asked for the order for the CPAP and documentation regarding when CPAP was administered to the resident.</p> <p>That afternoon, the ADON stated there were no orders for Resident #10's CPAP and no documentation CPAP was administered to the resident.</p> <p>On 4/25/13 at about 6:30 p.m., the Administrator, DON, and Clinical Resource Representative were also informed of the issue. The facility policy and procedure (P&P) regarding CPAP was requested at that time.</p> <p>On 4/25/13 at 11:15 a.m., the DON provided a</p>	F 328			

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F 328	<p>Continued From page 54</p> <p>"BiPap/C-Pap/V-Pap P&P," dated 5/07, which included the following documentation, "POLICY: ...BiPaP, C-Pap, or V-Pap be administered as ordered by the physician... PROCEDURES: 1. Verify settings per MD [physician] order. ... 3. Oxygen can be bled in at the port on the facemask. 4. Set IPAP [inspiration positive airway pressure] level per MD order. 5. Set EPAP [expiration positive airway pressure] per MD order. 6. Select spontaneous, spontaneous timed or timed mode per MD order. 7. Set rate per MD order. 8. Set % [percent] IPAP per MD order. 9. ...A. High alarm should be set... B. Low alarm should be set... 10. Physician will be notified immediately of any concerns."</p> <p>No other information or documentation was received from the facility that resolved the issue.</p> <p>3. Resident #12 was admitted to the facility on 1/4/13 with multiple diagnoses which included COPD (chronic obstructive pulmonary disease).</p> <p>The resident's care plan included the focus area, "Ineffective airway clearance r/t [related to] COPD \ Decreased energy and fatigue from work of breathing..." on 4/2/13. One intervention was, "Assist with wearing B-Pap at HS [night] and as needed to make sure is working correctly and has a secure seal. Parameters to set at as at home. [Resident's name] can assist with this." Note: No other information about VPAP (also called BiPAP) was found in the resident's care plan.</p> <p>There were no orders for VPAP in Resident #12's recapitulation (recap) of the All Active Orders for March 2013 and no orders, or settings for VPAP</p>	F 328			

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F 328	<p>Continued From page 55</p> <p>were found in the resident's clinical record. In addition, there were no entries regarding VPAP on the the resident's MARs or TARs for March or April 2013.</p> <p>On 4/24/13 at 6:30 p.m., Resident #12 was observed eating in his room. A VPAP Adapt machine was noted on the resident's bedside table. When asked about the VPAP, the resident said he managed and cleaned the equipment himself. He stated he put the facemask on at night and took it off in the morning and, "They [staff] help now and then."</p> <p>On 4/25/13 at about 10:20 a.m., the ADON confirmed Resident #10 had VPAP equipment and used VPAP at night. The ADON was asked for the order for the VPAP and documentation regarding when VPAP was administered to the resident.</p> <p>That afternoon, the ADON stated there were no orders for Resident #12's VPAP and no documentation VPAP was administered to the resident.</p> <p>On 4/25/13 at 6:30 p.m., the Administrator, DON, and Clinical Resource Representative were also informed of the issue. The facility policy and procedure (P&P) regarding CPAP was requested at that time.</p> <p>Note: Refer to example #2 above regarding the policy and procedure on VPAP.</p> <p>No other information or documentation was received from the facility that resolved the issue.</p>	F 328		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	<p>Continued From page 56 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 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 PRN (as needed) medications were consistently monitored for efficacy. This was true for 1 of 13 sample residents (#8). The failure created the potential for harm because unnecessary medications can lead to adverse reactions and health decline. Findings included:</p>	F 329			

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F 329	<p>Continued From page 57</p> <p>Resident #8 was admitted to the facility on 10/30/08 with multiple diagnoses which included migraine headaches.</p> <p>Resident #8's care plan included the following focus areas and interventions: * "Insomnia altered sleep pattern," - "Administer sleep aid as ordered;" and, * "...resident is on medication, 9 or more," - "Administer medication as ordered."</p> <p>The resident's recapitulation (recap) of All Active Orders for March 2013 and MAR for April 2013 included the orders: * Hydroxyzine 25 milligrams (mg) by mouth PRN every 4 hours for restlessness; and * Melatonin 5 mg by mouth PRN every HS (bedtime) for insomnia.</p> <p>Per the April 2013 MAR, the 2 aforementioned PRN medications were not consistently documented as monitored for effectiveness as follows: * Hydroxyzine - 9 of 24 administrations, or 37.5%; and * Melatonin - 4 of 12 administrations, or 33%.</p> <p>On 4/25/13 at approximately 11:15 a.m., the ADON was asked about the lack of consistent monitoring regarding the effectiveness of Resident #8's hydroxyzine and Melatonin. The ADON indicated he would review the resident's clinical record and get back with the surveyor.</p> <p>That afternoon, the ADON indicated there was no other documentation that staff monitored the efficacy of Resident #8's PRN hydroxyzine and</p>	F 329			

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F 329	Continued From page 58 Melatonin. On 4/25/13 at about 6:30 p.m., the Administrator, DON, ADON, and Clinical Resource Representative were informed of the issue. No other information or documentation was received from the facility that resolved the issue.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on group interview, test tray evaluation and staff interview, it was determined the facility failed to prepare palatable food. This affected 6 of 9 residents who attended the Quality of Life Assessment Group Interview, 13 of 15 sampled residents (#s 1-13) and had the potential to affect other residents who dined in the facility. This failed practice created the potential to negatively affect the resident's nutrition status and psychosocial well-being related to unpalatable food. Findings included: On 4/24/13 at 9:30 AM, during the Quality of Life Assessment Group Interview, 6 out of 9 residents said the broccoli was overcooked. On 4/24/13 at 1:15 PM, a lunch meal test tray was evaluated by the survey team, the DM, and the RD. The test tray included Italian vegetables	F 364		

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F 364	Continued From page 59 (mixed vegetables) which were determined to be unpalatable and mushy in consistency, indicating the vegetables were overcooked. On 4/24/13 at 1:25 PM, the DM was asked what the Italian vegetables looked like and he stated, "mush." He said he had been trying to find the right cooking methods for the vegetables to avoid overcooking them. On 4/24/13 at 4:40 PM, the Administrator, DON, ADON, and Clinical Resources Representative were informed of the issue. No other information was provided by the facility.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, evaluation of a potentially hazardous food, and staff interview, it was determined the facility failed to ensure food was stored, prepared, and served under sanitary conditions. This affected 13 of 13 (#s 1-13) sampled residents and had the potential to affect residents who dined in the facility, and who requested milk with meals and dined in the	F 371		

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F 371	<p>Continued From page 60</p> <p>Northside dining room. This practice created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included:</p> <p>1. On 4/22/13 at 12:10 p.m. during the initial tour of the kitchen, the Dietary Manager (DM) accompanied the surveyor.</p> <p>a. At 12:16 p.m., the outside of the double ovens had visible debris build-up and was sticky, tacky to the touch.</p> <p>b. At 12:17 p.m., the outside of the Vulcan range had visible debris build-up, sticky, tacky to the touch.</p> <p>c. At 12:24 p.m., the shelves inside the right side compartment of the thawing refrigerator had a build-up of debris. The debris were multi-colored, dry, flaky in appearance and dry, flaky to the touch.</p> <p>d. At 12:25 p.m., the inside bottom of the milk refrigerator had visible debris build-up, white, brown, and black in color.</p> <p>e. At 12:30 p.m., the scoop for the ice machine was located, serving side up, in an opaque plastic container, approximately 8 inches wide by 10 inches long by 2-3 inches deep. Approximately one-half inch of water was in the bottom of the plastic container. The ice machine scoop was in direct contact with the water and was not protected from possible contamination.</p> <p>2. The Northside dining room had a serve out kitchen area. In the seating area of the dining room there were two different counters both located against the same wall. Each of the two counters had a handwashing sink. During the survey process, numerous staff were observed</p>	F 371			

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F 371	<p>Continued From page 61</p> <p>washing their hands in each of the handwashing sinks while serving food and assisting residents to dine.</p> <p>a. On 4/24/13 at 9:16 a.m., a grey plastic 12-compartment pre-packaged condiment holder was located on one of the counters in the Northside dining room. Each of the 12 compartments had visible debris, of different colors, in the bottom of the compartments. The top three compartments had a plastic swivel cover that was visibly soiled with what appeared to be greasy fingerprints. Dishwasher #13 (D #13) was in the dining room clearing tables. The surveyor informed D #13 of the observation. D #13 stated, "That piece of equipment is for storing condiments. It needs to be cleaned." At 9:30 a.m., the DM removed the condiment holder from the counter and placed it on the used dish cart.</p> <p>The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 4-601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(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 4-602.13, Nonfood-Contact Surfaces, indicated, "Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues."</p> <p>b. At 9:17 a.m., there were 4 plastic drinking glasses laying horizontally in 1 of 2 handwashing sinks in the Northside dining room. D #13 stated, "Those glasses should not be in the sink. That</p>	F 371			

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F 371	<p>Continued From page 62 sink is for handwashing."</p> <p>The 2009 FDA Food Code, Chapter 5, Water, Plumbing, and Waste, Operation and Maintenance, Subpart 5-205.11 Using a Handwashing Sink indicated, "(B) A handwashing sink may not be used for purposes other than handwashing."</p> <p>c. At 12:47 p.m., a large black plastic bin was located on 1 of the 2 counters in the Northside dining room. The bin contained individual cartons of milk. The cartons were mounded approximately 5-6 inches above the lip of the plastic container. Not all the cartons of milk were in direct contact with ice. The surveyor asked the DM what the cartons of milk were used for. The DM said for "residents." The surveyor asked the DM to determine the temperature of a carton of milk laying on the top and not in contact with ice. The milk temperature was determined to be, "50 degrees Fahrenheit."</p> <p>The 2009 FDA Food Code, Chapter 3 Food, Part 3-5, Limitation of Growth of Organisms of Public Health Concern, Subpart 3-501.16, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding indicated, "(C) potentially hazardous food...in a homogenous liquid form may be maintained outside of the temperature control requirements...while contained within specially designed equipment that complies with the design and construction requirements as specified under § 4-204.13(E)."</p> <p>On 4/25/13 at 6:07 p.m., the Administrator, DON, and ADON were informed of the findings. The</p>	F 371		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/26/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
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F 371	Continued From page 63	F 371			
F 431	facility did not provide any additional information.				
SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			
	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <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>				

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F 431	Continued From page 64 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and policy and procedure review, it was determined the facility failed to ensure fentanyl patches (a controlled substance) were properly disposed with a record of the disposal; multi-dose flu vaccine and tuberculin vials included the open date, and outdated medications, they were not available for resident use; medication labels included the strength of the medication; and, pharmacy labels included expiration dates. This was true for 2 random residents (#19 and #20), one of two medication room refrigerators, one of two Pyxis machines, and one of three medication carts. These failures created the potential for diversion of Resident #19's used Fentanyl patch; reduced efficacy of Resident #20's topical lorazepam, topical morphine, and liquid haloperidol; over or under medication for pain for any resident who received an Oxy IR tablet without the strength identified; reduced efficacy for any resident who received outdated medications such as vaccines, antibiotic, anti-Alzheimer, anti-nausea, pain medication, and breathing treatment medications; and, inaccurate TB (tuberculosis) skin test results for any resident who received outdated Tubersol. Findings included: 1. Note: Informational Letter, Reference: S&C: 13-02 NH, stated, in part, "Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for abuse, misuse and diversion, and the substantial amount of fentanyl remaining in the patch after use. The facility's policies must address safe and	F 431			

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F 431	<p>Continued From page 65</p> <p>secure storage, limited access and reconciliation of controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and disposition of the medications. One benefit of the patch is the continuous delivery of fentanyl over 72 hours. This slow-release of fentanyl from the transdermal reservoir allows for more consistent pain control in patients with chronic pain. This unique delivery system, however, is not impervious to diversion, even after the fentanyl patch has been used, removed and/or disposed. One study determined that even after three days of use, 28 to 84.4% of the original fentanyl dose was still present in the patch. The study noted that the dose remaining in the patch was within the limits of a lethal fentanyl dose.⁷</p> <p>The remaining fentanyl in a used patch is a potential vehicle of abuse and accidental overdose and warrants implementation of adequate disposal policies. Fentanyl products contain several boxed warnings related to potential abuse, misuse, and diversion, and specifically, the contraindication of fentanyl transdermal patch use in individuals who are not opioid tolerant.</p> <p>Staff should dispose of fentanyl patches in the same manner as wasting of any other controlled substances, particularly because the active ingredient is still accessible. Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized. ..."</p> <p>On 4/24/13 at 7:55 p.m., during a medication pass observation, LN #1 removed a Fentanyl patch from Resident #19's right posterior shoulder, folded the used patch twice, and discarded it into a sharps container on the wall by</p>	F 431			

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F 431	<p>Continued From page 66</p> <p>the doorway. No other LNs were in the room at the time. The LN then administered a new Fentanyl 100 microgram patch and 6 other medications to the resident.</p> <p>Upon return to the medication cart in the hallway, LN #1 initialed the medications on Resident #19's MAR. However, the LN did not document the used Fentanyl patch had been wasted. When asked about a second LN to document the used Fentanyl patch had been wasted, LN #1 confirmed there was no witness and there was no documentation the used patch was wasted. When asked if he had been trained or in-serviced regarding wasting used Fentanyl patches in the presence of a second LN and a record that the used Fentanyl was wasted, the LN stated "No." The LN stated he had noticed a new form for some of the other residents with Fentanyl patches. He indicated the new form included areas for 2 LNs to sign when a used Fentanyl patch was wasted. He stated, however, the new form was not in use for Resident #19's Fentanyl patch.</p> <p>On 4/24/13 at about 6:30 p.m., the Administrator, DON, ADON, and and Clinical Resources Representative were informed of issue. They were asked to provide the facility's policy on wasting of controlled substances, particularly, used Fentanyl patches.</p> <p>On 4/25/13 at 11:00 a.m., the DON provided a Controlled Medications policy and procedure (P&P). She stated it applied to used Fentanyl patches.</p> <p>The Controlled Substances P&P documented, in part, "When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It</p>	F 431			

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F 431	<p>Continued From page 67</p> <p>must be destroyed in the presence of two licensed nurses and the disposal documented on the accountability record, on the line representing that dose. The same procedure applies to the disposal of unused partial tablets and unused portions of single dose ampoules."</p> <p>No other information or documentation was received from the facility that resolved the issue.</p> <p>2. On 4/25/13 at 2:30 p.m., during an inspection of the A-B Medication (Med) Room refrigerator, with LN #3 in attendance, the following was found:</p> <ul style="list-style-type: none"> * An opaque, brown bag with 11 syringes each labeled, "Lorazepam 1 mg/ml [1 milligram per milliliter] in PLO [Pluronic Lecithin Organel for transdermal (skin) application." The medication was filled on 4/19/13 for Resident #20. However, an expiration date was not on the pharmacy label on the bag, nor on any of the syringes. LN #3 stated hospice had provided the medication. The LN stated she would ask the hospice pharmacy to bring a new label with the expiration date. * Two ½ full multi-dose 1 ml vials of Tubersol (used to screen for TB) with no open date. * Two multi-dose 5 ml vials of Influenza Virus Vaccine with no open date. One vial had approximately ¼ left and the other vial was about ¾ full. * One multi-dose 2.5 ml bottle of pneumococcal vaccine - expired " 12Nov12. " <p>LN #3 confirmed there were no open dates on the Tubersols, the influenza vaccines, and that the pneumococcal vaccine was outdated. She stated she would discard all of them.</p> <p>Note: A search of the Internet on 4/29/13 at fda.gov/downloads/BiologicalsBloodVaccines/Vaccines/ApprovedProducts/ucm112904.pdf, included the following, "Preparation for</p>	F 431		

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F 431	<p>Continued From page 68</p> <p>Administration...Once entered [punctured], a multi-dose vial, and any residual contents, should be discarded after 28 days."</p> <p>On 4/25/13 at approximately 6:30 p.m., the Administrator, DON, ADON, and Clinical Resources Representative were informed of issues. No other information or documentation was received from the facility that resolved the issues.</p> <p>3. On 4/25/13 at 2:45 p.m., during an inspection of the Pyxis machine, with LN #3 in attendance, the following was found:</p> <ul style="list-style-type: none"> * Two tablets of levofloxacin (antibiotic) 500 mg (milligrams) - expired 7/2012; * One tablet of Namenda (anti-Alzheimer) 10 mg - expired 7/2012; * One Zofran (anti-nausea) 4 mg - expired 2/2013; and * One Oxy IR tablet (immediate release form of the opioid analgesic pain reliever, a controlled substance schedule III medication), strength not indicated - expired 7/2012. <p>At 2:50 p.m., LN #2 and the ADON arrived at the Pyxis machine. Both of them and LN #3 confirmed the outdated medications and that the strength of the Oxy IR was unknown. LN #2 stated, "The pharmacy guy was here yesterday." The ADON stated he would talk to the DON and that the controlled medication and the other expired medications would be wasted.</p> <p>On 4/25/13 at approximately 6:30 p.m., the Administrator, DON, ADON, and Clinical Resources Representative were informed of issues. No other information or documentation was received from the facility that resolved the issues.</p> <p>4. On 4/25/13 at 4:25 p.m., during an inspection</p>	F 431			

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F 431	Continued From page 69 of the B-C Medication Cart, with LN #3 in attendance, the following were found: * A 75 milliliter bottle labeled Haloperidol 5 milligrams/milliliter. The medication was filled on 4/19/13 for Resident #20. However, an expiration date was not on the pharmacy label or on the bottle itself. LN #3 stated hospice had provided the medication. The LN stated she would ask the hospice pharmacy to bring a new label with the expiration date. * An opaque, brown bag with 29 syringes each labeled "Morphine 10 mg/ml [1 milligram per milliliter] in PLO [Pluronic Lecithin Organel for transdermal (skin) application." The medication was filled on 4/23/13 for Resident #20. However, an expiration date was not on the pharmacy label on the bag, nor on any of the syringes. LN #3 stated hospice had provided the medication. The LN stated she would ask the hospice pharmacy to bring a new label with the expiration date. * A clear plastic bag with 10 unit dose vials of Ipratropium 0.4 milligrams (mg)/Albuterol 3.0 mg - all expired July 2012. LN #3 stated, "It's our stock supply." The LN indicated she would waste the expired medications. On 4/25/13 at approximately 6:30 p.m., the Administrator, DON, ADON, and Clinical Resources Representative were informed of issues. No other information or documentation was received from the facility that resolved the issues.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441			

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F 441	<p>Continued From page 70 of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff adhered to standard infection control practices.</p>	F 441			

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F 441	<p>Continued From page 71</p> <p>This was true for 1 of 13 sample residents (#9) and 1 random residents (# 17). The failure of staff to perform appropriate hand hygiene after resident contact, including incontinence care, created the potential for the spread of disease causing pathogens. Findings included:</p> <p>1. Resident #9 was admitted to the facility on 3/1/09 with multiple diagnoses, which included chronic pain and polymyalgia rheumatica.</p> <p>Resident #9's most recent quarterly MDS assessment, dated 3/28/13 coded, in part, intact cognition, with a BIMS score of 15; extensive assistance of 1 person for toileting and personal hygiene; indwelling urinary catheter; and, occasional bowel incontinence.</p> <p>The resident's care plan included the focus area, "...Hx [history of] Urinary Tract Infections..." on 10/23/12. Interventions included, "Provide pericare after each episode of incontinence..." and "Wash front to back during toileting/changing of briefs."</p> <p>On 4/23/13 at about 7:25 a.m., CNA #6 was observed as she provided incontinence care to Resident #9 who was in bed. The CNA cleansed BM off the resident's rectal area then she cleansed the resident's labia and vaginal area. The CNA said to the resident, "I need to make sure no BM is left."</p> <p>Note: The CNA cleansed the resident back to front instead of front to back, which could have transferred organisms to the resident's perineal area.</p> <p>At about 7:30 a.m., CNA #6 removed the used</p>	F 441			

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F 441	<p>Continued From page 72</p> <p>gloves, put on new gloves, then emptied the resident's urinary drainage bag. Note: The CNA did not wash her hands or use hand sanitizer between glove changes.</p> <p>At 7:50 a.m., CNA #6 did not respond when asked about cleansing Resident #9 back to front and no hand hygiene between glove changes then handling the resident's urinary drainage bag.</p> <p>On 4/25/13 at about 6:20 p.m., the Administrator, DON, ADON, and Clinical Resource Representative were informed of the observations.</p> <p>No other information or documentation was received from the facility that resolved the issue.</p> <p>2. On 4/24/13 at 7:15 p.m., LN #1 was observed as he performed a blood glucose check for Resident #17, removed the used gloves afterwards, then left the resident's room. Note: The LN did not perform any type of hand hygiene after the glove removal.</p> <p>Immediately upon return to the medication cart in the hallway, CNA #5 approached and asked the LN for cigarettes for another resident. The LN unlocked the medication cart, opened the bottom drawer and removed a clear plastic baggie with a package of cigarettes, from which the CNA took 2 cigarettes. The LN used hand sanitizer after that.</p> <p>LN #1 was interviewed immediately afterward. The LN acknowledged that he had not performed any type of hand hygiene before he left Resident #17's room then touched the medication cart and handled the baggie with cigarettes.</p>	F 441		

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F 441	Continued From page 73	F 441			
F 468 SS=E	<p>On 4/25/13 at about 6:20 p.m., the Administrator, DON, ADON, and Clinical Resource Representative were informed of the observations.</p> <p>No other information or documentation was received from the facility that resolved the issue.</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 interview, it was determined the facility failed to ensure all corridors were equipped with handrails. This affected 7 of 13 (#s 2-3, 5, 7, 11-13) sampled residents and had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents to not have a handrail for stability when and if needed. Findings included:</p> <p>1. On 4/25/13 at 2:00 p.m., the Maintenance Supervisor (MS), Housekeeping and Laundry Supervisor (HLS), and Administrator accompanied the surveyor during the General Observations of the Facility. There was a four way intersection of two corridors located in the vicinity of the A-B nurses station and adjacent to the DON's office. At 2:06 p.m., the surveyor informed the MS, HLS, and Administrator: a. The corridor from the facility to the designated smoking area and one of two parking lots did not</p>	F 468			

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F 468	<p>Continued From page 74</p> <p>have handrails attached to each side of the corridor. One side of the corridor, without a handrail, measured 25 feet long. The other side of the corridor had a handrail firmly attached for approximately 6 feet. During the survey process, residents and staff were observed exiting and entering by way of this corridor leading to one of two parking lots.</p> <p>b. At this same intersection, in the opposite direction, there was a 17 foot long corridor leading outside to an enclosed courtyard. There were no handrails attached to either side of this corridor. During the survey process, the surveyor did not observe residents attempting to exit or enter the facility by way of this specific corridor.</p> <p>On 4/25/13 at 2:10 p.m., the MS and HLS both stated, "We have never been told there was an issue with handrails in the facility."</p>	F 468			

May 16, 2013

Federal Citations

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F 164 D

1. All staff assigned to care for resident #4 were immediately educated on the need to protect the residents privacy during cares by closing blinds and privacy curtains.
2. All residents have the potential to be affected. In servicing provided to all staff regarding privacy issues by 5/8/2013.
3. LN's to audit assigned residents daily for privacy being maintained during cares. Start date 5/13/2013.
4. Audits by DNS or RN designee will be conducted during resident cares, 3 times per week for four weeks, weekly for three weeks and then monthly until resolved. Start date 5/13/2013. Results will be reported to Quality Assurance Committee monthly.
5. Date of Compliance is 6/7/2013.

F 167 C

1. No specific resident was identified.
2. All residents, family and visitors have the potential to be affected.
3. All staff educated on the importance of survey results being maintained in facility at all times, education provided on 5/17/2013.
4. Housekeeping and maintenance management to audit survey binder weekly and ongoing. Results reported to Quality Assurance Committee monthly. Audits to start 5-13-2013.
5. Date of Compliance is 6/7/2013.

F 225 D

1. Resident #6 was identified; the Incident/Accident (I/A) report was recreated through staff interviews for the skin issues reported on 3/17/2013. Note: documentation was provided to the survey team in the form of Incident/Accident tracking log and IDT review record that in fact the incident had been reported to the administrator and the resulting investigation did not conclude that neglect had occurred.
2. All residents have the potential to be affected.
3. In process for signatures and interview data will be placed in a red folder for high visibility and all I/A's will be maintained in a central location on the ADON's desk until completed and filed. Management staff in serviced on P&P for I/A processing completed on 5/17/2013.
4. ADON to monitor I/A log to actual I/A's daily. DNS or administrator to audit weekly for two months and then monthly ongoing. Audits to start 5-13-2013. Report to Quality Assurance Committee.
5. Date of Compliance is 6/7/13.

F 246 D

1. All staff assigned to care for resident #6 were immediately educated on the need to ensure resident access to call light at all times.
2. All residents have the potential to be affected. In servicing provided to all staff regarding call light placement by 5/8/2013.
3. LN's to audit assigned residents daily for call light accessibility, Start date 5/13/2013.
4. Audits by DNS or RN designee will be conducted when patients are alone in room, 3 times per week for four weeks, weekly for three weeks and then monthly until resolved. Start date 5/13/2013. Results will be reported to Quality Assurance Committee monthly.
5. Date of Compliance is 6/7/2013.

F 281 D

1. Residents #9 and 19 were identified. Assigned LN's were immediately educated on manufacturers recommendations for steroid administration.
2. All residents receiving inhaled medications have the potential to be affected. All physicians' orders were audited for all residents to identify those receiving inhaled medications.
3. 1 : 1 education was provided to all LN's and in-service to all staff on 5/13/2013.
4. Audits by DNS or RN designee daily for one week, three times a week for four weeks and one time per week for three weeks, if problem continues will return to monitoring as appropriate and report to Quality Assurance Committee monthly. Audits to start 5-13-2013.
5. Date of Compliance is 6/7/2013.

F 309 E

1. Residents #1,2,4,6,8,9,12 were identified.
 - a. Hospice: Residents # 1,4,6. Implemented new P&P for documentation by hospice per visit. Hospice notes obtained for residents records.
 - b. Dialysis: resident #12 has been discharged from the facility.
 - c. Intrathecal pumps for residents #2 and 9: All required safe guards for the pumps were immediately placed in the care plan, instructions for pump use and safety was printed and placed in P&P manual, MDS checked for accuracy.
 - d. Patient Transfers: Resident # 8, Aide's immediately educated on care plan for two person transfers.
 - e. Lab Tests: Resident #8, Lab orders were put into electronic system and were printed out on the medication administration record.
2. All residents on hospice, dialysis, intrathecal pumps, residents requiring two person assist for transfers and residents requiring laboratory tests have the potential to be affected.
3.
 - a. Meetings with all of the hospice agency's contracting with the facility were conducted to discuss implementation of written communication with each visit.
 - b. In the event a resident requiring dialysis is admitted to the facility, protocol to ensure daily communication will be initiated.
 - c. A check list of all required monitoring, care planning, MDS coding, has been implemented.
 - d. Resident cardex communication system has been updated to include transfer level of assistance.
 - e. Base line audit of all resident's lab orders has been completed and all lab orders found to be absent from the electronic record system have been entered into the electronic system.
4. DNS or RN designee will audit all hospice communication, care plans and lab orders weekly for three months. Audits of transfers by aides will be conducted by LN's three times per week for four weeks, then weekly for three weeks and then every month, reported to Quality Assurance monthly. . Audits to start 5-13-2013.
5. Date of Compliance is 6/7/2013.

F314 G

1. Resident #6 was identified. Care plan was updated on 3-18-13 to include all identified wounds and treatment modalities. Care plan was also updated for pain discomfort. NOTE: The 3-18-2013 update to the skin care plan was not visible on the printed copies supplied to the survey team, however, by clicking on the history symbol, the revision was visible and date stamped 3-18-2013. A timed stamped printed copy of the update to the care plan will be available to the survey team on revisit.
2. All residents at risk of skin breakdown have the potential to be affected.
3.
 - a. All LN's and CNA's were educated on turning and repositioning of patients at risk for skin breakdown on 5-8-13.
 - b. Wound nurse was educated on updating care plans with any changes in wounds.
 - c. LNs were trained on performing accurate assessments, documentation and treatment of pain.
 - d. IDT to review daily change of condition reports for changes that may increase the risk of skin impairment and update assessments and care plans as needed.
4.
 - a. DNS or RN designee to monitor all nursing documentation for residents assessed as high risk for skin issues and all residents receiving skin and wound treatment, including weekly skin notes, for accuracy/timeliness and care plan updated daily for 2 months, then twice weekly ongoing. Audits to start on 5-20-2013. DNS or RN designee to audit proper repositioning of patient according to patient care plan three times weekly for four weeks, weekly for four weeks. Audit to start 6-3-2013.
 - b. Weekly skin at risk committee meetings will be expanded to include high risk residents for increased intervention oversight and care plan review ongoing. Audits to start on 5-20-2013.
 - c. Reported to QA monthly.
5. Date of Compliance is 6-7-2013.

F 322 D

1. Resident #16 was identified. Assigned LN's were immediately educated on proper flushing of the PEG tube.
2. All residents with Tube feedings have the potential to be affected.
3. 1 : 1 education was provided to all LN's and in-service to all staff on 5/13/2013. Physician orders were audited to identify all residents who had the potential to be affected.
4. Audits by DNS or RN designee daily for one week, three times a week for four weeks and one time per week for three weeks, if problem continues will return to monitoring as appropriate and report to Quality Assurance Committee monthly. Audits to start 5-13-2013.
5. Date of Compliance is 6/7/2013.

F 328 D

1. Residents #10, 12 have been discharged from the facility. For Resident #9 assigned staff was immediately educated on correct liter flow. All staff immediately educated that LN's are responsible for setting correct liter flow.
2. All residents on O2 therapy or using CPAP, VPAP, BIPAP and AVAP have the potential to be affected.
3. All residents on O2 CPAP, VPAP, BIPAP and AVAP were care planned for their use and physician orders were obtained as necessary. Stickers indicating ordered liter flow were placed on all concentrators.
4. DNS or RN designee to audit liter flow three times per week for four weeks then weekly for two months, DNS or RN designee to audit care plans or physician orders for CPAP, VPAP, BIPAP and AVAP weekly for four weeks. Audits to start 5-13-2013.
5. Date of compliance is 6/7/2013.

F 329 D

1. Resident #8 was identified; staff immediately educated on documentation efficacy of all PRN medications.
2. All residents have the potential to be affected.
3. All LN's will review Medication Administration Records jointly at shift change to ensure efficacy is documented.
4. DNS or RN designee to audit Medication Administration Records three times per week for four weeks then weekly for two months. Audits to start 5-13-2013.
5. Date of Compliance is 6/7/2013.

F 364 E

1. Residents #1-13 were affected. Dietary manager and cooks were immediately educated by Registered Dietitian regarding proper cooking methods for vegetables.
2. All residents dining in the facility have the potential to be affected.
3. Dietary manager will provide In-service training to all cooks on properly cooking and steaming tender vegetables to ensure they reach/maintain their texture and appearance for tray line service while meeting the Serve Safe cooking temperature for vegetables.
4. Dietary Manager will perform weekly audits to ensure the palatability is maintained. The register Dietitian will perform monthly test try audits to ensure that all vegetables meet federal and state standards for time, temperature control while maintaining palatability. Test trays will be audited by management team members five times weekly for two months, (varied meals by varied staff), Audits to start 5-13-2013.
5. Date of Compliance is 6/7/2013.

F371 F

1. Residents 1-13 were identified. All sanitation/cleanliness items documented as being present during the initial tour were immediately cleaned.
2. All resident dining in the facility have the potential to be affected by the deficient practice.
3.
 - a. In-service provided to all dietary employees on cleanliness, food, sanitation, holding temperatures, storage, and transportation.
 - b. Upright fridge was installed in the dining room for milk storage.
 - c. Signs were posted above hand washing sinks reminding staff of proper dish and utensil storage. Additional bins are provided for soiled items.
 - d. Installed proper ice scoop container adjacent to ice machine for proper ice scoop storage.
4.
 - a. Administrator to preform weekly sanitation/temperature audits in all food service areas once a week for 3 months then monthly ongoing. Audits to start 5-13-2013.
 - b. Registered Dietitian to conduct in-depth sanitation audits monthly. Audits to start 5-13-2013.
 - c. Report to QA monthly.
 - d. Administrator to preform weekly audits of ice scoop for 2 months. Audit to start 6-3-2013.
5. Date of Compliance is 6-7-2013

F431 E

1. Residents number 19 and 20 all expired, unlabeled, undated medications immediately disposed of.
2. All residents have the potential to be affected by the deficient practice.
3. All LN staff educated on checking for expirations dates on medications upon delivery from pharmacy. All LN staff educated on placing date on medications when opening them. All LN staff educated on maintaining double locks conditions for all controlled substances. All LN staff educated on proper disposal of fentanyl patches.
4. DNS or RN designee to audit medication refrigerators, carts, and pixis for expired and undated medications weekly x 4 then monthly ongoing. Pharmacy personnel to audit pixis storage monthly and ongoing. Audit results reported to quality assurance committee monthly. Audits to start 5-13-2013. DNS or RN designee to audit proper disposal of fentanyl patches twice a week for 4 weeks then weekly for four weeks.
5. Date of Compliance is 6-7-2013

F441 D

1. Resident number 9 staff immediately educated on hand hygiene after cares to residents and proper peri care procedure. Resident number 17 discharged form facility
2. All residents have the potential to be affected by the deficient practice.
3. All LN and CNA'S educated on hand hygiene, peri care, glove use.
4. LN to audit CNA'S daily 4 weeks and weekly times 4 weeks during cares/peri care. DNS or RN designee to audit cares 3 x per week x 4 weeks, weekly x 3 weeks, then monthly x 2 months. Audits to start 5-13-2013. DNS or RN designee to audit hand hygiene after blood glucose monitoring 3 times a week for 4 weeks then weekly for 4 weeks. Report to Q.A. monthly.
5. Date of Compliance is 6-7-2013

F468 E

1. Residents 2, 3, 5, 7, 11, 13. Staff was immediately instructed to provide assistance to residents who needed it when using the identified door.
2. All residents using the identified door have the potential to be affected.
3. All staff educated on hand rail placement and safety. And to report problems immediately to maintenance. Hand rail installed on to be installed by 6/7/2013
4. Monthly monitoring by maintenance or designee for presence and safety of all hand rails. Audits to start 5-13-2013.
5. Date of Compliance is 6-7-2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/26/2013
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NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201
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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
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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 federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly RN Karen Marshall, RD Brad Perry, LSW</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed</p>	C 000		
C 125	<p>02.100,03,c,ix Treated with Respect/Dignity</p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;</p> <p>This Rule is not met as evidenced by: Refer to F164 as is related to privacy during cares.</p>	C 125		
C 175	<p>02.100,12,f Immediate Investigation of Incident/Injury</p>	C 175		

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FACILITY STANDARDS

Bureau of Facility Standards	TITLE <i>Executive Director</i>	(X6) DATE 5-20-13
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 		

Bureau of Facility Standards

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C 175	Continued From page 1 f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F225 as it related to investigations to rule out potential neglect of a resident.	C 175		
C 268	02.107.01 DIETARY SERVICE 107. DIETARY SERVICE. 01. Dietary Supervision. A qualified food service supervisor shall be designated by the administrator to be in charge of the dietary department. This person shall: This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the person in charge of Dietary Services (Dietary Manager, DM) had not completed an approved program for Food Service Supervision. This had the potential to affect 13 of 13 (#s 1-13) sampled residents and all other residents who dined in the facility. Findings included: The Idaho Administrative Code, Department of Health and Welfare, IDAPA (Idaho Administrative Procedures Act) 16.03.02 - Rules and Minimum Standards for Skilled Nursing & Intermediate Care Facilities, sub-section 002.13.a,b,c, & d, defines a Food Service Supervisor as a person who: "a. Is a qualified dietitian; or b. Has a baccalaureate degree with major studies in food and nutrition or food service management; or	C 268		

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C 268	Continued From page 2 c. Is a graduate of a state approved Food Service Supervisor's (Dietetic Assistant) course, classroom or correspondence; or d. Has training and experience in food service management in military service equivalent in content to program in paragraph c." On 4/22/13 at 12:30 p.m., the DM stated, "I am scheduled to begin the DM course through the IHCA this summer. I do have an Associates in Culinary Services." On 4/26/13 at 11:30 a.m., the Administrator and DON were informed of the finding. The facility did not provide any additional information.	C 268		
C 311	02.107,07 FOOD PREPARATION AND SERVICE 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. This Rule is not met as evidenced by: Refer to F364 regarding vegetable palatability issues.	C 311		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by:	C 325		

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C 325	Continued From page 3 Please refer to F371 as it related to the not maintaing a potentially hazardsous food in a temperature controled environment, non food contact surfaces, using the handwashing sink in the Northside dining room for purposes other than handwashing, and not protecting an ice scoop from potential contamination.	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 as it related to corridors without handrails attached to each side of the corridor.	C 389		
C 393	02.120,04,b Staff Calling System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by:	C 393		

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C 393	Continued From page 4 Please refer to F246 as it related to a call light not accessible to the resident.	C 393		
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F441 as it related to hand hygiene following contact with resident.	C 644		
C 762	02.200,02,c,ii When Average Census 60-89 Residents ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. This Rule is not met as evidenced by: Based on review of a 3 week nursing schedule provided by the facility, it was determined the facility did not meet the State requirement for registered professional nurse (RN) coverage when the resident occupancy rate was between 60 to 89 residents for each of the days reviewed. Inadequate RN coverage had the potential to negatively affect all residents living in the facility. Findings included: Review of the 3 week nursing schedule for	C 762		

Bureau of Facility Standards

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C 762	Continued From page 5 3/31/13 through 4/20/13 revealed the following: RN coverage on the a.m. shift (approximately 7:00 a.m. to 3:00 p.m.) was: * 4/6 and 4/20/13 = 0 hours, resident census 65 and 61 respectively; and, * 4/13 = 7.47 hours, resident census 63. * RN coverage on the p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) was: * 3/31 = 5.45. hours, resident census 66; * 4/6 = 4.5 hours, resident census 65; * 4/11 = 6.83 hours, resident census 64; * 4/13 = 5.23 hours, resident census 63; * 4/14 = 3.95 hours, resident census 63; and * 4/20 = 5.49 hours, resident census 61. The facility failed to meet the requirement for 8 hours of RN coverage during the shifts, when the facility census was between 60 to 89 residents. The facility Time Detail (time sheets used for payroll) were reviewed to confirm the lack of coverage on the identified dates. The Administrator, DON, ADON, and Clinical Resource Representative were advised of this finding on 4/26/13 at approximately 6:30 p.m. No further information was provided by the facility.	C 762		
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 as it related to the provision of care related to hospice, dialysis, implanted pain pumps, and following physician orders and care	C 784		

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C 784	Continued From page 6 plans.	C 784		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it related to respiratory services.	C 788		
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 related to the development of multiple pressure ulcers and a suspected deep tissue injury.	C 789		
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders;	C 798		

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C 798	Continued From page 7 This Rule is not met as evidenced by: Refer to F281 as it related to standard nursing practice with regard to administration of steroid inhalers.	C 798		
C 808	02.200,04,g,iv Site of Injection iv. Site of injections; This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the injection site was documented when residents received medications by injection. This was true for 2 of 2 injections during medication pass observations. This affected Resident #17 and could lead to soreness, discomfort or pain, bruising, and open areas with the potential for infection if injections were repeatedly administered in the same vicinity on the body. Findings included: On 4/24/13 at 7:15 p.m., LN #1 was observed as he administered Levemir insulin per subcutaneous (SQ) injection into Resident #17's left upper arm. Upon return to the medication cart, the LN initialed the medication on the resident's MAR, however, he did not document the site of the injection. On 4/24/13 at 7:30 p.m., LN #1 was observed as he administered Novolog insulin per subcutaneous (SQ) injection into Resident #17's right upper arm. Upon return to the medication cart, the LN initialed the medication on the resident's MAR, however, he did not document the site of the injection. LN #1 was interviewed immediately. When asked if the site of injections was documented anywhere, LN #1 said, "No. There's nothing on	C 808		

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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 808	Continued From page 8 the MAR for that detail. That would help so we're not always giving them in the same place." On 4/25/13 at about 6:30 p.m., the Administrator, DON, ADON, and Clinical Resource Representative were informed of the observations. No other information or documentation was received from the facility.	C 808		
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 related to expired and/or opened, time sensitive medications without an open date.	C 821		
C 822	02.201,01,c Medication Storage and Dangerous Chemicals c. Reviewing the facility for proper storage of medications and dangerous chemicals at least every thirty (30) days and notifying the administrator of the facility of any nonconformance. This Rule is not met as evidenced by: Refer to F431 as it related to the storage and disposal of controlled substances.	C 822		
C 832	02.201,02,f Labeling of Medications/Containers	C 832		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/26/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
(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 832	Continued From page 9 f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F431 as it related to hospice medications without expiration dates.	C 832			
C 856	02.201,04,c Documentation of Use and Results c. Reasons for administration of a PRN medication and the patient's/resident's response to the medication shall be documented in the nurse's notes. This Rule is not met as evidenced by: Refer to F329 as it related to monitoring the efficacy of PRN (as needed) medications.	C 856			
C 880	02.203,01 RESPONSIBLE STAFF 01. Responsible Staff. The administrator shall designate a staff member the responsibility for the accurate maintenance of medical records. If this person is not a Registered Records Administrator (RRA) or an Accredited Records Technician (ART), consultation from such a qualified individual shall be provided periodically to the designated staff person.	C 880			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2013
NAME OF PROVIDER OR SUPPLIER POCATELLO CARE & REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 527 MEMORIAL DRIVE POCATELLO, ID 83201		
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C 880	<p>Continued From page 10</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the staff member responsible for the accurate maintenance of medical records periodically received consultation from a qualified individual. This affected 15 of 15 (#s 1-15) sampled residents and had the potential to affect all residents who resided in the facility. Findings included:</p> <p>On 4/22/13 during the entrance conference, the Administrator was asked for a list of Key Facility Personnel which included the name of the facility Registered Health Information Technician (RHIT).</p> <p>On 4/23/13 at 7:40 AM, the Administrator said he was fairly new and thought the facility had a RHIT consultant, but he would need to check.</p> <p>On 4/23/13 at 9:40 AM, the Administrator said he found out the RHIT consultant left employment at the facility a few months ago and the facility was in the process of looking at other options to satisfy the requirement.</p> <p>On 4/23/13 at 4:00 PM, the Administrator, DON, ADON, and Clinical Resource Representative were informed of the issue. No other information was provided by the facility.</p>	C 880		

May 16, 2013

State Citations

C 125

1. All staff assigned to care for resident #4 were immediately educated on the need to protect the residents privacy during cares by closing blinds and privacy curtains.
2. All residents have the potential to be affected. In servicing provided to all staff regarding privacy issues by 5/8/2013.
3. LN's to audit assigned residents daily for privacy being maintained during cares. Start date 5/13/2013.
4. Audits by DNS or RN designee will be conducted during resident cares, 3 times per week for four weeks, weekly for three weeks and then monthly until resolved. Start date 5/13/2013. Results will be reported to Quality Assurance Committee monthly.
5. Date of Compliance is 6/7/2013.

C 175

1. Resident #6 was identified; the Incident/Accident (I/A) report was recreated through staff interviews for the skin issues reported on 3/17/2013. Note: documentation was provided to the survey team in the form of Incident/Accident tracking log and IDT review record that in fact the incident had been reported to the administrator and the resulting investigation did not conclude that neglect had occurred.
2. All residents have the potential to be affected.
3. In process for signatures and interview data will be placed in a red folder for high visibility and all I/A's will be maintained in a central location on the ADON's desk until completed and filed. Management staff in serviced on P&P for I/A processing completed on 5/17/2013.
4. ADON to monitor I/A log to actual I/A's daily. DNS or administrator to audit weekly for two months and then monthly ongoing. Audits to start 5-13-2013. Report to Quality Assurance Committee.
5. Date of Compliance is 6/7/13.

C 268

1. Facility acquired a CDM on a temporary basis.
2. All residents have the potential to be affected.
3. Dietary Manager will enroll, complete, and pass the Certified Dietary Manager course through an accredited course. After course the Dietary Manager will successfully pass the test and maintain all credentials associated with CDM certificate.
4. Executive Director to monitor the enrollment and completion of the CDM course and exam by being provided with the start and end dates of the CDM class and start dates for the CDM exam.
5. Date of compliance for temporary CDM is 6/7/2013.

C 311

1. Residents #1-13 were affected. Dietary manager and cooks were immediately educated by Registered Dietitian regarding proper cooking methods for vegetables.
2. All residents dining in the facility have the potential to be affected.
3. Dietary manager will provide in-service training to all cooks on properly cooking and steaming tender vegetables to ensure they reach/maintain their texture and appearance for tray line service while meeting the Serve Safe cooking temperature for vegetables.
4. Dietary Manager will perform weekly audits to ensure the palatability is maintained. The register Dietitian will perform monthly test try audits to ensure that all vegetables meet federal and state standards for time, temperature control while maintaining palatability. Test trays will be audited by management team members five times weekly for two months, (varied meals by varied staff). Audits to start 5-13-2013.
5. Date of Compliance is 6/7/2013.

C 325

1. Residents 1-13 were identified. All sanitation/cleanliness items documented as being present during the initial tour were immediately cleaned.
2. All resident dining in the facility have the potential to be affected by the deficient practice.
3.
 - a. In-service provided to all dietary employees on cleanliness, food, sanitation, holding temperatures, storage, and transportation.
 - b. Upright fridge was installed in the dining room for milk storage.
 - c. Signs were posted above hand washing sinks reminding staff of proper dish and utensil storage. Additional bins are provided for soiled items.
4.
 - a. Administrator to perform weekly sanitation/temperature audits in all food service areas once a week for 3 months then monthly ongoing. Audits to start 5-13-2013.
 - b. Registered Dietitian to conduct in-depth sanitation audits monthly. Audits to start 5-13-2013.
 - c. Report to QA monthly.
5. Date of Compliance is 6-7-2013.

C 389

1. Residents 2, 3, 5, 7, 11, 13. Staff was immediately instructed to provide assistance to residents who needed it when using the identified door.
2. All residents using the identified door have the potential to be affected.
3. All staff educated on hand rail placement and safety. And to report problems immediately to maintenance. Hand rail installed on to be installed by 6/7/2013
4. Monthly monitoring by maintenance or designee for presents and safety of all hand rails. Audits to start 5-13-2013.
5. Date of Compliance is 6-7-2013.

C 393

1. All staff assigned to care for resident #6 were immediately educated on the need to ensure resident access to call light at all times.
2. All residents have the potential to be affected. In servicing provided to all staff regarding call light placement by 5/8/2013.
3. LN's to audit assigned residents daily for call light accessibility, Start date 5/13/2013.
4. Audits by DNS or RN designee will be conducted during resident cares, 3 times per week for four weeks, weekly for three weeks and then monthly until resolved. Start date 5/13/2013. Results will be reported to Quality Assurance Committee monthly.
5. Date of Compliance is 6/7/2013.

C 644

1. Resident number 9 staff immediately educated on hand hygiene after cares to residents and proper peri care procedure. Resident number 17 discharged from facility
2. All residents have the potential to be affected by the deficient practice.
3. All LN and CAN'S educated on hand hygiene, peri care, glove use.
4. LN to audit CAN'S daily 4 weeks and weekly times 4 weeks during cares/peri care. DNS or RN designee to audit cares 3 x per week x 4 weeks, weekly x 3 weeks, then monthly x 2 months. Audits to start 5-13-2013. Report to Q.A. monthly.
5. Date of Compliance is 6-7-2013

C 762

1. No specific residents were identified.
2. All residents have the potential to be affected.
3. AN RN was assigned to provide an additional eight hours of coverage on weekend days when census was above 59.
4. RN weekend coverage will be verified every Friday and Monday by DNS, ED for compliance, reported to QA monthly.
5. Date of compliance is 6/7/2013.

C 784

1. Residents #1,2,4,6,8,9,12 were identified.
 - f. Hospice: Residents # 1,4,6. Implemented new P&P for documentation by hospice per visit. Hospice notes obtained for residents records.
 - g. Dialysis: resident #12 has been discharged from the facility.
 - h. Intrathecal pumps for residents #2 and 9: All required safe guards for the pumps were immediately placed in the care plan, instructions for pump use and safety was printed and placed in P&P manual. MDS checked for accuracy.
 - i. Patient Transfers: Resident # 8, Aide's immediately educated on care plan for two person transfers.
 - j. Lab Tests: Resident #8, Lab orders were put into electronic system and were printed out on the medication administration record.
2. All residents on hospice, dialysis, intrathecal pumps, residents requiring two person assist for transfers and residents requiring laboratory tests have the potential to be affected.
3.
 - f. Meetings with all of the hospice agency's contracting with the facility were conducted to discuss implementation of written communication with each visit.
 - g. In the event a resident requiring dialysis is admitted to the facility, protocol to ensure daily communication will be initiated.
 - h. A check list of all required monitoring, care planning, MDS coding, has been implemented.
 - i. Resident cardex communication system has been updated to include transfer level of assistance.
 - j. Base line audit of all resident's lab orders has been completed and all lab orders found to be absent from the electronic record system have been entered into the electronic system.
4. DNS or RN designee will audit all hospice communication, care plans and lab orders weekly for three months. Audits of transfers by aides will be conducted by LN's three times per week for four weeks, then weekly for three weeks and then every month, reported to Quality Assurance monthly. . Audits to start 5-13-2013.
5. Date of Compliance is 6/7/2013.

C 788

1. Residents #10, 12 have been discharged from the facility. For Resident #9 assigned staff was immediately educated on correct liter flow. All staff immediately educated that LN's are responsible for setting correct liter flow.
2. All residents on O2 therapy or using CPAP, VPAP, BIPAP and AVAP have the potential to be affected.
3. All residents on O2 CPAP, VPAP, BIPAP and AVAP were care planned for their use and physician orders were obtained as necessary. Stickers indicating ordered liter flow were placed on all concentrators.
4. DNS or RN designee to audit liter flow three times per week for four weeks then weekly for two months, DNS or RN designee to audit care plans or physician orders for CPAP, VPAP, BIPAP and AVAP weekly for four weeks. Audits to start 5-13-2013..
5. Date of compliance is 6/7/2013.

C 789

1. Resident #6 was identified. Care plan was updated on 3-18-13 to include all identified wounds and treatment modalities. Care plan was also updated for pain discomfort. NOTE: The 3-18-2013 update to the skin care plan was not visible on the printed copies supplied to the survey team, however, by clicking on the history symbol, the revision was visible and date stamped 3-18-2013. A timed stamped printed copy of the update to the care plan will be available to the survey team on revisit.
2. All residents at risk of skin breakdown have the potential to be affected.
3.
 - a. All LN's and CNA's were educated on turning and repositioning of patients at risk for skin breakdown on 5-8-13.
 - b. Wound nurse was educated on updating care plans with any changes in wounds.
 - c. LNs were trained on performing accurate assessments, documentation and treatment of pain.
 - d. IDT to review daily change of condition reports for changes that may increase the risk of skin impairment and update assessments and care plans as needed.
4.
 - a. DNS or RN designee to monitor all nursing documentation for residents assessed as high risk for skin issues and all residents receiving skin and wound treatment, including weekly skin notes, for accuracy/timeliness and care plan updated daily for 2 months, then twice weekly ongoing. Audits to start on 5-20-2013.

- b. Weekly skin at risk committee meetings will be expanded to include high risk residents for increased intervention oversight and care plan review ongoing. Audits to start on 5-20-2013.
 - c. Reported to QA monthly.
5. Date of Compliance is 6-7-2013.

C 798

1. Residents #9 and 19 were identified. Assigned LN's were immediately educated on manufacturers recommendations for steroid administration.
2. All residents receiving inhaled medications have the potential to be affected. All physicians' orders were audited for all residents to identify those receiving inhaled medications.
3. 1 : 1 education was provided to all LN's and in-service to all staff on 5/13/2013.
4. Audits by DNS or RN designee daily for one week, three times a week for four weeks and one time per week for three weeks, if problem continues will return to monitoring as appropriate and report to Quality Assurance Committee monthly. Audits to start 5-13-2013.
5. Date of Compliance is 6/7/2013.

C 808

1. Resident # 17 was identified. LN'S were immediately educated on proper documentation of injection sites.
2. Any resident receiving parenteral medications has the potential to be affected.
3. LN's educated on correct entry on physician order, to include site documentation on Medication Administration Record. Written procedure for correct order entry placed at each nurse's station.
4. DNS or RN designee to audit weekly for two months then monthly ongoing. Report to Quality Assurance.
5. Date of Compliance is 6/7/2013.

C 821

1. Residents number 19 and 20 all expired, unlabeled, undated medications immediately disposed of.
2. All residents have the potential to be affected by the deficient practice.
3. All LN staff educated on checking for expirations dates on medications upon delivery from pharmacy. All LN staff educated on placing date on medications when opening them. All LN staff educated on maintaining double locks conditions for all controlled substances. All LN staff educated on proper disposal of fentanyl patches.
4. DNS or RN designee to audit medication refrigerators, carts, and pixis for expired and undated medications weekly x 4 then monthly ongoing. Pharmacy personnel to audit pixis storage monthly and ongoing. Audit results reported to quality assurance committee monthly. Audits to start 5-13-2013.
5. Date of Compliance is 6-7-2013

C 822

1. Residents number 19 and 20 all expired, unlabeled, undated medications immediately disposed of.
2. All residents have the potential to be affected by the deficient practice.
3. All LN staff educated on checking for expirations dates on medications upon delivery from pharmacy. All LN staff educated on placing date on medications when opening them. All LN staff educated on maintaining double locks conditions for all controlled substances. All LN staff educated on proper disposal of fentanyl patches.
4. DNS or RN designee to audit medication refrigerators, carts, and pixis for expired and undated medications weekly x 4 then monthly ongoing. Pharmacy personnel to audit pixis storage monthly and ongoing. Audit results reported to quality assurance committee monthly. Audits to start 5-13-2013.
5. Date of Compliance is 6-7-2013

C 832

1. Residents number 19 and 20 all expired, unlabeled, undated medications immediately disposed of.
2. All residents have the potential to be affected by the deficient practice.
3. All LN staff educated on checking for expirations dates on medications upon delivery from pharmacy. All LN staff educated on placing date on medications when opening them. All LN staff educated on maintaining double locks conditions for all controlled substances. All LN staff educated on proper disposal of fentanyl patches.
4. DNS or RN designee to audit medication refrigerators, carts, and pixis for expired and undated medications weekly x 4 then monthly ongoing. Pharmacy personnel to audit pixis storage monthly and ongoing. Audit results reported to quality assurance committee monthly. Audits to start 5-13-2013.
5. Date of Compliance is 6-7-2013

C 856

1. Resident #8 was identified; staff immediately educated on documentation efficacy of all PRN medications.
2. All residents have the potential to be affected.
3. All LN's will review Medication Administration Records jointly at shift change to ensure efficacy is documented.
4. DNS or RN designee to audit Medication Administration Records three times per week for four weeks then weekly for two months. . Audits to start 5-13-2013.
5. Date of Compliance is 6/7/2013.

C 880

1. Residents # 1-15 were identified.
2. All residents have the potential to be affected.
3. Contract RHIT certified technician for quarterly audits to meet state requirements by date of compliance.
4. Executive Director will monitor ongoing the quarterly basis the RHIT audits. Report to Quality Assurance.
5. Date of Compliance is 6/7/2013.



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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May 23, 2013

Stephen Farnsworth, Administrator
Pocatello Care & Rehabilitation Center
527 Memorial Drive
Pocatello, ID 83201

Provider #: 135011

Dear Mr. Farnsworth:

On **April 26, 2013**, a Complaint Investigation survey was conducted at Pocatello Care & Rehabilitation Center. Bradley Perry, L.S.W., Linda Kelly, R.N. and Karen Marshall, R.D. conducted the complaint investigation. This complaint was investigated during the annual Recertification and State Licensure survey conducted on April 22 through April 26, 2013.

The following documents were reviewed:

- The personal belongings inventory lists for the identified resident and one other resident;
- The entire medical record of the identified resident;
- The records of four residents for possible Activities of Daily Living (ADL) decline;
- Facility's grievance logs; and
- Resident council meeting minutes.

The following interviews were conducted:

- Nine residents in a group interview were questioned about missing items and quality of care issues;
- Four individual residents were interviewed about missing items and quality of care issues;
- Two residents' family members were interviewed about missing items and quality of care issues;
- The admission coordinator was interviewed regarding personal inventory procedures;
- The laundry supervisor was interviewed regarding laundry procedures;

Stephen Farnsworth, Administrator
May 23, 2013
Page 2 of 3

- The central supply supervisor was interviewed regarding personal care supply procedures.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005627

ALLEGATION #1:

The complainant stated the identified resident was admitted to the facility on Thursday, June 21, 2012, for respite care. The complainant does not recall filling out a personal inventory sheet for the resident.

The complainant stated that the resident's discharge was very disorganized on Sunday, June 24, 2012. The family ended up going back the next day to pick up the resident's clothing; however, the clothes were not located and still were not available to be picked up.

FINDINGS:

The identified resident's nurse progress notes revealed that the facility did not have all of the resident's clothing available at discharge and a family member had to go back to the facility to retrieve the missing clothing at a later date. The facility failed to ensure a personal inventory sheet was completed upon admission. The complaint was substantiated and the facility was cited at F204.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated that when the identified resident was discharged on June 24, 2012, she was unable to walk or transfer, which was a decline in ADL status.

FINDINGS:

The identified resident's admission assessment documented the resident had weakness in both legs, used a wheelchair to ambulate and required one to two persons to assist the resident. The resident's progress note on the date of discharge noted the resident required the assistance of one to two persons.

In addition, three residents' records were reviewed for transfer and walking ability and interviews were conducted with facility staff. No concerns were identified in these areas.

Stephen Farnsworth, Administrator
May 23, 2013
Page 3 of 3

Based on assessments and interviews it could not be determined there was an ADL decline in these areas.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that when the identified resident was picked up about 4:00 p.m. on June 24, 2012, the resident had a mouth full of chocolate cake. An unidentified CNA stated the resident had cake for lunch. In addition, the resident had not been toileted.

FINDINGS:

During the initial tour and throughout the remainder of the survey, residents were observed for grooming and hygiene issues. Residents were noted to have their grooming and hygiene needs met.

Although the incident may have occurred as stated, based on observations as well as record reviews and interviews with staff, residents and family, it could not be determined that residents' grooming and hygiene needs were unmet.

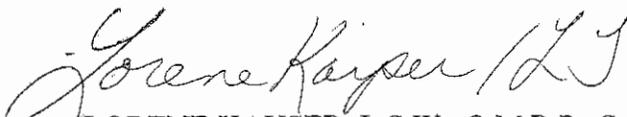
CONCLUSIONS:

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 or concerns regarding our investigation, please contact us 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



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May 23, 2013

Stephen Farnsworth, Administrator
Pocatello Care & Rehabilitation Center
527 Memorial Drive
Pocatello, ID 83201

Provider #: 135011

Dear Mr. Farnsworth:

On **April 26, 2013**, a Complaint Investigation survey was conducted at Pocatello Care & Rehabilitation Center. Bradley Perry, L.S.W., Linda Kelly, R.N. and Karen Marshall, R.D. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on April 22 - 26, 2013.

The following documents were reviewed:

- The facility's grievance file;
- The entire medical record of the identified resident;
- The facility's August 2012 Medication Error Report;
- The identified nurse's personnel record;
- Nursing 2012 Drug Handbook; and
- The Medication Administration Records (MARs) of eleven sample residents including that of the identified resident.

Interviews were completed with the following individuals:

- Nine residents in a group interview;
- The Director of Nursing (DoN), the identified Licensed Nurse (LN) and a different LN nurse who had administered medications to the identified resident.

Stephen Farnsworth, Administrator
May 23, 2013
Page 2 of 3

The following observations were completed:

- Twenty medication pass opportunities involving nine other residents.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005677

ALLEGATION #1:

The complainant stated an identified resident had a diagnosis of hypertension, and on August 6, 2012, the identified resident's 8:00 a.m. scheduled blood pressure medication was not given until 12:00 p.m. The complainant asked an identified nurse why the medication had not been given at 8:00 a.m., and the nurse said they were too busy at the time. The complainant stated that on August 8, 2012, the blood pressure medication was given very late as well.

A second complainant said that on August 6, 2012, an identified nurse came into the room at 11:30 a.m. and gave the resident her 8:00 a.m. medications. The second complainant said the nurse stated he was really busy with other residents. The second complainant said the Director of Nursing (DoN) was informed that the medications were given three and a half hours late.

FINDINGS:

The identified resident's MAR for August sixth and eighth was signed according to industry standards, and nursing notes for those two days did not indicate any medications were administered incorrectly. The identified LN and DoN could not recall the resident, a visitor or family member talking to them about administering medications late to the identified resident. The DoN, the identified LN and a second LN all stated the resident chose to take her medications after breakfast in her room with yogurt.

There were no medication pass errors observed for the nine residents and twenty medications administered.

Nine of nine residents interviewed in the group interview stated they received their medications within an hour of when they were to receive them.

It could not be determined that the incidents occurred as stated.

Stephen Farnsworth, Administrator
May 23, 2013
Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script that reads "Lorene Kayser" followed by a stylized flourish.

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

LKK/dmj



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May 23, 2013

Stephen Farnsworth, Administrator
Pocatello Care & Rehabilitation Center
527 Memorial Drive
Pocatello, ID 83201

Provider #: 135011

Dear Mr. Farnsworth:

On **April 26, 2013**, a Complaint Investigation survey was conducted at Pocatello Care & Rehabilitation Center. Bradley Perry, L.S.W., Linda Kelly, R.N. and Karen Marshall, R.D. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on April 22 - 26, 2013.

The following documents were reviewed:

- The facility's grievance and investigation about this issue;
- Mandatory staff meetings and a list of staff in attendance for April 10, 2013;
- A list of staff members responsible for answering call lights and providing residents' care during the staff meeting on April 10, 2013;
- Medical record's progress notes of the identified resident;
- Twelve other resident were reviewed for Quality of Life and Quality of Care concerns; and
- An identified Certified Nurse Aide's (CNA) personnel record.

The following interviews were completed:

- A group interview with nine residents involved;
- Three CNA's, a licensed practical nurse (LPN) and an registered nurse (RN) were interviewed regarding knowledge of neglect/abuse policies;
- The interim Director of Nursing (DoN) was interviewed regarding the alleged incident; and

Stephen Farnsworth, Administrator
May 23, 2013
Page 2 of 3

- The DoN was interviewed regarding staff coverage during meetings.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006002

ALLEGATION #1:

The complainant stated that on April 10, 2013, an identified resident was incontinent and needed to be taken to the bathroom or bedroom to be cleaned and changed.

The complainant said a nearby identified CNA was informed of the resident's needs, and the CNA stated he did not have time to change the resident until after he attended a mandatory meeting that started at 1:00 p.m.

The complainant stated there were no CNAs, LPNs or RNs on the floor at the time.

FINDINGS:

During the initial tour and throughout the remainder of the survey, call lights and staff attentiveness were observed. No problems were noted in these areas.

The facility provided a list of staff who were covering for those in the mandatory training on the day of the alleged incident and explained what is done each time there is a mandatory staff meeting to ensure the residents needs are met. If things go according to plan, there should be adequate staff available to meet residents' needs during those times.

Nine of nine residents interviewed in the group interview stated they had not been told by staff that they could not help them.

Although the incident may have occurred as described, based on records reviewed, interviews and observations the allegation could not be verified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated on April 10, 2013, the identified resident was found wearing the same clothes for three days.

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FINDINGS:

During the initial tour and throughout the remainder of the survey, residents were observed for grooming and hygiene issues. Residents were noted to have their grooming and hygiene needs met.

Although the incident may have occurred as stated, based on observations as well as record reviews and interviews with staff, residents and family, it could not be determined that resident grooming and hygiene needs were unmet.

A facility's grievance form documented that the resident wanted to stay in the gown she was wearing and an identified CNA thought it was a clean gown. The grievance form documented the resident's clothes were changed after the concern was brought to the facility's attention.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,


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

LKK/dmj