



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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3232 Elder Street
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Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7007 3020 0001 4044 7243

May 6, 2013

Mindy R. Shepard, Administrator
Royal Plaza Retirement Center Lewiston, LLC
2870 Juniper Drive
Lewiston, ID 83501

Provider #: 135116

Dear Ms. Shepard:

On **April 26, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Royal Plaza Retirement Center Lewiston, LLC by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Mindy R. Shepard, Administrator
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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 20, 2013**. Failure to submit an acceptable PoC by **May 20, 2013**, may result in the imposition of civil monetary penalties by **June 10, 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 20, 2013**. If your request for informal dispute resolution is received after **May 20, 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

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

PRINTED: 05/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2013
NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA RETIREMENT CENTER LEWISTON LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification and complaint investigation survey of your facility. The surveyors conducting the survey were: Nina Sanderson, BSW, LSW - Team Coordinator Sherri Case, LSW QMRP Karla Gerleve, RN Survey Definitions: ADL = Activities of Daily Living BID = Twice Daily BIMS = Brief Interview for Mental Status C1-C2 = Cervical Spine #1 and #2 CNA = Certified Nurse Aide CVA = Cerebrovascular Accident or stroke DNS/DON = Director Nursing Services/Director of Nursing HS = At Bedtime MD = Medical Doctor/Physician MDS = Minimum Data Set MG = Milligram OT = Occupational Therapist POA = Power of Attorney Q = Every RCM = Resident Care Manager RN = Registered Nurse UTI = Urinary Tract Infection	F 000	This Plan of Correction (PoC) is submitted as required under Federal and State regulations applicable to long term care providers. The submission of the plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Please accept this PoC as our credible allegation of compliance. Royal Plaza Retirement Center requests the continuation of existing approved waivers.	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the	F 156	F156 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents #1-15 were provided an updated copy of the "Notice of Rights" and the admission agreement which includes "Protection of Funds."	5-31-2013

RECEIVED
JUN - 6 2013
FACILITY STANDARDS

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

M. Supa

TITLE

Administrator

(X6) DATE

5-17-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 156	<p>Continued From page 1</p> <p>notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of</p>	F 156	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All other residents and/or their responsible party were provided updated copies of the "Notice of Rights" and the admission agreement which includes "Protection of Funds."</p> <p>The updated changes to the "Notice of Rights" and the admission agreement which includes the "Protection of Funds" will be reviewed at the next Resident Council meeting.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur:</p> <p>All new admissions and re-admissions to the facility will be provided with an updated copy of the "Notice of Rights" and the admission agreement that includes the updated "Protection of Funds" at the time of their admission.</p> <p>The Social Service Director will provide further explanation at the time of the resident's initial, quarterly, annual and significant change care conferences.</p> <p>The Activity Director will review the resident's rights during the monthly Resident Council meeting.</p>	

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F 156	<p>Continued From page 2</p> <p>institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure</p>	F 156	<p>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.</p> <p>The Administrator and/or their designee will be provided a list of any residents who have not received the "Notice of Rights" or the Admission agreement and will investigate for quality assurance and performance improvement opportunities.</p>		

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F 156	Continued From page 3 residents were fully informed of their rights during their stay in the facility. This was true for all sampled residents (#'s 1-15), and any resident admitted to the facility under the current admission agreement. Findings included: On 4/23/13, during the surveyor's review of the facility's admissions agreement, it was discovered: -The "Notice of Rights" area of the agreement documented, "You have the right to inspect and purchase photocopies of your records." However, there was no explanation indicating the resident could request this either orally or in writing, or that the record should be provided within 24 hours of the request. -The "Protection of Funds" area of the agreement documented, "The facility will provide you with an individualized financial report at least quarterly and upon your request." However, the agreement did not notify residents the facility must deposit funds in excess of \$50, or in the case of a resident utilizing their Medicare benefit \$100, in an interest-bearing account. On 4/24/13 at 8:50 AM, the Administrator was asked about the items not included in the resident admission agreement. The Administrator stated, "Those items are probably not in there. I fixed the interest-bearing statement last year after survey, but a statement regarding interest was not required as part of the plan of correction." The facility provided no further information to resolve the concern.	F 156			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	F 221			

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F 221	<p>Continued From page 4</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure residents were free from physical restraints. This was true for 2 of 2 residents sampled for physical restraints (Residents # 1 and 11.) The deficient practice had the potential to cause more than minimal harm if the residents fell and sustained injuries related to the use of restraints. Findings included:</p> <p>1. Resident #11 was admitted to the facility on 2/11/13 with diagnoses including C1-C2 fracture with surgical repair, history of falls, and chronic renal failure.</p> <p>Resident #11's admission MDS assessment, dated 1/18/13, coded: -BIMS of 4, indicating severely impaired cognition. -Required extensive assistance of 1 person for most ADLs and mobility, extensive assistance of 2 persons for bed mobility. -Falls within the month prior to admission, but no falls since admission. -No physical restraints.</p> <p>On 3/12/13 at 8:55 AM, a facility Event Investigation Report documented: -"[Resident] was sitting in day room in his [wheelchair] waiting for exercise group to start. [Resident] fell asleep</p>	F 221	<p>F221</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident's # 1 and 11 have each had a new Physical Restraint Assessment completed and their care plans updated accordingly.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All residents will have a Physical Restraint Assessment completed and care plans updated accordingly.</p> <p>All new admissions will have a Physical Restraint Assessment completed within 48 hours of admission.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur:</p> <p>The facility obtained a new Physical Restraint Assessment form that includes identification of attempts of least restrictive interventions, identification of the most appropriate restraint type and the goal of utilizing the restraint.</p>	5-31-2013	

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F 221	<p>Continued From page 5</p> <p>in [wheelchair] and fell forward out of his [wheelchair] onto the floor." -Plan to prevent recurrence documented, "[Resident] has appointment [with] physician today. Encourage [resident] to lay down after meals for rest period."</p> <p>On 3/12/13, a physician's progress note documented in the "Impression & Plan Summary" area, "Transient Disorder/Maintaining Wakefulness. Unclear why this is happening...He needs to have a restraint always used that prevents him from falling forward on his head. I think this is critical. He has agreed to it as has his daughter. This must always be used when he is in a chair of any kind. He generally doesn't like to recline."</p> <p>On 3/12/13 a physician's telephone order documented, "Soft restraint so patient can sit in chair without chance of falling forward on his head..."</p> <p>Resident #11's nurse's progress notes documented: -3/14/13 at 1:30 PM, "...let MD know that we have not instituted use of soft restraint per order, but have had OT assess [and] placed [resident] in highback reclining [wheelchair] for safety [and] positioning. [Resident #11] is only able to get up with assist which is his prior level when he lived at [assisted living facility]. Request order to [discontinue] soft restraint. Will continue to monitor [and] await MD response." NOTE: There was no documentation of a response from the MD to this request. -3/20/13 at 11:40 AM, "Self release seat belt ordered for [wheelchair], for positioning/safety</p>	F 221	<p>The facility Physical Restraint Policy and Procedure was reviewed and updated.</p> <p>The nursing staff was in-serviced on the updated Physical Restraint Policy and Procedure and the new form.</p> <p>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.</p> <p>All new admissions will have a Physical Restraint Assessment completed within 48 hours of admission.</p> <p>The Director of Nursing, Administrator and/or their designee will review the Physical Restraint Assessment and corresponding care plans during the weekly Case Mix meeting for quality assurance and performance improvement (QAPI) opportunities.</p>		

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F 221	<p>Continued From page 6</p> <p>[related to] [history of] falls from [wheelchair]. Will assess when arrives [and] is placed on [wheelchair]. Will [continue] [with] reclining [wheelchair] for safety at this time."</p> <p>-3/27/13 at 10:10 AM, "Received orders...self release seatbelt to [wheelchair] when up in [wheelchair], release [every hour] if resident unable to release..."</p> <p>-4/6/13 at 9:40 AM, "Son found [resident] on floor of his room...son stated he was walking by window [and] saw [resident] leaning forward in recliner, but by the time son got to his room [resident] was on the floor..."</p> <p>-4/10/13 at 7:40 PM, "Fax received from [physician] [related to] fall asking if he [Resident #11] was wearing the restraint. Faxed back Resident was in his recliner. He does not have a restraint in his recliner."</p> <p>On 3/28/13, Resident #11's Care Plan documented, "Resident requires a self release seatbelt to his wheelchair."</p> <p>On 4/3/13, a Restraint Assessment form for Resident #11 documented:</p> <p>-Mental status as lethargic, moderately disoriented, and communication only when asked.</p> <p>-Activity status as wheelchair dependent, one person assist, and abnormal gait.</p> <p>-Balance from supine to sit with assistance, sitting to standing with assistance, able to sit at the edge of bed, in a wheelchair, or in a straight chair for one minute each.</p> <p>-Factors affecting balance were the use of hypertensive or psychotropic medications, and arthritis.</p> <p>-Resident #11 qualified for a restraint based on</p>	F 221			

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F 221	<p>Continued From page 7</p> <p>the above factors.</p> <p>NOTE: There was no documentation on the form stating what type of restraint would most benefit Resident #11, which restraint might be assessed as safe for Resident #11, or less restrictive measures staff had attempted and ruled out for this resident. There was no documentation as to how the use of this restraint addressed the original MD concern from 3/12/13 of the necessity of preventing the resident from falling forward from the chair on his head.</p> <p>NOTE: This assessment form was dated as completed 22 days after the physician ordered the restraint.</p> <p>On 4/5/13, a Risk and Benefit form documented: -Issue Concern as, "Resident requested a self-releasing seat belt to his wheelchair for safety reasons due to multiple falls from his wheelchair." NOTE: The facility documented only one fall for this resident from his wheelchair, when the resident fell asleep and fell forward from his wheelchair. The facility's corrective action for this fall had been to encourage rest periods after meals. -Risks, "...include entrapment, restraint [due to] not being able to release the belt, injury up to and including death." NOTE: There was no description of how the resident may sustain injury or death from being unable to release the seat belt, or what had been done to ensure this measure was implemented as safely as possible. -Benefits, "...safety while in chair, and decreased falls due to falling forward in chair...security for resident related to resident feeling safe with self-releasing seat belt."</p>	F 221			

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NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA RETIREMENT CENTER LEWISTON LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501		
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F 221	<p>Continued From page 8</p> <p>NOTE: There was no description as to how the seat belt would increase Resident #11's safety given his history of falling forward from the wheelchair. The facility did not address the potential for the wheelchair to fall forward, with the resident secured to it, should the circumstance present itself again.</p> <p>-The areas of the form for Resident Signature and Witness Signature were blank.</p> <p>-The area of the form for Resident Responsible Party Signature was signed, with the signature designated as "POA." It was dated 4/5/13.</p> <p>NOTE: This form was signed 24 days after the order was received from the physician to initiate the restraint.</p> <p>A "Potential Risks of Physical Restraints" form in Resident #11's medical record documented a list of "Changes in the Quality of Life" as reduced social contact; withdrawn from surroundings; less participation in activities; loss of independence with mobility, toileting, and bathing; decreased desire to eat; and increased problems with sleep patterns. The form was signed by Resident #11's daughter/POA, and dated 4/5/13. There was an area on the form to document, "Physical Restraint Request", which included the definition of a physical restraint, which restraint was to be used, the duration, and the reason. This area of the form was blank, as was the area on the form for signatures and dates from the resident, the resident representative, and a facility representative.</p> <p>On 4/24/13 at 2:30 PM, Resident #11 was observed sitting in the day room of the facility. He was seated in a high-back wheelchair. There was a seat belt fastened around his waist in the</p>	F 221			

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F 221	<p>Continued From page 9 wheelchair.</p> <p>On 4/25/13 at 8:15 AM, RCM #3 was interviewed about the use of the seat belt as a restraint for Resident #11. RCM #3 stated Resident #11 had a tendency to lean forward while sitting to rub his knees, and after Resident #11 fell from the wheelchair the idea behind the seatbelt was to keep him from falling forward again and hitting his head. RCM #3 stated Resident #11's daughter was "on board" with the idea. When asked to clarify what that meant, RCM #3 stated, "She requested the seatbelt." RCM #3 was asked how the facility had assessed the seatbelt to be safe for Resident #11, if he fell forward with the wheelchair attached to him, and how the seatbelt would keep him from hitting his head. RCM #3 reviewed the assessment form for Resident #11's seatbelt and stated, "The assessment does not say this thing [the seatbelt] is safe for this guy." RCM #3 referred instead to the Risk and Benefit form signed by Resident #11's daughter/POA. RCM #3 stated, "We had a discussion with the family, including potential hazards up to and including death." RCM #3 was asked for the physician response to the facility request to discontinue the seatbelt on 3/14/13. RCM #3 indicated he would have to look for the document. RCM #3 was asked about the delay between the physician's order for the seatbelt, the implementation of the seatbelt, and the dates on the assessment and consent forms. RCM #3 stated he would have to look into those items further.</p> <p>On 4/25/13 at 10:00, RCM # 3 approached the surveyor and stated there was no follow-up from the MD on the 3/14/13 request to discontinue the</p>	F 221			

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F 221	<p>Continued From page 10</p> <p>seatbelt restraint. RCM #3 also stated he had no further information on the other items he was investigating.</p> <p>On 4/25/13 at 2:15 PM, the Administrator and the DON were informed of these findings. The facility offered no further information to resolve the concerns.</p> <p>2. Resident #1 was admitted to the facility on 9/17/10 with diagnoses including history of CVA, dementia with behavioral disturbances, and chronic pain.</p> <p>Resident #1's most recent quarterly MDS, dated 3/20/13, coded: -BIMS of 3, indicating severely impaired cognition. -Extensive assistance of 1-2 persons required for ADLs and mobility; did not ambulate. -2 or more falls in the past quarter. -No physical restraints in use.</p> <p>On 3/6/13 at 2:15 PM, a facility Event Investigation Report documented, "Resident was found on her back on the floor of her room...Resident had been put in recliner [with] remote behind so resident couldn't reach it and move it to move the chair. Resident didn't explain how the incident happened but it is surmised a passerby handed her the remote and she tipped herself out of the chair..."</p> <p>NOTE: Please see F 323 as it pertains to falls and supervision.</p> <p>On 4/25/13 at 8:50 AM, RCM #5 was interviewed about the removal of Resident #1's recliner</p>	F 221			

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F 221	<p>Continued From page 11</p> <p>controls. RCM #5 was asked if it had been documented to remove the recliner controls from Resident #1. RCM #5 stated, "It is not. Or at least it was not at the time. It is done now, as of yesterday." RCM #5 was asked if the use of the chair in this fashion had been assessed as safe for Resident #1. RCM #5 stated, "No. Not until yesterday." RCM #5 was asked if there was a physician's order to remove the recliner controls from Resident #1. RCM #5 stated, "No." RCM #5 was asked if the facility had received consent to remove the recliner controls from Resident #1. RCM #5 stated, "No."</p> <p>There was no documentation from the facility to determine when the facility had initially removed the chair controls from Resident #1, or why the controls were removed. There was no documentation addressing how this measure may have impacted her freedom of movement. From the time of the incident on 3/6/13, when the incident documentation describes the chair controls to be removed from the resident, until the time of the facility's assessment to determine the appropriateness of this measure, was a total of 49 days.</p> <p>On 4/25/13 at 2:15 PM, the Administrator and DON were informed of the surveyor's findings. The facility offered no further information to resolve the concerns.</p>	F 221		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of</p>	F 246	<p>F246</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p>	5-31-2013

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F 246	<p>Continued From page 12</p> <p>the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure a resident could access her fluids as independently as possible, or was assisted as needed to drink fluids. This was true for 1 of 8 residents (Resident #1) sampled for accommodation of needs. This had the potential to cause more than minimal harm if the resident became dehydrated from not receiving enough fluids. Findings included:</p> <p>Resident #1 was admitted to the facility on 9/17/10 with diagnoses including history of CVA, history of constipation, dementia with behavioral disturbances, and chronic pain.</p> <p>Resident #1's most recent quarterly MDS, dated 3/20/13, coded: -BIMS of 3, indicating severely impaired cognition. -Extensive assistance of 1-2 persons required for ADLs and mobility; did not ambulate. -Extensive assistance of 1 person for eating. -2 or more falls in the past quarter. -UTI within the past 30 days.</p> <p>Resident #1's care plan documented on 2/26/16, for the problem area "UTI", the approach, "Push fluids." There was no further guidance on Resident #1's care plan regarding hydration.</p>	F 246	<p>Resident #1's care plan has been reviewed and updated to reflect her ability to self-hydrate and the amount of assistance that is required.</p> <p>The staff involved were provided education and counseling regarding the standard of practice, Federal and State Regulations and facility expectations as they relate to accommodation of resident needs i.e., accessibility of fluids.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All resident who have been identified to require assist with hydration will have their care plans reviewed and updated to reflect their current needs.</p> <p>All nursing staff will be in-serviced regarding accommodation of resident needs i.e., accessibility of fluids.</p> <p>All residents will be assessed for changes quarterly and PRN.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur: All nursing staff has been in-serviced on appropriate placement of fluids both in resident rooms and during meal service.</p>		

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F 246	<p>Continued From page 13</p> <p>During the morning of 4/23/13 the following observations were made of Resident #1:</p> <p>-8:40 AM, CNA #6 took Resident #1 into the resident's room. Resident #1 was placed in the approximate center of the room. Her bedside table sat approximately 4 feet away, under the window in the room. A glass of water was on top of the bedside table. From her position in the room, Resident #1 could not reach the water glass. CNA #6 did not offer Resident #1 a drink before leaving the room.</p> <p>- 9:00 AM, RCM #5 entered Resident #1's room to offer her a blanket. RCM #5 did not offer Resident #1 anything to drink, nor move her glass of water where Resident #1 could reach it.</p> <p>-9:31 AM, CNA #7 and CNA #8 approached Resident #1 to prepare her for a shower. Resident #1 stated, "I want a drink." CNA #8 retrieved Resident #1's glass of water from the bedside table, and assisted her to drink from it. CNA #8 then returned the glass of water to the bedside table. Resident #1 was then assisted from her room to shower.</p> <p>-11:05 AM, Resident #1 was back in her room, resting in her recliner, which was approximately 6 feet from her bedside table. Her water was still on the bedside table, out of Resident #1's reach.</p> <p>During the afternoon/evening of 4/23/13, the following observations were made:</p> <p>-1:00 PM, Resident #1 was sitting in her wheelchair in the approximate center of her room. Her glass of water was on her bedside table, still positioned under the window approximately 4 feet from Resident #1, and not within her reach.</p> <p>-2:15 PM, No change.</p> <p>-2:20 PM, Door to room closed.</p> <p>-2:30 PM, Resident #1 was sitting in her room in</p>	F 246	<p>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.</p> <p>The RCM's will audit the placement of fluids in both resident rooms and in the dining room for 5 days per week for one month, then weekly for 1 month and PRN thereafter. <i>Audit started 4-26-13.</i></p> <p>The DNS, Administrator and/or their designee will provide random "walking rounds" to monitor for appropriate placement of fluids both in resident rooms and in the dining room for quality assurance and to identify performance improvement opportunities. <i>("Walking Rounds" are daily.)</i></p>		

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F 246	<p>Continued From page 14</p> <p>her recliner, in a reclined position. Her glass of water had been moved from the bedside table, and was now positioned on her dresser. With her chair in the reclined position, Resident #1's water was on her left, approximately 2 feet behind her head, out of both her line of sight and her reach.</p> <p>-3:05 PM, Resident #1 was fidgeting in her recliner. The glass of water was in the same position.</p> <p>-4:10 PM, Resident #1 resting in recliner with eyes closed, water still in same position.</p> <p>-4:15 PM, Awake, talking to herself in her room. Water in same position.</p> <p>-4:35 PM, Door to room closed.</p> <p>-4:50 PM, Placed in day room in her wheelchair.</p> <p>-5:15 PM, Resident #1 was in the dining room, seated at a bedside table between her and the regular table. A cup of hot chocolate was sitting on the regular table, out of Resident #1's reach. She was then served water and milk in covered two-handled cups. Both were placed on the regular table, outside Resident #1's reach.</p> <p>-5:35 PM, Resident #1's dinner meal was served and she was assisted to eat, and her beverages placed on the bedside table within her reach. Once handed one of the two-handled cups, she did grasp and hold it, and attempted to drink when cued to do so.</p> <p>On 4/24/13 at 8:55 AM, RCM #5 was interviewed about Resident #1's fluids. RCM #1 stated in general, water should always be available and accessible to residents in their rooms and at meals. RCM #5 stated Resident #1 had increasing difficulty getting a glass to her mouth on her own, so staff should be offering her fluids and assisting her to drink whenever they were in the room. RCM #5 stated, "But they should be</p>	F 246		

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F 246	Continued From page 15 leaving the water within her reach. There is no reason not to."	F 246			
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure a sanitary, orderly and comfortable environment. This was true for 14 of 14 sample residents (#1 - 12, 14 & 15) and all other residents eating their meals in the main dining room. Findings include: During the initial tour, on 4/22/13 at 3:50 p.m., there was a green leafy item dried to the floor under the steam table. Additionally there were numerous brown food crumbs under the steam table. The Dietary Manager (DM) was present during the tour and stated that housekeeping had not moved the steam table to clean under it. The Administrator and the DON were informed of the above concern on 4/25/13 at 2:30 p.m. The facility provided no further information.	F 253	F253 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The dining room floor under the steam table was moved and cleaned per infection control/housekeeping protocol. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. The dining room floor under the steam table was moved and cleaned per infection control/housekeeping protocol. Measures the facility will take or the systems it will alter to ensure that the problem does not recur: The housekeeping staff has been in-serviced on the expectations that the steam table and all other portable equipment will be moved after meals so that the floor can be appropriately cleaned and sanitized 7 days per week.	5-31-2013	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280			

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F 280	<p>Continued From page 16</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure care plans were evaluated and revised as the residents requests, needs, or status changed. This affected 2 of 8 (#s 1 & 5) sampled residents. This had the potential for staff to not provide appropriate care due to lack of direction in the care plan. Findings include:</p> <p>1. Resident #5 was admitted to the facility 10/10/12 with diagnoses of hypertension, arthritis, depression, dementia, malnutrition, and history of hip fracture.</p> <p>A quarterly MDS assessment, dated 4/16/13,</p>	F 280	<p>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.</p> <p>The Housekeeping/Laundry Director and/or their designee will complete inspections of the dining room floors five days per week for one month, weekly for one month and monthly thereafter. <i>Audit started 4-29-13</i></p> <p>The Administrator, DNS and RCM's will provide monitoring during their "walking rounds" for quality assurance and to identify performance improvement opportunities <i>(Walking Rounds are daily.)</i></p> <p>F280 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents # 1 and 5's care plans were reviewed and updated to reflect their current care needs.</p>	5-31-2013	

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F 280	<p>Continued From page 17</p> <p>documented the resident:</p> <ul style="list-style-type: none"> * was severely cognitively impaired, * required extensive assistance of two staff for bed mobility and transfers, * had weight loss that was not physician prescribed, * was frequently incontinent of bladder. <p>The resident's care plan for Alteration In Nutrition, dated 10/10/12, included interventions of house supplement with meals, snacks twice a day and fortified foods. The print date for the Care Plan was 4/17/13.</p> <p>The resident's medical record included the the following "Diet Order" sheets: House shakes with all meals - dated 3/21/13 Fortified foods - dated 4/4/13 Diet supplement of choice twice a day - dated 4/10/13</p> <p>On 4/23/13 at 2:00 p.m. the dietitian was asked about Resident #5 losing weight toward the end of February 2013 and the lack of documentation of interventions on the nutrition Care Plan. She stated the Diet Order sheets were internal communication sheets and the dates on them would be the date the interventions were started to address the resident's current weight loss. When told there were no documented interventions after the start date of 10/10/12 on the Care Plan printed 4/17/13, she agreed. Later that day the dietitian brought a copy of the Care Plan, with a print date of 1/17/13, from the resident's overflow record. That Care Plan had the Diet Order sheets' interventions handwritten on it with corresponding intervention dates. The resident's current care plan did include the</p>	F 280	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All resident's care plans will be reviewed and updated to reflect their current status.</p> <p>All residents who are followed in the Skin/Nutrition at Risk (SNAR) meeting will have their care plans reviewed during the meeting to ensure that all current interventions are listed.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur:</p> <p>The Assistant Dietary manager was in-serviced regarding the resident care plans and timeliness of updating with new interventions.</p> <p>The IDT was in-serviced regarding manually typing in the date and their initials next to the intervention on the computer so that the origination date of all interventions will always print out on the resident's care plan.</p> <p>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.</p>

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F 280	<p>Continued From page 18</p> <p>interventions; however, it was not clear if the interventions were previously in place (on Care Plan with print date of 1/17/13) or had been implemented to address the resident's weight loss in February 2013.</p> <p>On 4/24/13 at 5:00 p.m. the Administrator and the DON were informed of the above concern. The facility provided no further information.</p> <p>2. Resident #1 was admitted to the facility on 9/17/10 with diagnoses including history of CVA, history of constipation, dementia with behavioral disturbances, and chronic pain.</p> <p>Resident #1's most recent quarterly MDS, dated 3/20/13, coded: -BIMS of 3, indicating severely impaired cognition. -Extensive assistance of 2 persons required for bed mobility, transfers, and dressing. -Extensive assistance of 1 person required for wheelchair mobility, eating, toileting, hygiene, and bathing.</p> <p>Resident #1's care plan for transfers, dated 9/17/10, documented the resident required contact guard assistance of 1 or 2 with transfers.</p> <p>Resident #1's care plan for ADLs and mobility included hand-written additions for bed against the wall and a Broda chair. These additions were not signed or dated.</p> <p>Resident #1's care plan for bruising, dated 4/3/13, included a new wheelchair on order, to decrease time in her current wheelchair, and increase time in her recliner.</p>	F 280	The Director of Nursing, Administrator and/or their designee will review residents care plans during the weekly SNAR meeting and Case Mix meeting for quality assurance and performance improvement issues.	

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F 280	Continued From page 19 On 4/23/13 at 8:40 AM, CNA #6 was observed to take Resident #1 into the resident's room. The resident stated she had to use the restroom. CNA #6 stated, "I'll get help. She has to be a 2 person [transfer] now." Resident #1 was observed to be sitting in a Broda wheelchair on the following occasions during the survey: -4/23/13 at 8:00 AM, 1:00 PM, 3:05 PM, 4:50 PM, and 5:15 PM. On 4/24/13 at 8:55 AM, RCM #5 was interviewed about Resident #1's care plan. -For transferring, RCM #5 stated Resident #1 had recently begun to "push back" (extend) during transfers, so was requiring more help. RCM #5 stated these changes should have been reflected in Resident #1's care plan. -For care plan additions, RCM #5 stated all hand-written additions to the care plan should be signed and dated at the time they were added. -For the bruising, RCM #5 stated Resident #1 had received her Broda wheelchair the previous week, and seemed to be in less pain and have decreased restlessness when in the Broda, although it was still being monitored. RCM #5 agreed the care plan should include updated guidance for staff as to whether to encourage the use of the Broda chair or the recliner. On 4/25/13 at 2:15 PM, the Administrator and DON were informed of these findings. The facility offered no further information to resolve the concerns.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	Continued From page 20 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 record review and staff interview, it was determined the facility failed to ensure a physician ordered skin treatment was provided. This affected 1 of 8 (#8) sampled residents reviewed. This had the potential of causing harm to the resident, such as decreased healing or infection, due to the treatment not provided as ordered. Findings included: Resident #8 was admitted on 6/16/11 with diagnoses of Alzheimer's disease, diabetes, anxiety, and pain. A Physician Communication document from the facility to Resident #8's physician, dated 3/31/13 read as follows: "Res (resident) has a very large reddened area under her abdominal fold. When area is cleaned res yells out. Please advise!" The Physician Communication document had a written order in reply to the request, signed by the physician on 4/1/13 which stated, "apply Nystatin powder (twice daily)". Resident #8's April 2013 Physician Order Flow Sheet or TAR, stated, "Apply Nystatin powder to abdominal folds BID." The form indicated	F 309	F309 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #8's treatment administration record (TAR) will be audited 5 days per week to ensure that the treatments are being completed per physician order until resolved. Audit started 4-26-13. All licensed nurses who failed to document the treatment provided to resident #5 were provided education and counseling relating to standards of practice, federal and state regulations and facility expectations regarding resident treatments and documentation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All resident's TARs will be audited 5 days per week for one month, weekly for two months and monthly thereafter. Audit started 4-26-13. Measures the facility will take or the systems it will alter to ensure that the problem does not recur: Licensed nurses have been in-serviced on the standards of practice, federal and state regulations and facility	5-31-2013	

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F 309	Continued From page 21 treatments were to be performed two times daily; once on the 6-2 shift and once on the 2-10 shift. It did not state whether these shifts were AM or PM. There were blanks in the treatment sheet for the 6-2 shift on April 6, 13, and 14. There were also blanks for the 2-10 shift on April 11, 20, 21, and 22. On 4/24/13 at 11:15 AM, RCM #1 was interviewed and asked if he could explain why the Nystatin skin treatment was not performed for Resident #8 for the days and times listed above. The RCM#1 replied, "No". On 4/25/13 at 2:30 PM the Administrator and DNS were notified of the Nystatin treatment issue for Resident #8. No other documentation was provided that resolved the issue.	F 309	expectations regarding resident treatments and documentation. 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. The RCM's will continue their monthly audits and submit them to the Director of Nursing and/or her designee for quality assurance and to identify performance improvement opportunities.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure residents received the type and frequency	F 315	F315 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1's care plan has been reviewed and updated to reflect her current care needs. C.N.A. #6 was provided education and counseling regarding timeliness of answering call lights and responding to resident toileting needs.	5-31-2013

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F 315	<p>Continued From page 22</p> <p>of physical assistance necessary to access the toilet. This was true for 1 of 8 residents (Resident #1) sampled for toileting assistance. The deficient practice had the potential for more than minimal harm if the resident had increased incontinence, or fell trying to get to the restroom on her own. Findings included:</p> <p>Resident #1 was admitted to the facility on 9/17/10 with diagnoses including history of CVA, history of constipation, dementia with behavioral disturbances, and chronic pain.</p> <p>Resident #1's most recent quarterly MDS, dated 3/20/13, coded: -BIMS of 3, indicating severely impaired cognition. -Extensive assistance of 2 persons required for bed mobility, transfers, and dressing. -Extensive assistance of 1 person required for wheelchair mobility, eating, toileting, hygiene, and bathing. -UTI within the last 30 days.</p> <p>Resident #1's care plan, onset date 11/25/11, documented, "Toileting: Prompt resident to toilet with verbal prompt and physical assistance prior to and after meals and at [bedtime]. Ensure resident is given enough time on [bedside commode] or toilet. Do not rush. Assist of 1."</p> <p>On 4/23/13 at 8:00 AM, Resident #1 was observed in the dining room, sitting in her wheelchair. At 8:30 AM, she was assisted in her wheelchair by CNA # 6 to the day room, then up the Tamarack hallway, then brought back down that hallway to her room on the Maple hallway. At 8:40 AM, as CNA #6 was assisting Resident #1</p>	F 315	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All residents who have been identified to require assist with their toileting needs will have their care plans reviewed and updated to reflect their current status.</p> <p>All nursing staff will be in-serviced on care plan changes accordingly.</p> <p>All residents will be assessed for changes in their toileting status quarterly and PRN.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur:</p> <p>All nursing staff have been in-serviced regarding timeliness of responding to call lights and to resident toileting needs.</p> <p>All residents with toileting programs will be reassessed and care plans updated regarding their toileting needs.</p>		

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F 315	<p>Continued From page 23</p> <p>into her room, Resident #1 stated, "I have to go to the bathroom." CNA #6 stated, "I'll get help. She has to be a two-person now." CNA #6 then left the room. Resident #1 was sitting in the approximate center of her room, in her wheelchair. The surveyor then made the following observations:</p> <p>-8:50 AM. No change in the resident's position, no staff had entered the resident's room.</p> <p>-9:00 AM. RCM #5 entered the resident room and covered Resident #1's lap and legs with a blanket. RCM #5 did not prompt or assist Resident #1 to use the toilet.</p> <p>-9:05 AM. Resident #1 was alone in her room. She began fidgeting in her wheelchair.</p> <p>-9:25 AM. Resident #1 was dozing in her wheelchair. No staff had entered the room to prompt or assist Resident #1 to use the toilet.</p> <p>-9:28 AM. Resident #1 was awake and talking to herself in her room. She was again fidgeting in her wheelchair.</p> <p>-9:30 AM. CNA # 7 entered Resident #1's room to offer her a shower. CNA #7 stated, "It will be just a minute. I'm waiting for [CNA #8] to help me. We're going to get you all cleaned up."</p> <p>-9:31 AM. CNA #8 entered the room. CNA #7 and CNA #8 then transferred Resident #1 to a shower chair with a commode. They removed Resident #1's incontinence brief, which was damp, and she was able to use the commode.</p> <p>NOTE: 51 minutes had elapsed since Resident #1 had asked for the restroom. Resident #1 was not prompted or assisted to use the toilet as her care plan specified.</p> <p>On 4/24/13 at 8:55 AM, RCM #5 was interviewed about the surveyor's observation of Resident #1's toileting experience. RCM # 5 stated, "That</p>	F 315	<p>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.</p> <p>The RCM's will audit for call light placement, the timeliness of call lights and resident requests for toileting assistance for five days per week for one month, then weekly for one month and PRN thereafter. Audit started 4-29-13.</p> <p>The Director of Nursing, Administrator and/or their designee will provide random "walking rounds" to monitor quality assurance and to identify performance improvement opportunities.</p> <p><i>(Walking Rounds are daily.)</i></p>	<p><i>Following care planned toileting programs,</i></p>

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F 315	Continued From page 24 should not have happened. She should have been taken to the bathroom sooner." On 4/25/13 at 9:00 AM, CNA #6 was asked about caring for residents when he needed additional help. CNA #6 stated he would prioritize which residents to help based on their fall risk. CNA #6 stated only sometimes was he able to find someone else to help. NOTE: The surveyor did not observe whether or not CNA #6 asked for help to assist Resident #1 to the toilet. On 4/25/13 at 2:15 PM, the Administrator and DON were informed of these findings. The facility offered no further information to resolve the concern.	F 315			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure residents received adequate supervision to prevent accidents, accidents were investigated thoroughly to address the root cause, and resident care plans were revised to reflect new interventions implemented after accidents had	F 323	F323 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A Fall Assessment was completed for residents #1, 5 and 11 and their care plans have been updated accordingly. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. The Event Investigation Report was revised to include a list of all staff on shift.	5-31-2013	

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F 323	<p>Continued From page 25</p> <p>occurred. This was true for 3 of 12 residents (Resident #s 1, 5, and 11) sampled for accidents. The deficient practice had the potential to cause more than minimal harm if the residents were injured due to a fall. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 9/17/10 with diagnoses including history of CVA, dementia with behavioral disturbances, and chronic pain.</p> <p>Resident #1's most recent quarterly MDS, dated 3/20/13, coded:</p> <ul style="list-style-type: none"> - BIMS of 3, indicating severely impaired cognition. - Extensive assistance of 2 persons required for bed mobility, transfers, and dressing. - Extensive assistance of 1 person required for wheelchair mobility, eating, toileting, hygiene, and bathing. - Two or more falls in the past quarter. <p>On 3/5/13 at 5:20 AM, a facility Investigation Report documented, "Resident found lying on [right] side on floor beside bed..." The Event Investigation - Final Summary documented, "Resident has restless legs at night [and] when in bed or recliner...was found by CNA on floor beside bed...CNA had checked resident at 3 AM and was late checking on her because of multiple call lights on TCU [Transitional Care Unit] [and] other CNA busy as well." The Event Investigation - Witness Statement documented, "I checked [resident] about [3:00 AM]. I had been trying to re-check between 4:00 [and] 4:30 however call lights primarily on the TCU prevented me from accomplishing this..."</p>	F 323	<p>Each Event Investigation Report and the corresponding witness statements will be reviewed in the morning meeting by the Interdisciplinary Team and an investigation will be initiated for all unanswered questions.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur:</p> <p>All nursing staff has been in-serviced regarding resident supervision in general and more specifically as it related to fall prevention.</p> <p>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.</p> <p>The Director of Nursing, Administrator and/or their designee will review each Event Investigation Report, witness statements and summary of interventions to prevent reoccurrence during the morning meeting to provide quality assurance and performance improvement opportunities.</p>		

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F 323	<p>Continued From page 26</p> <p>On 4/24/13 at 8:55 AM, RCM #5 was interviewed about the witness statement and summary for Resident #1's fall. RCM #5 stated, "It's no excuse. She should have been checked on."</p> <p>NOTE: The fall investigation did not include an investigation regarding the number of staff working that night, how many call lights were going off, or what other factors may have explained why Resident #1 was not checked on for an extended period of time.</p> <p>2. Resident #11 was admitted to the facility on 2/11/13 with diagnoses including C1-C2 fracture with surgical repair, history of falls, and chronic renal failure.</p> <p>Resident #11's admission MDS assessment, dated 1/18/13, coded:</p> <ul style="list-style-type: none"> - BIMS of 4, indicating severely impaired cognition. - Required extensive assistance of 1 person for most ADLs and mobility, extensive assistance of 2 persons for bed mobility. - Falls within the month prior to admission, but no falls since admission. <p>On 3/26/13 at 7:30 AM, a facility Event Investigation Report documented, "Bath aid was walking by the resident's room and saw resident roll out of bed to the floor...[Resident] states he was trying to get up." The Event Investigation - Witness Statement documented, "I had just finished a shower and was walking down the hallway past [Resident #11's] room as he fell out of bed...I asked what happened. He said he didn't know but he'd been awake for hours..." The Event Investigation - Final Summary documented,</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>"[Resident] did climb out of bed stating he wanted to get up on last rounds..." The "Plan to prevent recurrence" area of the form documented, "Educated pt. [patient] on use of call light. Frequent checks. Low bed. Non-skid socks."</p> <p>NOTE: There was no documentation the facility had investigated Resident #11's statement that he had been awake for hours, or if he had been awake why he was still in bed.</p> <p>On 4/25/13 at 8:15 AM, RCM #3 was interviewed about Resident #11's fall. RCM #3 stated, "We always educate the resident to use the call light, even if they are confused, just in case this is the time it sinks in. And using non-skid socks is pretty common, too. The low bed was just an additional precaution because of the C2 fracture, to keep him from re-injuring." RCM #3 was asked to define the approach of, "frequent checks." RCM #3 stated, "It just means we're going to keep a closer eye on him." RCM #3 was unable to further describe how the "frequent checks" were to occur. RCM #3 was asked if there was a reason Resident #11 had not been assisted to get up by that time, since the breakfast meal is served at 7:30 AM. RCM #3 stated, "I don't know. I'll have to research that."</p> <p>On 4/25/13 at 2:15 PM, the Administrator and DON were informed of the surveyor's findings. The facility offered no further information to resolve the concern.</p> <p>3. Resident #5 was admitted to the facility 10/10/12 with diagnoses of hypertension, arthritis, depression, dementia, malnutrition, and history of hip fracture.</p>	F 323		

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F 323	<p>Continued From page 28</p> <p>A quarterly MDS assessment, dated 4/16/13, documented the resident:</p> <ul style="list-style-type: none"> * was severely cognitively impaired, * required extensive assistance of two staff for bed mobility and transfers, * two no injury falls, * was frequently incontinent of bladder. <p>Resident #5's medical record included a 2/1/13 "Event Investigation Report (EIR)." The EIR documented the resident had attempted to self transfer and the housekeeper found him on the floor. The "Plan to prevent recurrence" section documented staff were to not leave the resident in his room unattended and to address his needs in a timely manner.</p> <p>The resident's Care Plan for Potential For Falls, dated 10/10/12, had a goal for the resident not to have any injury falls. The interventions included:</p> <ul style="list-style-type: none"> * Remind to use call bell * Bed in lowest position * Non skid socks * Do not leave alone in bathroom and to assist to transfer to recliner in his room per his preference * Monitor at night for restlessness in bed <p>On 4/25/13 at 9:00 a.m. RCM #3 was asked where the 2/1/13 intervention to not leave the resident unattended in his room was on the Care Plan for fall prevention. RCM #3 stated the intervention had not been added to the care plan.</p>	F 323		
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any</p>	F 329	<p>F329 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p>	5-31-2013

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F 329	<p>Continued From page 29</p> <p>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 did not ensure residents were free from unnecessary drugs as evidenced by a lack of physician justification for the continued use of antipsychotic medications. This was true for 2 of 8 sample residents (Residents #7 & 8) reviewed for medication use. This created the potential for harm because unnecessary medications can lead to adverse reactions and health decline. Findings included: Resident #7 was admitted to the facility on 6/1/10</p>	F 329	<p>Resident #7 and 8's antipsychotic medications and care plans have been reviewed and updated to reflect their current medical status.</p> <p>The Administrator sent a letter outlining the state and federal regulations as they pertain to antipsychotic medications and gradual dose reductions (GDR) to resident #8's physician and to the facility Medical Director.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents who receive an antipsychotic medication will be reviewed for current status, past GDR attempts, current justification to remain on the medication (if appropriate) and their care plans will be updated to reflect their current status.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur: All residents who receive an antipsychotic medication will be reviewed on a quarterly basis and PRN in the weekly Psychotropic Medication Committee.</p> <p><i>The facility Medical Director will see the residents as needed</i></p>	
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to ensure resident safety + regulatory compliance.

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F 329	<p>Continued From page 30 with diagnoses that included cardiomegaly (enlarged heart), dementia with behavioral disturbances, diabetes mellitus, atrial fibrillation and pulmonary fibrosis.</p> <p>The resident's 2/20/13 quarterly MDS assessment documented: * Moderate cognitive impairment * Received antipsychotic medication * No behaviors or delusions/hallucinations</p> <p>Resident #7's April 2013 Physician Order, (recapitulation), included an order for Risperdal (antipsychotic) for dementia with behavioral disturbances.</p> <p>The Behavior/Intervention-Monthly Flow Record (BIMFR) for 9/2012 through 2/2013 was used to document behaviors of anger with others, paranoia/anxiousness and being uncooperative or verbally abusive to staff. The 6 months of BIMFRs had 0 behaviors documented or was left blank.</p> <p>The 3/1/13 Consultant Pharmacist Communication to Physician form documented Resident #7 had been on .25 mg of Risperdal since 2/15/12 and suggested a dose reduction. The form included an area to document the rationale for not attempting a dose reduction. The physician had written "cont (continue) with Risperdal related dose (unreadable) a GDR (gradual dose reduction)."</p> <p>On 4/25/13 at 9:00 a.m. RCM #3 was asked if the physician had given rationale for not attempting a GDR. The RCM stated he/she had not.</p>	F 329	<p>The RCM and/or their designee will notify the Director of Nursing if they receive an order to start or continue a antipsychotic medication without appropriate justification from the physician.</p> <p>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.</p> <p>The Director of Nursing, Administrator and/or their designee will review all residents who receive antipsychotics during the weekly Psychotropic Medication Committee for quality assurance and performance improvement opportunities.</p>

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F 329	<p>Continued From page 31</p> <p>The DON and the Administrator were informed of the above concern on 4/25/13 at 2:30 p.m. The facility provided no further information.</p> <p>2. Resident # 8 was admitted to the facility on 6/16/11 with diagnoses of Alzheimer's disease, bipolar disorder, seizures, and anxiety.</p> <p>Resident #8's Quarterly MDS dated 3/14/13 and Annual MDS, dated 6/18/12, indicated the resident had received an antipsychotic medication 7 days during the last 7 days.</p> <p>Resident #8's Quarterly MDS dated 3/14/13 coded no behavioral symptoms. Resident #8's Annual MDS dated 6/18/12 coded physical behavioral symptoms 4-6 days out of the past 7 days. The 6/18/12 MDS coded those behaviors as posing no risk of injury to the resident or others, and not interfering with care or socialization for the resident or others.</p> <p>Resident #8's April 2013 Physician Order Report (Recapitulation) stated in part: -Zyprexa 2.5 mg PO QD (my mouth every day) for the diagnosis of "dementia with behavioral disturbances." The origination date for the medication was 3/21/12.</p> <p>Resident #8's Behavior Intervention Monthly flow records indicated the following, for the target behavior, "Yelling Out": *February 2013-2 days on the evening shift, *March 2013-2 days on the day and evening shifts, *April 2013-April 1-April 11 was not documented and had a line through them, *April 12-April 25-12 days throughout all shifts.</p>	F 329		

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F 329	<p>Continued From page 32</p> <p>A 4/19/13 Physician Communication form from the facility to Resident #8's physician stated, "Resident has an order for Zyprexa 2.5 mg PO QD for dementia with behavioral disturbances. Medication used to manage behaviors, stabilize mood or treat psychiatric conditions require a gradual dosage reduction (GDR) twice within the first year of use and annually thereafter. In order to meet this regulation, please provide either a GDR order to decrease psychotropic use or clinical justification for continued use. Documentation that the issue of GDR has been addressed is required in this resident's chart. [Resident #8's name] dementia has advanced considerably since this medication was initiated. A reduction may be indicated in order to determine if the Zyprexa is of any benefit at this point." NOTE: The Zyprexa had been used for a year and there was no documentation of a GDR attempt.</p> <p>A reply from the physician on the same Physician Communication form included an order as follows, "No change at this time per family request", and was signed and dated by the physician on 4/22/13.</p> <p>NOTE: Other than family request, the physician did not document a justification for continued use of the Zyprexa.</p> <p>On 4/23/13 at 3:00 PM, the DNS was interviewed regarding the need for a GDR or clinical justification for the use of Zyprexa for Resident #8. The DNS indicated the RCM#1 was currently trying to get the physician to explain his rationale and reasons for not making any changes in the Zyprexa.</p>	F 329		

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F 329	Continued From page 33 The Nursing Progress Notes for Resident #8, dated 4/24/13 at 8:10 AM stated, "MD stated, This is a bunch of crap. When did family and patient rights get over-ruled by some law? I sent the justification the first time. The family does not want a dose reduction. Isn't that reason enough? That is the medical justification. I'm not changing anything." On 4/24/13 at 11:15, during interview regarding Resident #8, RCM #1 stated, "I've tried with the doctor, but he was almost belligerent. What do you do when the doctor won't do a GDR?" On 4/25/13 at 2:30 PM the Administrator and DON were informed of the GDR issue for Resident #8. No documentation was provided that resolved the issue.	F 329			
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 and interview it was determined the facility failed to store and serve food under sanitary conditions. This was true for	F 371	F371 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The oven was cleaned and the wet pot was removed to ensure sanitation and prevention of cross contamination for the 14 residents identified. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.	5-31-2013	

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F 371	Continued From page 34 14 of 14 sample residents (#1 - 12, 14 & 15) and all other residents eating their meals at the facility. This practice created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included: During the initial tour of the kitchen on 4/22/13 at 3:50 p.m., the convection oven was observed to have numerous areas of black burned-on food on the bottom of the oven. Additionally, the oven under the stove top range had a layer of aluminum foil on the bottom of the oven. There was burned-on black food underneath the aluminum foil. On 4/25/13 at about 2:00 p.m. the convection oven was again observed to have black burned on food on the bottom of the oven. During an observation of the kitchen, on 4/25/13 at 8:45 a.m., a cooking pot was observed stacked inside of another cooking pot. Both of the cooking pots were observed to be wet inside. Cook #4 was present and stated cooking pots were not to be stacked while wet and the cook immediately removed the cooking pots. On 4/25/13 at 11:35 a.m. the dietitian stated that she completed sanitation audits once a month. When told about the above concerns, she stated the aluminum foil in the bottom of the oven acted as a barrier but the cooking pots should not have been stacked while wet.	F 371	All residents had the potential to be affected by the deficient practice as the kitchen provides all meals for all residents. Measures the facility will take or the systems it will alter to ensure that the problem does not recur: Dietary staff has been in-serviced on how to appropriately dry dishes. The kitchen/dish area was assessed to make sure there was adequate space for the drying of the dishes. Cleaning of the oven will be assigned to particular days of the week reflective of its use. The cooks have been in-serviced on the cleaning schedule that includes the cleaning of the oven. 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.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	The Cooks will notify the Dietary Service Manager (DSM) if they observe stacking of wet pots in their daily cleaning. Audit started 5-1-13 The DSM will provide random audits of the kitchen and will "sign off" on the daily cleaning checklist from the cooks.	

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F 431	<p>Continued From page 35</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure proper and accurate labeling of medications. This affected 2 of 8 random residents (#14 & 15) observed during their medication pass. This had the potential to cause</p>	F 431	<p>The Dietician will provide random audits of the kitchen, specifically checking for the cleanliness of the oven and appropriate drying of dishes on each of her visits and will sign off on the daily cleaning checklist. <i>Audit started 5.1.13.</i></p> <p>The Dietician will continue to complete random monthly sanitation audits of the kitchen that will include the ovens and the dish drying process.</p> <p>The Administrator and/or their designee will provide random "walking rounds" to monitor quality assurance and to identify performance improvement opportunities. <i>(Walking Rounds are daily.)</i></p>	

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F 431	<p>Continued From page 36</p> <p>harm to these residents due to the possibility of them receiving the wrong dose of medication or receiving their medication at the wrong time. Findings included:</p> <p>1. During medication pass on 4/23/13 at 4:30 PM, the surveyor noted LPN #1 dispensing Divalproex to Resident #14. LN #1 stated, "There has been a time change to 5:00."</p> <p>Resident #14's label on her bubble pack medication read as follows: -Divalproex Tab 250 mg- Take one tablet by mouth every day at bedtime with 125 mg to equal 375 mg, -Divalproex tab 125 mg-Take one tablet by mouth every day at bedtime with 250 mg to equal 375 mg. NOTE: Divalproex is a generic form of Depakote. The label indicated the medication was to be given at bedtime, but the nurse administered it at 4:30 PM.</p> <p>A Physician Communication form dated 1/31/13, from the facility to Resident #14's physician read, "Resident has order for Depakote 375 mg PO QHS. May we have order to change time to 1700 (5:00 PM) related to frequent refusals at HS." The physician signed and dated the same Physician Communication form on 1/4/13 with an order which stated: "May change dose time to above."</p> <p>Resident #14's April 2013 Physician Order Report or Recapitulation stated in part: -Depakote 375 mg PO QPM - Give 125 mg with 250 mg to equal 375 mg QHS.</p>	F 431	<p>F431</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident's # 14 and 15's medication cards were audited against the medication administration record (MAR). <i>Audit started 4.26.13</i></p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All resident's medication cards were audited against the MAR to ensure that they match and were transcribed as they were ordered. <i>Audit started 5.6.13</i></p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur:</p> <p>Licensed nurses were in-serviced on the new process of checking all new medication cards against the resident's MAR on the date that they are received. The LN will then place their initials and date on the medication card.</p> <p>The Medical Records Director was provided education and counseling on the importance of accurate transcription of orders to the MAR.</p>	5-31-2013

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F 431	<p>Continued From page 37</p> <p>Resident #14's April 2013 Physician Order Flow Sheet or MAR stated in part: -Depakote 375 mg PO QPM- Give 125 mg with 250 mg to equal 375 mg QHS. NOTE: HS was crossed out and 1700 (5:00 PM) was written in.</p> <p>On 4/24/13 at 11:14 AM, the DNS was interviewed regarding the discrepancies of the time Resident #14's Depakote was to be administered. The DNS indicated she had called the pharmacy to see why the label had not been changed on the Divalproex bubble pack, as she had previously requested. The surveyor informed the DNS the Recapitulation and the MAR also indicated the wrong times the medication was to be administered.</p> <p>2. During a medication pass on 4/25/13 at 8:20 AM, the surveyor observed RN#2 dispensing 6 mg of Prednisone to Resident #15, instead of 7 mg as ordered on the label of the bubble pack. RN#1 stated "I'm only giving 6 mg like it says on the MAR. It was changed."</p> <p>The labels on the bubble pack medications for Resident #15 read as follows: -Prednisone tab 1 MG-Take 2 tablets (2 MG) by mouth every day in the morning with food. Take with 5 MG to equal 7 MG -Prednisone tab 5 MG-Take one tablet by mouth every day in the morning with food. Take with 2 x 1 MG to equal 7 MG dose.</p> <p>A Physician Communication form dated 4/7/13, from the facility to Resident #15's physician read in part: "Resident was admitted to facility today and two medication orders need clarification.</p>	F 431	<p>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.</p> <p>The Director of Nurses and/or their designee will complete weekly audits of the medication cards against the MARS to provide quality assurance and identify performance improvement opportunities. <i>Audit started 5.12.13</i></p>	

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F 431	<p>Continued From page 38</p> <p>Resident has Prednisone ordered but one form says 6 mg and another says 7 mg. The pharmacy sent us 7 mg. What dosage would you like resident to receive?" The physician signed and dated the same Physician Communication form on 4/7/13, with an order which read in part: "prednisone should be 6 mg daily".</p> <p>Resident #15's April 2013 Physician Order Report or Recapitulation read in part: "Prednisone 6 mg PO QAM."</p> <p>Resident #15's April Physician Order Flow Sheet or MAR read in part "Prednisone 6 mg PO daily. 8 AM."</p> <p>On 4/25/13 at 10:00 AM the DNS was interviewed regarding Resident #15 and the discrepancies of her Prednisone dosage. The DNS stated, "I just got off the phone with the pharmacy. She never was on 7 mg of Prednisone here. The pharmacy was just here looking at meds and they should have caught that."</p> <p>On 4/25/13 at 2:30 PM, the Administrator and DON were informed of the labeling issues. No other documentation was provided to resolve the issue.</p>	F 431		

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the state licensure and complaint investigation survey of your facility. The surveyors conducting the survey were: Nina Sanderson, BSW, LSW - Team Coordinator Sherri Case, LSW QMRP Karla Gerleve, RN	C 000		
C 118	02.100,03,c,ii Available Services and Charges ii. Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate; This Rule is not met as evidenced by: Please see F 156 as it pertains to notification of resident rights at the time of admission.	C 118	Please see F156 for the POC.	5-31-13
C 123	02.100,03,c,vii Free from Abuse or Restraints vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to	C 123	Please see F221 for the POC.	5-31-13

RECEIVED
JUN - 6 2013
FACILITY STANDARDS

Bureau of Facility Standards	<i>M. Shepard</i>	TITLE <i>Administrator</i>	(X6) DATE 5.17.13
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2013
NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA RETIREMENT CENTER LEWIST		STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 123	Continued From page 1 himself or to others; This Rule is not met as evidenced by: Please see F 221 as it pertains to physical restraints.	C 123		
C 362	02.108,07,a Interior Surfaces Kept Clean & Sanitary a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: Please see F253 as it relates to a clean, sanitary environment.	C 362	Please see F253 for the POC.	5-31-2013
C 640	02.122,02,d Equipment/Supply Storage Areas d. Equipment and supplies shall be stored in a designated area specific for equipment and supplies. Utensils not in use shall be sterilized prior to being stored. Those which cannot be sterilized shall be thoroughly cleansed in accordance with procedures approved by the Department. This Rule is not met as evidenced by: Please refer to F 371 as it pertains to the improper storage of cooking pots.	C 640	Please see F371 for the POC.	5-31-2013
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and	C 664	C664 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? There were no specific residents identified.	5-22-2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2013
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C 664	Continued From page 2 maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Quality Assurance Meeting & Infection Control Summary, it was determined the facility failed to have the Pharmacist attend the Infection Control Meetings. This had the potential to affect all residents, visitors, and staff. Findings included: During an interview with Infection Control Nurse (ICN) on 4/25/13 at 1:30 PM, the ICN indicated the Infection Control Committee was held during the Quality Assurance Meeting and the Administrator had the attendance sheets from that meeting. On 4/25/13 at 2:00 PM the Administrator provided the attendance sheets for the Quality Assurance Meeting & Infection Control Summary dated May 2012, August 2012, November 2012, and February 2013. The pharmacist had not signed in as attending any of those meetings. The Administrator was asked if the pharmacist attended the meetings. The Administrator indicated the pharmacist did not attend the meetings, but reviewed the minutes during his monthly visits. The Administrator was informed of the State Regulation that the Pharmacist attend the Meetings. No other documentation was provided that resolved the issue.	C 664	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. There are no other residents to be identified. Measures the facility will take or the systems it will alter to ensure that the problem does not recur: The Administrator and/or their designee will send written communication to the Pharmacist at the beginning of the month to inform them of the date and time of the QAPI meeting and will provide a follow up communication the week of the meeting. 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. The Administrator and/or their designee will review the sign in sheet and minutes prior to the end of the QAPI meeting to ensure that all participants have signed in.	
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please see F 280 as it pertains to care plan revisions.	C 782	Please see F280 for the POC.	5-31-2013

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2013	
NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA RETIREMENT CENTER LEWIST		STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501		
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C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please see F 315 as it pertains to toileting assistance. Please see F309 as it pertains to following physicians orders.	C 784	Please see F315 and F309 for the POC.	5-31-2013
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please see F 246 as it pertains to accessibility of fluids.	C 787	Please see F246 for the POC.	5-31-2013
C 832	02.201,02,f Labeling of Medications/Containers 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: Please see F 431 as it pertains to the labeling of medications.	C 832	Please see F431 for the POC.	5-31-2013



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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May 22, 2013

Mindy R. Shepard, Administrator
Royal Plaza Retirement Center Lewiston, LLC
2870 Juniper Drive
Lewiston, ID 83501

FILE COPY

Provider #: 135116

Dear Ms. Shepard:

On **April 26, 2013**, a Complaint Investigation survey was conducted at Royal Plaza Retirement Center Lewiston, LLC. Nina Sanderson, L.S.W., Karla Gerleve, R.N. and Sherri Case, L.S.W., Q.M.R.P. conducted the complaint investigation. The complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on April 22 - 26, 2013.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005883

ALLEGATION #1:

The complainant stated the following concerns regarding the cleanliness of the kitchen:

- a. The can opener is dirty.
- b. The counters are dirty and sandwiches are prepared on the counter.
- c. The facility does not clean under the steam table and it is dirty.
- d. Pots and Pans are put away wet.
- e. Dirty Rags are stored in dirty water.
- f. Two ovens are lined with aluminum foil and the ovens are dirty under the foil.
- g. Meat is thawed over other food and the blood drips on the food below it.

- h. Residents do not receive special diets, and residents on puree diets never get bread.
- i. Some of the food is outdated.
- j. The person who is responsible for washing dishes goes from washing dishes to unloading the clean dishes without washing hands or changing aprons.
- k. The gasket on the reach-in refrigerator is loose, and temperatures are not taken on the refrigerators.
- l. Temperatures are not taken for the cooked food.
- m. The facility does not serve the food that is on the menu, as they do not order enough food.

FINDINGS:

- a. During the initial tour of the kitchen on April 22, 2013, at 3:50 p.m., the can opener was in the dishwasher being washed. During an observation on April 23, 2013, at 1:30 p.m., the can opener was observed to be clean.
- b. The counters were observed during the initial tour and were documented to be clean. On April 23, 2013, at 1:30 p.m., the dietary aide was observed making sandwiches on the counter, which was lined with parchment paper. The dietary aide was interviewed and stated the counters were cleaned continually and were wiped with the sanitizing solution, but when sandwiches were made parchment paper was used to line the counters.
- c. During the initial tour of the kitchen, it was not observed to be dirty under the steam table; however, there was food debris under the steam table in the dining room. The complaint was substantiated and the facility was cited at F253.
- d. During an observation on April 25, 2013, at 8:45 a.m., a cooking pot was stacked in another cooking pot. Both cooking pots were documented to be wet. The allegation was substantiated and the facility was cited at F371.
- e. During the initial tour observations on April 23, 2013, at 1:30 p.m. and 5:30 p.m. and on April 25, 2013, at 8:45 a.m., rags were not observed to be dirty. A rag was observed in the bucket with the sanitizing solution. Neither the rag nor the bucket of water was observed to be dirty. The water was tested and was within the appropriate sanitizing range.
- f. During the initial tour and during an observation on April 25, 2013, at about 2:00 p.m., the ovens were documented to be dirty. The allegation was substantiated and the facility was cited at F371.
- g. During the initial tour, thawing meat was not observed on shelves above other food items. There were several large covered bins on the bottom shelves of the refrigerator, and thawing

meat was placed in the bins to thaw.

- h. On April 23, 2013, during observations of the morning and evening meals, two sample residents were observed to receive the appropriate pureed diets. Their evening meal included a pureed sandwich and pureed bread pudding. During the tray line observation for the noon meal on April 23, 2013, two residents were documented to receive their mechanical soft meals as ordered.
- i. During the initial tour, food that had been opened was documented to have the "use by" date written on the package or containers. Random checks of food in the refrigerator and in the dry storage area were checked. There were no items that were past the "use by" date.
- j. Two staff was observed on April 23, 2013, at 1:30 p.m. to be washing dishes. One was placing the dirty dishes in the dishwasher and the other was removing the clean dishes and putting them away. The kitchen manager was present and stated there were always two people assigned to the dishwashing area.
- k. Temperature logs for the refrigerators for the current month and previous months were reviewed. The gasket on the reach-in refrigerator was observed, and the door was observed to seal when closed.
- l. The temperature logs for the cooked food were reviewed for March 2013 and April 2013. The temperature of a breakfast item was not documented for one day in April. The cook for the evening meal was interviewed on April 23, 2013, at 5:45 p.m. and stated food temperatures were always taken and pointed to the log of food temperatures attached to the side of the steam table.
- m. During the mealtime observations on April 23, 2013, the items served were the menu items. In a meeting with the residents, all present stated that in the past year they did not remember running out of a food item. Four sample residents and family members of two sample residents were interviewed and did not state any concerns regarding the facility not serving food items on the menu. A family member visiting with her mother during the evening meal on April 23, 2013, stated she had not observed any problems with the menu items. The evening cook stated on April 22, 2013, that the facility did not run out of food items, because the kitchen also prepared food for assisted living facility and there was always plenty of food.

CONCLUSIONS:

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

Based on the findings of the complaint investigation, deficiencies were cited and included on the

Mindy R. Shepard, Administrator
May 22, 2013
Page 4 of 4

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,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

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

LKK/dmj