



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 1611

June 5, 2014

Corwin G. Lewis, Jr., Administrator
Parke View Rehabilitation & Care Center
2303 Parke Avenue
Burley, ID 83318-2106

Provider #: 135068

Dear Mr. Lewis:

On May 9, 2014, a Recertification and State Licensure survey was conducted at Parke View Rehabilitation & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 18, 2014**. Failure to submit an acceptable PoC by **June 18, 2014**, may result in the imposition of civil monetary penalties by **July 8, 2014**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring.
 - * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
 - * The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
 - * A plan for "random" audits will not be accepted.
 - * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column (X5).

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

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June 5, 2014
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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 **June 20, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 20, 2014**. A change in the seriousness of the deficiencies on **June 20, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 20, 2014** includes the following:

Denial of payment for new admissions effective **August 9, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 9, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 9, 2014** and continue until substantial

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

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

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

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

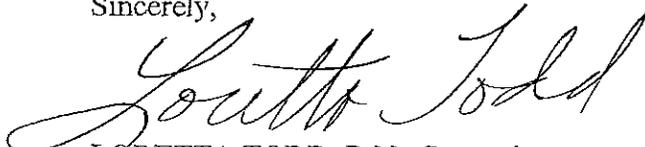
- BFS Letters (06/30/11)

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

This request must be received by **June 18, 2014**. If your request for informal dispute resolution is received after **June 18, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



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

LT/dmj
Enclosures

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

PRINTED: 06/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2014
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Lauren Hoard, RN, BSN, Team Coordinator Brad Perry, BSW, LSW Nina Sanderson, BSW, LSW Noel Mathews, MSW</p> <p>The survey team entered the facility on May 5, 2014 and exited on May 9, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living AIT = Administrator in Training BID = Twice a day BIMS = Brief Interview for Mental Status CHF = Congestive Heart Failure CNA = Certified Nurse Aide CP = Care plan DNS = Director of Nursing Services FSI = Fall Scene Investigation HOB = Head of bed LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment POA = Power of Attorney PRN = As Needed RD = Registered Dietitian r/t = related to s/sx, s/s = signs and symptoms TAR = Treatment Administration Record TID = Three times per day</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Parke View Rehabilitation & Care Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p><i>changes to 7314 made 9/5/14 w/ administrator Coryn Lewis / Ranson</i></p>	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164	F164(D): Resident Rights to Privacy 1) Resident #15's nurse was formally counseled on maintaining resident's	

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

TITLE

(X6) DATE



ADMINISTRATOR

6/18/14

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

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F 164	<p>Continued From page 1</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents' clinical records remained confidential. This was true for 1 Random Resident (Resident #15). The deficient practice had the potential to cause loss of self esteem when the resident's personal health information was available for public view. Findings included:</p>	F 164	<p>privacy. Blister pack was immediately removed from med cart</p> <p>2) All residents have the potential to be affected by this practice. Nursing staff in-serviced on protecting residents privacy.</p> <p>3) The facility practice will be established to ensure empty blister packs and completed narcotic sheets will be kept in the drawers of the medication carts until they can be properly disposed of. All LN staff will be in-serviced on this procedure.</p> <p>4) Beginning on <u>6-5-14</u> the DNS or RN management designee will audit medication carts weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5) Date of compliance is on <u>6-12-14</u></p>		

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F 164	Continued From page 2 On 5/6/14 at 9:25 AM, an empty medication card and a Controlled Drug Record sheet for Random Resident #15 were observed on top of the East hallway nurse's cart. The cart was unattended. The medication card documented, "Clonazepam 0.5 mg tab...take one-half tablet...every morning and 1 tablet every night at bedtime." The Controlled Drug Record sheet contained documentation of how many tablets of Clonazepam had been used between 4/7/14 and 5/5/14. At 9/28 AM, LPN # 5 returned to the medication cart. When the surveyor asked about the exposed information, LPN #5 stated, "Oh, I should have turned that over." On 5/9/14 at 9:45 AM, the Administrator and DNS were informed of the surveyor's observations. The facility offered no further information.	F 164		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of the facility's abuse policies and procedures, staff personnel files, and staff interviews, it was determined the facility failed to operationalize its abuse policies and procedures when the facility failed to obtain a background check for 1 of 3 employees reviewed for background checks. This practice created the	F 226	F-226 (D): 1. The employee file that was found that did not have the current clearance letter printed from the Department of Health & Welfare had it printed and placed in the file. 2. All employees have the potential to be affected by this practice. 3. The new hire checklist was updated to include the State of Idaho Finger Printing along with the affidavit signature page and Idaho Clearance letter printed page.	

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F 226	<p>Continued From page 3</p> <p>potential to place residents at risk for and subject to abuse, neglect, or misappropriation of property. Findings included:</p> <p>The facility abuse policy and procedures documented the following: "3. Criminal Background Checks will be completed on all employees..."</p> <p>On 5/7/14 at about 4:00 PM, three employee personnel files were reviewed for the state's criminal history background check verification. Staff A who was hired on 3/25/14, did not have a copy of the Notice of Clearance letter or background check verification in her personnel file.</p> <p>On 5/7/14 at 4:05 PM, the Human Resource (HR) Manager was interviewed regarding where the clearance letter was located in the personnel file. She printed it for the surveyor at that time and said she only viewed the clearance letter at the time of hire and had no documentation to show she viewed it.</p> <p>On 5/7/14 at 6:50 PM, the Administrator, DON, AIT, and Quality Improvement Resources were informed of the issue.</p> <p>Upon review of the clearance letter printed on 5/7/14 by the HR Manager, the letter documented the staff member's clearance date was 5/28/09, more than three years before the recent hire date.</p> <p>On 5/8/14 at 9:25 AM, the Administrator and HR Manager were asked about the outdated clearance letter. They provided the surveyor with a copy of a third party company background check for the employee in question and said they</p>	F 226	<p>4. All current employee files will be audited for the State of Idaho Finger Printing. Beginning on <u>6-5-14</u> the Administrator or designee will audit all new hires within 21 days of hire for 6 months. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5. Date of Compliance is on 6/20/14</p>		

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NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
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F 226	Continued From page 4 would also provide an updated clearance letter. The third party background check did not require a fingerprint, but rather used the employee's name and social security number. The third party check dated 3/26/14, documented: "Results pertaining to the subject's potential criminal background results are only included in the report if there is an exact match between the full name and date of birth provided by the subject and the court record...As it may not be permissible or recommended to use certain information contained in this report for employment decisions, it is advisable to consult with counsel prior to making any adverse hiring decisions..." On 5/8/14 at 1:10 PM, the Administrator brought the surveyor an updated Notice of Clearance which documented a print date of 5/8/14 and a clearance date of 7/13/11. Note: Verification Reports dated 5/20/09 and 7/13/11 for Staff A did not document any abuse findings. Guidelines at F226 specified: "I. Screening (483.13(c)(1)(ii)(A)&(B): Have procedures to screen potential employees for a history of abuse, neglect or mistreating residents as defined by the applicable requirements at 483.13(c)(1)(ii)(A) and (B). This includes attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries."	F 226			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241	F241(D): Dignity 1) Resident #1's w/c cushion was immediately removed and a new cushion was provided		

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F 241	<p>Continued From page 5</p> <p>manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to provide an environment which maintained dignity for residents. This was true for 1 of 12 (Resident #1) sampled resident. The deficient practice had the potential to cause more than minimal psychosocial harm. The resident has the potential to be harmed and/or embarrassed by the smell of urine on her wheel chair cushion.</p> <p>1. Resident #1 was admitted to the facility on 10/3/05 with multiple diagnoses. The most current diagnoses include peptic ulcer, depression, and osteoarthritis.</p> <p>Resident #1's Annual MDS assessment, dated 3/4/14, coded: *BIMS of 13, indicating the resident was cognitively intact; *No behavioral symptoms; *Extensive assistance of one for bed mobility; extensive assistance of two for transfers; and supervision after setup for eating.</p> <p>Resident #1's care plan documented: *Focus-"At risk for ADL Self Care Performance Deficit [related to] Confusion, Dementia," date initiated on 8/30/13. *Goals-"Will maintain current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene through the review date," target date on 6/3/2014.</p>	F 241	<p>2) Other residents with similar cushions had the potential to be affected by this practice. All other residents' w/c cushions were inspected for cleanliness and odor and cleaned as needed.</p> <p>3) All w/c and cushions will be washed weekly. All staff was in-serviced on reporting odors and need for cleaning to housekeeping.</p> <p>4) Beginning on <u>6-6-14</u> the administrator or designee will audit for w/c cushion cleanliness and odor free weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5) Date of compliance is on <u>6-18-14</u></p>		

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F 241	<p>Continued From page 6</p> <p>*Interventions-"...Promote dignity by ensuring privacy, toilet use: requires [one] assist with toileting needs. High John to toilet..., encourage to participate to fullest extent possible with each interaction."</p> <p>*Focus-"Has bladder incontinence and history of bowel incontinence [related to] Dementia and history of urinary retention," date initiated on 8/30/13.</p> <p>*Goals-"Will remain free from skin breakdown due to incontinence and brief use," through the review date on 6/3/14.</p> <p>*Interventions-"...notify nursing if incontinent during activities, use disposable briefs. [Change every three hours and as needed], encourage fluids during the day to promoted prompted voiding responses. Assist to the bathroom [every three hours] while awake...check as required for incontinence. Wash, rinse and dry perineum. Change clothing [as needed] after incontinence episodes," date initiated on 8/30/13.</p> <p>The following observations were made by the surveyor of Resident #1 in her room:</p> <p>*On 5/5/14 at 3:35 PM, the resident was in her room sleeping in her bed. The room had a strong smell of urine which was isolated to the resident's wheel chair cushion.</p> <p>*On 5/6/14 at 9:27 PM, two additional surveyors observed Resident # 1 sleeping in her room. The resident's wheel chair was at the end of her bed and the surveyors were approximately one foot from the wheel chair. The surveyors approached the wheel chair and reported the cushion placed in the wheel chair smelled of urine.</p> <p>*On 5/7/14 at 3:17 PM, the Assistant Director of Nurses was informed the wheel chair cushion smelled of urine.</p>	F 241			

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F 241	Continued From page 7 On 5/9/14 at 3:50 PM, Administrator and DNS were informed of the dignity issues.	F 241	<p style="text-align: right;">RECEIVED JUL 11 2014 FACILITY STANDARDS</p> <p>F280(D): Assessment – Care Plan revision 1) Resident #3 care plan has been updated with current level of assistance for eating. Resident #5 care plan for constipation, non-pharmacological interventions for insomnia, and target behaviors for hallucinations, delusions, and risk for self-harm have been updated. On 2/11/14 resident #5 wrist fracture and brace use were resolved. 2) Other residents' care plans for significant changes in health status have been audited to ensure appropriate interventions are in place. 3) The Change of Condition (COC) communication tool will be used to identify residents who have or are experiencing changes in function to ensure their care plan is revised to reflect their current status. All Nursing staff will be in-serviced on use of the communication tool. 4) Beginning on <u>6-5-14</u> the DNS or management designee will audit the communication tool results and care plans related to eating to ensure accuracy weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p>	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure care plans were revised for a resident who required assistance to dine, and for a resident whose care plan did not provide instruction for target behavior monitoring or the instruction for the resident not use her right hand related to a fracture. This was true for 2 of 12 sampled residents (#s 3 and 5). This had the</p>	F 280		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/09/2014
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F 280	<p>Continued From page 8</p> <p>potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 11/18/11 with multiple diagnoses which included ischemic cerebrovascular disease and dementia.</p> <p>The most recent significant change MDS assessment, dated 4/14/14, documented Resident #3 required extensive assistance with one person for eating.</p> <p>Resident #3's Care Plan documented: * Focus - "At risk for an ADL Self Care Performance Deficit r/t [related to] Musculoskeletal impairment, Impaired balance, Limited ROM [Range of Motion], Stroke," initiated on 8/11/13; and, * Interventions - "EATING: I am able to feed self independently after set up." Initiated on 8/11/13.</p> <p>The following was observed by the surveyor during meals of Resident #3: * On 5/6/14 at 8:23 a.m., the resident was sitting at the assistive table in the 500 hall dining room. A CNA was assisting the resident to dine by providing bites of food; * On 5/6/14 at 12:46 p.m., the resident was sitting at the assistive table in the 500 hall dining room. A student CNA was assisting the resident to dine by providing bites of food; and, * On 5/7/14 at 6:13 p.m., the resident was sitting at the assistive table in the 500 hall dining room. The resident was receiving assistance to dine with bites of food.</p> <p>On 5/7/14 at 2:57 p.m., LN #1 was asked if Resident #3 ate independently or required</p>	F 280	5) Date of compliance is on <u>6-18-14</u>		

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F 280	<p>Continued From page 9</p> <p>assistance. She said the resident ate at the assistive table and sometimes initiates with drinks and some bites of food. The LN added, "We've been helping him." LN #1 was informed of the observations which contradicted the instruction on Resident #3's Care Plan.</p> <p>On 5/8/14 at 4:50 p.m., the Administrator and DON were informed of the Care Plan revision issues. No further information was provided.</p> <p>2. Resident #5 was admitted to the facility on 6/20/12. Her multiple diagnoses included CHF, dementia, depression and anxiety. She was re-admitted on 12/29/13 with a new diagnosis of a right wrist fracture.</p> <p>a. On 1/14/14, a physician's progress note for resident #5 documented, "Doctor concerns...Don't let her use this hand!! Make sure the brace stays on all the time!! Keep hand elevated. Don't let her take the brace off. Check on her frequently."</p> <p>On 5/7/14 at 11:45 AM, the SDC and LSW were asked how the instructions from the physician were addressed by the facility. The SDC stated there should have been new interventions on the resident's care plan. However, when reviewed, the resident's care plan did not document any new interventions related to the physician's progress note from 1/14/14.</p> <p>b. Resident # 5's Active Orders (Recapitulation Orders) for May 2014 documented: *Alprazolam .025 mg TID PRN for anxiety, beginning 12/31/13; *Ambien 5 mg at bedtime PRN for insomnia,</p>	F 280			

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F 280	<p>Continued From page 10 beginning 3/26/14; *Cymbalta 60 mg daily for depression, beginning 12/29/13; *Seroquel 25 mg at bedtime daily for dementing illness with hallucinations, delusions, and risk of self-harm, beginning 3/28/14; *Colace 100 mg twice daily for constipation, beginning 12/29/13; *Lactulose 20 gm/ml, 30 mls given twice daily for constipation, beginning 1/27/14; and *MiraLax 17 gm at bedtime daily for constipation, beginning 1/27/14.</p> <p>Review of Resident #5's care plan revealed: *No care plan focus area, goals, or interventions for constipation; *A care plan for insomnia was initiated 2/2/14. However, the care plan did not document non-medication interventions to be attempted prior to the use of an "as needed" medication; *There was no care plan for hallucinations, delusions, or the risk of self-harm; there were no specific target behaviors identified for the use of an anti-psychotic medication in conjunction with a diagnosis of dementia, and no non-pharmacological interventions identified if hallucinations, delusions, or self-harm occurred.</p> <p>On 5/8/14 at 1:10 PM the DNS was asked about the care plan for Resident #5. The DNS stated she would look for additional information regarding the identified issues.</p> <p>[NOTE: Please see F 329 as it pertains to indications for use and monitoring for psychotropic and bowel medications.]</p> <p>On 5/9/14 at 9:45 AM, the Administrator and DNS were informed of the surveyor's concerns. The</p>	F 280			

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F 280 F 309 SS=D	Continued From page 11 facility offered no additional information. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure coordination of care between the facility and hospice provider. This was true for 1 of 1 resident (#3) sampled for hospice services. This deficient practice had the potential to cause more than minimal harm if aspects of a resident's care and treatment were not adequately communicated with all entities involved in resident care. Findings included: Resident #3 was admitted to the facility on 11/18/11 with multiple diagnoses which included dementia and ischemic cerebrovascular disease. May 2014 Physician recapitulation orders for Resident #3 documented, "Admit to [local hospice agency]. Continue meds [medications] as previously ordered." Dated 3/28/14. The Care Plan for Resident #3, dated 4/2/14, documented: * Focus - "Has a terminal prognosis r/t [related to]	F 280 F 309	F309(D): Quality of Care – Hospice 1) Resident #3's Hospice care plan was updated to integrate the hospice services as required. 2) Other residents on Hospice have the potential to be affected by this practice. Hospice care plans have been audited for integration of services. 3) All residents admitted to Hospice will have an initial IDT meeting scheduled within 5 days and weekly thereafter to ensure coordinated care plans are integrated for Hospice services. 4) Beginning on <u>6-9-14</u> the DNS or RN designee will audit the Hospice care plans to ensure integration of Hospice services is in place weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective. 5) Date of compliance is on <u>6-12-14</u>	

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F 309	<p>Continued From page 12</p> <p>Dementia and refusal to eat/wt [weight]loss. He is on Hospice...;" and,</p> <p>* Interventions - "Keep linens clean, dry and wrinkle free. Keep lighting per his choice and familiar objects near; Adjust provision of ADLS to compensate for resident's changing abilities. Encourage participation [sic] to the extent the resident wishes to participate; Consult with physician and Social Services to have Hospice care for resident in facility; Encourage resident to express feelings, listen with non-judgmental acceptance, compassion; Encourage support system of family and friends; Review resident's living will and ensure it is followed. Involve family in discussion; Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met; Work with nursing staff to provide maximum comfort for the resident."</p> <p>Note: The Care Plan did not identify which provider, hospice or facility, was responsible for various aspects of care.</p> <p>The Hospice Plan of Care, dated 3/27/14, documented the Skilled Nurse (SN) was to - "assess overall patient status, pain and symptom control, medication compliance, patient/family/caregiver concerns, and environmental safety. SN to instruct on disease progression, pain and symptom management, medications, signs and symptoms of dying, comfort measures, and home safety. PRN [as needed] SN visits as needed for symptom management. Instruct in fall prevention measures as appropriate. Instruct in pressure ulcer prevention and skin care as appropriate." The Social Worker was to - "assess psychosocial and emotional status, patient/family/caregiver</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>concerns and coping. MS to instruct on coping techniques, comfort measures, and emotional aspects of the dying process...PRN phone visits for coordination and care for visits and inpatient stays." The Chaplain (CH) was to - "assess spiritual status. Chaplain to provide patient/family spiritual care and terminal support. Chaplain visits as needed for spiritual support."</p> <p>On 5/7/14 at 3:05 p.m., LN #2 was asked if the facility had a coordinated plan of care with the hospice agency. She stated, "Yes." The documented coordinated plan of care was requested.</p> <p>On 5/7/14 at about 4:00 p.m., an additional copy of Resident #3's Care Plan related to hospice was provided, as well as two Progress Notes.</p> <p>The Progress Notes documented: * 3/31/14 - "Met with daughter and Hospice regarding plan of care. No concerns or medication changes at this time. [Resident's responsible party] states that a lot of the family have been coming in to visit him. Reviewed plan of care;" and, * 4/28/14 - "Care Conference with Hospice and [responsible party] regarding plan of care. No concerns voiced. No changes to plan of care at this time."</p> <p>On 5/8/14 at 4:40 p.m., the Administrator and DON were informed of the coordinated plan of care issue. The Administrator asked the surveyor if the Hospice book had been provided. The surveyor stated, "No" but would be happy to look at it the following morning.</p> <p>On 5/9/14 at 9:15 a.m., the Administrator was</p>	F 309			

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F 309	Continued From page 14 asked for the hospice book to review. He stated after discussing the issue with staff it was determined they did not have further information to provide.	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents who entered the facility without pressure sores did not develop pressure sores. This was true for 3 of 3 (#s 1, 9 & 4) sampled residents reviewed for pressure sores. Resident #9 developed a stage II pressure ulcer to her coccyx which developed into an unstageable ulcer with undermining and became infected, which harmed the resident. The facility also failed to prevent unstageable pressure ulcers to Resident #1's left hip and Resident #4's coccyx. Findings included: 1. Resident #9 was admitted to the facility on 9/22/03 with multiple diagnoses which included hyperhidrosis, dementia without behavioral disturbances, heart failure and pressure ulcer.	F 314	F 314 (G) Pressure Ulcer Prevention 1) Resident # 9 was discharged from the facility on 5-8-14, Resident #1 saw the Wound Ostomy Continency Nurse on 5-14-14, 5-29-14, and on 6-6-14 for wound evaluation, treatment and reassessment of her wound and will see her again on 6-18-14. Resident # 1 saw her physician 5-13-14 and 5-27-14 for wound evaluation, treatment and reassessment. Resident # 4 has been being followed by the Wound Ostomy Continency Nurse since 1-24-14 and continues to be followed for wound evaluation, treatment and reassessment the WOCN as per orders. She also sees her primary physician monthly for wound evaluation and overall health status. Resident #4's wound continues to heal. . 2) All other residents at high risk for pressure ulcer development could be affected. These residents were identified by nursing review of their Braden scales and other assessments. Care plans will be updated to ensure high risk areas are addressed. 3) Nursing staff were inserviced on preventative skin care on 5-29-14 and 6-11-14. 4) Beginning on 6-6-14 the DNS or RN designee will audit to ensure turning and		

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F 314	Continued From page 15 Resident #9's most recent annual MDS assessment, dated 3/26/14, documented: * Moderately impaired cognition with a BIMS of 8; * Extensive assistance required with 2 or more people for bed mobility, transfers, dressing and toilet use; * Extensive assistance required with 1 person for personal hygiene; * Always incontinent of bladder and bowel; * At risk of developing a pressure ulcer with no unhealed pressure ulcers; * Pressure reducing device for bed and chair; and, * No turning/repositioning program and no nutrition or hydration intervention to manage skin problems. Resident #9's Care Plan, dated 10/24/13, documented the focus area of, "Has actual and potential for skin breakdown & pressure ulcer development with poor wound healing potential r/t [related to] decreased mobility, total bowel incontinence, poor caloric & protein intake to support wound healing, hypothyroidism, CHF [Congestive Heart Failure] with edema & diuretic therapy and chronic reoccurrence of blood blisters to bilateral lower extremities, anticoagulation therapy, advanced age, deteriorating vascular disease. (MD statement that skin breakdown is expected and unavoidable) Pt. [patient] choice for no artificial nutrition or hydration." Revised on 5/7/14. Initial interventions included: "Encourage fluid intake and assist to keep skin hydrated;" "Float heels off of bed as resident will allow;" "Needs monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often	F 314	repositioning are taking place on identified high risk residents weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective. 5) Date of compliance is on <u>6-18-14</u> .		

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F 314	<p>Continued From page 16 as needed or requested;" "Shift weight in chair Q [every] 2 hours and PRN;" and, "Weekly head to toe skin at risk assessment;" The Care Plan had an additional focus area of, "Has bowel incontinence r/t Physical limitations, Impaired Mobility, Activity Intolerance," initiated on 10/2/14. The interventions included: "BRIEF USE: uses disposable briefs. Change Q 2 hrs and prn;" and, "INCONTINENT: Check as required for incontinence. Wash, rinse and dry perianal area. Change clothing PRN after incontinence episodes."</p> <p>A Braden Scale for Predicting Pressure Sore Risk for Resident #9, dated 3/18/14, documented a score of 14, which placed the resident in the moderate risk category.</p> <p>An ADL flowsheet documented Resident #10 was turned and repositioned on 3/26/14 at 5:50 a.m., 1:37 p.m., 4:12 p.m. and 11:14 p.m. Note: From 5:50 a.m. to 1:37 p.m., over 7 hours passed before it was documented the resident was turned/repositioned. Over 2.5 hours went by between 1:37 p.m. and 4:12 p.m. before it was documented the resident was turned/repositioned. Another 7 hours passed between 4:12 p.m. and 11:14 p.m. before turning/repositioning the resident was documented.</p> <p>The ADL flowsheet documented Resident #10 was turned and repositioned on 3/27/14 at 8:36 p.m. Turning/repositioning was not documented again until the following day, 3/28/14 at 4:32 a.m. Note: From 3/26/14 at 11:14 p.m. until 8:36 p.m. on 3/27/14, over 21 hours passed before it was</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>documented the resident was turned or repositioned. From 3/27/14 at 8:36 p.m. until 4:32 a.m. on 3/28/14, 8 hours went by before it was documented the resident was turned or repositioned.</p> <p>Note: Documentation of toileting or check and changes was requested on 5/8/14. No documentation was provided.</p> <p>An Incident Report for Resident #10, dated 3/28/14 at 7:00 a.m., documented:</p> <p>* Description - "During AM cares noted 1cm x [centimeter by] 1cm superficial open area just [left] of coccyx non-blanchable. Surrounding tissue red- blanches well."</p> <p>* Corrective Action - "Cleansed [with] NS [normal saline], skin protectant applied Covered [with] Hydrocolloid dsg [dressing] Will place air mattress - pt. already has RoHo in w/c [wheelchair]."</p> <p>* Medication/DX [diagnostic] labs that may contribute to incident - "101 year old pt. [patient with] extremely fragile skin. Hypothyroidism. Poor appetite, Constantly Consumes [less than] 25 % at meals. Accepts supplement shakes TID. Receives Anticoagulant daily."</p> <p>* Staff/Visitors/other residents interviewed - Blank</p> <p>* Resident Statement - Unaware of skin issue - denies pain at site;"</p> <p>* Comments of investigation/prevention measures in place - "Resident is a 101 year old female [with] dx of Dementia, Hypothyroidism, CHF. Res[ident] is on anticoagulant of Elequis BID [two times per day] r/t reoccurring blood blisters to bilat[eral lower] legs as well as recent DVT [deep vein thrombosis] to [left] leg. Res has extremely fragile skin [with] chronic ecchymotic areas to bilat extremities. Res is one of the last</p>	F 314		

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F 314	<p>Continued From page 18</p> <p>residents up [and] last down for meals. [Note: there was no documetation on the CP related to the resident being last resident up and last resident down for meals. In addition, the intervention of, "last up last down" should be last up, first down to decrease the amount of time spent up in the wheelchair.] res transfers [with] 1 assist during the day x2 during evenings is check and [change] during noc [night] [every] 2 [hours] and PRN r/t Hx [history] of vagal episodes on toilet during noc when gotten up Res has had [increased] weakness and down time in bed since DVT to [left] leg. Res is on a RoHo cushion to her w/c, Airbed was placed upon finding of skin concern. Moisture barrier is applied [with] peri[neal] care Res is incontinent of urine. Will leave OTA [open to air] [at] noc [with] frequent changing of airpad. Will monitor via tx [treatment] sheet [un]til resolved."</p> <p>A Fax Request for Physician Response, dated 3/28/14, documented, "Noted superficial open area just [left] of coccyx - non-blanchable. Placed Hydrocolloid dsg per protocol - will [change every] 3 days [and] PRN. May we have an order for an airbed?" Three days later on 3/31/14 the doctor responded with new orders of, "Air bed."</p> <p>* 9 The following documentation was gathered from Resident #10's LN-Skin Pressure Ulcer Weekly assessment (SPUW), Interdisciplinary Team Skin Review - Weekly Update (ITSR) reports, Physician Orders (MD orders) and care plan (CP): 3/28/14 - MD order, "Document status of ulcer to coccyx on daily ulcer observation record Q [every] day;" 4/2/14 - SPUW, "Date of Onset: 3/28/14; Site: coccyx; Stage: Stage 2; Size: 1cm x 0.5cm;</p>	F 314		

*CEP/ML
9/5/14*

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F 314	Continued From page 19 depth: superficial; Comments: New pressure ulcer identified to coccyx 3/28/14. Wound at stage 2 ulcer, superficially open, red and granular in color. No drainage, no odor and no s/s of infection present. Wound is improved since identified. No periwound redness, skin is pink periwound and is blanchable. Wound size is smaller since identification. Wound cleansed with NS, no sting skin barrier applied to periwound skin and Hydrocolloid dressing was placed over wound per aseptic technique. Pt. tolerated dressing change without c/o [complaints of] pain or discomfort. Pt. was turned and repositioned off right side onto left side when wound assessment and dressing change was completed. Pt. is using airbed for additional pressure reduction and roho cushion when in wheelchair, pt. is checked and changed/toileted q2hrs [every 2 hours] and PRN and has been totally incontinent of bowel and bladder. Pt. is assisted to turn and reposition q2hrs and PRN." 4/9/14- SPUW, "Site: Coccyx; Stage 2; Size: 0.5cm x 0.3cm; Comments: Pressure ulcer to coccyx is healing, measures smaller in size over past week and remains superficially open with presentation as stage 2 ulcer. Periwound skin is pink and blanchable [sic] without maceration. No s/s of infection are evident. Scant serosanguinous drainage present from wound. Pt. denies pain to coccyx wound with assessment and with dressing change. Wound was cleansed with NS, no sting skin barrier applied to periwound skin and hydrocolloid dressing was applied over wound per aseptic technique. Pt. was turned onto left side from right side following wound care. Pt. education was provided to pt. regarding importance of adequate fluid and food intake to help heal wound as well as importance of tuning at least q2hrs off coccyx to help with wound	F 314			

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F 314	Continued From page 20 healing. Pt. verbalizes understanding of instruction." 4/9/14 - ITSR, "Skin Progress/Status and Compliance with Treatment Plan: Pressure ulcer to coccyx continues to improve and shows signs of healing over past week. Wound is smaller in size and is superficially open with no s/s [signs and symptoms] of infection evident. Pt. is turned q2hrs and PRN off coccyx, is checked, changed, toileted q2hrs and PRN. Current wt. is 104# with no change in wt. in 1 month. Meal intakes are poor with majority of meals taken less than 25% consumed. Pt. accepts mighty shakes TID at meals and will take toast at each meal as well. Pt. is served fortified mechanical soft diet with small portions at pt. request. Accepts about 1/3 of TID snacks. Pt. continues taking MVI with mineral po qd [by mouth every day]. Pt. is using airbed, roho cushion in w/c to help off load pressure from coccyx; IDT Recommendations/Comments: Dietician consult was completed 4/2/14, requests MD be contacted to add 2cal 2oz to hot chocolate TID at meals. With improvement in wound recommended contacting MD for possible change in topical treatment to Marathon q3d [every 3 days] and PRN along with possibly adding 2 scoops protein powder TID with meals to boost protein intake and aid wound healing as MD sees fit. Request pt. be added to weekly wt.'s from monthly. [MD's name] and [Responsible Party] were notified of current status of coccyx pressure ulcer healing and of current wound healing interventions in place. Pt. remains at high risk for skin breakdown, poor or delayed wound healing due to poor caloric and protein intake at meals, wt. loss, hypothyroidism, CHF with edema & diuretic therapy, total bowel and bladder incontinence and diminished independent mobility skills.; This resident is at High Risk for Skin	F 314			

ask for copy 9/15/14

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F 314	Continued From page 21 Integrity Breakdown which may not be Preventable and may have Delayed healing Due To the Identified Conditions/Risk Factors: Yes; Care Plan Updated and Revised: Yes." 4/9/14 - CP revisions, "Administer pain relieving medication prior to treatments as needed and as per MD orders; Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD; Document status of pressure ulcers qd [every day] on Daily Ulcer Observation Record; Educate resident, family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during mobility, good nutrition and frequent repositioning; Encourage pt. to keep HOB [head of bed] as flat as possible to reduce sheer; If refuses treatment, meet with resident, IDT [interdisciplinary team] and family to determine why and try alternative methods to gain compliance. Document alternative methods; Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx [signs and symptoms] of infection, wound size and stage; Requires supplemental MVI [multivitamin] with mineral po [by mouth] qd to promote wound healing." 4/13/14 - A Braden Scale documented a score of 9 which placed the resident in the very high risk category for pressure ulcer development. 4/16/14 -SPUW, "Site: Coccyx; Stage 2; Size 1cm x 0.5cm; Comments: Pressure ulcer to coccyx is larger in size over past week since change of treatment from hydrocolloid dressing to marathon skin protectant. Wound presents as stage 2 pressure ulcer, superficially open with red	F 314			

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F 314	Continued From page 22 wound bed. Periwound skin is bright red, but blanchable extending out 3cm from wound edges. No wound drainage, no odor and no s/s of infection. Pt. continues to use airbed, roho w/c cushion, is up for limited time in w/c and is turned side to side predominantly to off load pressure from coccyx. Pt. is totally incontinent of bowel and bladder and requires total assistance with check and change q2hrs and PRN. Wound cleansed with NS, Marathon skin protectant applied to wound bed. Cavilon skin barrier applied to periwound skin. [MD's name] notified of large wound size with change of treatment over past week." 4/16/14 - ITSR, "Skin Progress/Status and Compliance with Treatment Plan: Pressure ulcer to coccyx continues to present as stage 2 ulcer. Wound measures larger in size this week since change of treatment from hydrocolloid dressing to marathon skin protectant... is accepting 2oz 2Cal TID with med passes and accepts TID snacks about half of the time. Pt. is provided with supervision and cues during meal, but will not allow staff to assist her with meals... Current wt. is 104# with no change in 1 week; IDT Recommendations/Comments: New orders were received over past week for 2oz 2Cal TID, to change treatment from hydrocolloid dressing to Marathon skin protectant. [MD's name] notified of current status of wound with increased wound size since last treatment orders change and request possible change of treatment as MD sees fit. Request also make to [MD's name] for possible prealbumin lab draw. Pt. and [Responsible Party] were notified of wound status and current healing interventions in place. Patient remains at very high risk for poor or delayed wound healing due to advanced age, poor nutrition with inadequate caloric and protein	F 314			

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F 314	Continued From page 23 intake to heal wound...dependence with ADL cares, anticoagulant therapy; Care Plan Updated and Revised: Yes." Note: No CP update was documented. 4/21/14 - MD order, "Monitor coccyx Q shift for placement of dressing every shift;" 4/23/14 - SPUW, "Site: Coccyx; Stage 2; Size 3cm x 2.5cm; Comments: Pressure ulcer to coccyx is larger in size and shows increased amount of drainage. Wound is open superficially 2cm x 1.5cm with dark red wound color, moderate serosanguinous drainage is present without foul odor. No s/s of infection is evident. Open portion of wound is surrounded by 1cm of nonblanchable dark purple/red coloration that is with intact skin, but is boggy to touch. Total wound size 3cm x 2.5cm including open and nonblanchable portions. Skin surrounding nonblanchable area is pink and intact. [MD's name] has been contacted to clarify treatment orders. Orders for PT to diagnose and recommend treatment orders. Pt. has been OOB [out of bed] for extended periods of time over weekend for celebration parties with family for 102nd birthday. Wound care provided as per MD orders per aseptic technique. Pt. tolerated well without c/o pain." 4/23/14 - ITSR, "Skin Progress/Status and Compliance with Treatment Plan: Patient pressure ulcer to coccyx has worsened over past week, is larger in size and is surrounded by non blanchable purple discoloration, serosanguinous drainage is present without s/s of infection...Patient was up in wheelchair for extended time frames over the weekend for various parties for 102nd birthday. Pt. is using Genesis III airbed... Skin turgor is very poor and tenting. Skin is extremely fragile and thin due to age. Braden Scale recalculated with score of 9	F 314			

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F 314	Continued From page 24 putting pt. at very high risk for skin breakdown... IDT Recommendations/Comments: New orders received 4/18/14 for prealbumin (results pending) along with PT to diagnose and recommend treatment for coccyx wound. Request dietician consult. Request from MD clarification of treatment orders...PT to complete consult for wound diagnoses & treatment recommendations ordered 4/18/14. Request from MD 2 scoops protein powder TID mixed in mighty shakes. Request airbed with rotation function. Request from MD unavoidable wt loss & skin breakdown. Pt. has chosen no artificial hydration or nutrition directives per her living will. Pt. is at very high risk for skin breakdown...thinning of subcutaneous tissue, very poor skin turgor, very poor nutritional intake w/ [with] inadequate caloric and protein intake to support wound healing... Care Plan Updated and Revised: Yes." 4/24/14 - MD order (telephone), "Full Airbed with 4 1/2 siderails and siderail pad for skin integrity." Written above the order in pen was, "Air Dyne Air Bed;" "Hydrocolloid dsg [dressing] to coccyx wound. Change Q 3 days and PRN every day shift every 3 day(s) for pressure ulcer;" Note: On 4/16/14 the Physician was notified of the increased wound size after a change in the dressing order, and a new dressing order was requested. On 4/24/14, 8 days after the request had been made, the dressing order was changed back to the hydrocolloid dressing. It is unclear why it took over a week to receive an order for a different dressing. 4/25/14 - CP revision, "Requires pressure relieving/reducing device on bed: Static LAL [low air loss] airbed with four 1/2 side rails with padding chair: roho cushion in w/c [wheelchair] seat;"	F 314			

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F 314	Continued From page 25 "Use foley catheter 16 French with 5ml [milliliters] balloon change q month and PRN to help prevent contamination of pressure ulcers;" 4/30/14 - SPUW, "Site: Coccyx; Stage: Unstageable(Slough/Eschar); Size: 4cm x 3cm; Comments: Pressure ulcer to coccyx measures larger size length and width and presents as an unstageable ulcer due to presence of gray slough 90% of wound and black eschar 10% of wound. Portions of slough/eschar are loose, but unable to remove with cleansing. Large amount of purulent drainage present from wound with dressing removed 100% saturated and leaking onto underpad. Wound has foul odor even after cleansing. Periwound skin is bright red and blanchable extending out from wound edge 0.5cm. Slight maceration is present at wound edges. Wound was cleansed with NS, no sting skin barrier was applied to periwound skin and hydrocolloid dressing was placed over wound. Pt. is using Static LAL airbed was turned and positioned onto left side at time of dressing change. Pt. tolerated dressing change without c/o pain or discomfort." 5/1/14 - ITSR, "Skin Progress/Status and Compliance with Treatment Plan: Pressure ulcer to coccyx is larger in size and is 100% covered with gray slough and black eschar with portions that are very loose and stingy. Wound is malodorous even after cleaning. Presents as an unstageable pressure ulcer...Current wt. is 105# up 1# in 1 week. Pt. has consumed all but one meal over past week less than 25% consumed or refused and has accepted TID snacks only 1/3 of the time. Pt. drinks mighty shakes at meal times and 2 scoops protein powder is added TID and 2 cal 2oz with meals. Pt. is using Static LAL airbed with 1/2 side rails x4... up for short periods of times for meals... foley catheter in place to help	F 314			

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F 314	Continued From page 26 prevent contamination of wound bed from urine... IDT Recommendations/Comments: Contact [MD's name] to request wound culture or treatment for possible infection & PT for debridement of coccyx wound. New orders received from [MD's name] that pt. skin breakdown & wt. loss is expected & unavoidable due to pt.'s advanced age, deterioration of vascular disease & wishes for no aggressive treatment measures including no artificial nutrition or hydration. New orders received from [MD's name] for protein powder 2 scoops TID with meals & airbed, foley catheter to help prevent wound contamination, hydrocolloid dressing to coccyx change q3days & PRN...Pt. is at risk for worsening, delayed & poor wound healing d/t deterioration of vascular disease... Care Plan Updated and Revised: Yes." 5/1/14 - CP revision, "Wt. [weight] loss and skin breakdown is expected and unavoidable d/t [due to] advanced age, deterioration of vascular disease and family requests for no aggressive treatment as per MD orders;" 5/2/14 - MD order, "Foam dressing to coccyx one time a day every 2 day(s) for Coccyx wound;" 5/6/14 - MD order, "Minnesota Solution wet to dry dressing to coccyx TID [three times per day]. pack loosely in wound three times a day for Skin breakdown." 5/7/14 - SPUW, "Site: Coccyx; Stage: Unstageable; Size: 4cm x 4.5 cm; Undermining: 11-2 o'clock; Exudate Type: Purulent; Exudate Amount: Large; Odor: Foul; Wound Bed: Black/Brown (Eschar); Surrounding Skin Color: Bright Red Is resident experiencing pain related to wound: Yes; Non-verbals Demonstrated: Grimacing, Moaning/Crying; Pain Location: coccyx wound; Nature of Pain: "that's tender", only with palpation/touch of wound with	F 314			

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F 314	<p>Continued From page 27</p> <p>assessment; Comments: Coccyx pressure ulcer measures larger in size over past week. Wound was debrided by PT 5/6/14. Wound is unstageable d/t presence of slough and eschar. Wound bed covered 90% with gray loose slough and 10% black eschar. Wound measures at least 1.3cm deep, but unable to measure full depth d/t slough/eschar. Wound edge undermining present 11-2 o'clock measuring 0.5 cm with likely further undermining present with further debridement of wound, intact skin at wound edges 11-2 o'clock is boggy to touch and bright red/purple, extending out 2cm-blanchable. Periwound skin 2cm red blanchable extending out 2cm more dark pink, blanchable. Wound drainage remains purulent, large amount, dressing removed 100% saturated, with foul odor evident. Pt. using oral and topical antibiotic treatment to resolve infection. Dressing changed per aseptic technique per MD orders, periwound skin protected with No Sting.</p> <p>5/7/14 - CP revision, "Minnesota solution wet to dry dressing to coccyx TID [three times per day], open gauze fully and loosely pack into wound;" "Monitor nutritional status. Serve diet as ordered (trial full liquid, fortified, Mighty shakes TID and offer toast with each meal, 2oz [ounces] 2Cal TID, snacks TID, 2 scoops protein powder TID mixed in pudding or fruit, monitor intake and record;" and,</p> <p>"PT [Physical Therapy] to evaluate and treat for sharp debridement of coccyx wound."</p> <p>Note: The pressure ulcer started as a stage 2 and deteriorated to an unstageable pressure ulcer with an infection.</p> <p>On 5/8/14 at 8:40 a.m., the DON and LN #4 were interviewed regarding Resident #9's pressure ulcer. When asked how the pressure ulcer</p>	F 314			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2014
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318	
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F 314	Continued From page 28 developed in the first place, LN #4 said it was because of age, skin fragility and vascular disease issues which were mostly in the resident's legs. The LN added the Physician stated that the pressure ulcer was unavoidable. The LN was asked about the resident's nutritional status prior to the development of the pressure ulcer. She stated the resident had poor nutritional status related to eating less than 25% of meals, would push staff away and the resident did not want supplemental nutrition. The LN said the CNA staff did not chart repositioning or toileting. When asked how the LN knows staff are turning and toileting the resident, she said the charge nurses oversee cares everyday with general oversight to ensure cares are being provided. LN #4 was asked what interventions were put into place after the pressure ulcer developed. She said the facility changed support surfaces to an airbed, continued with the roho cushion, dietary changes and continued with repositioning and check and change. The LN added they inserted a foley catheter to prevent infection. When asked what extended periods of time in the wheelchair meant, which was written in the SPUW notes, the LN stated, "Greater than 2 hours at a time." The LN continued that the weekend of 4/20/14 the resident celebrated her 102nd birthday and had multiple parties throughout the weekend with family and friends. LN #4 was asked if during that weekend the nursing staff attempted to provide pressure relief for the resident such as off-loading, laying in bed or toileting. She was also asked if the nursing staff provided any education to the family regarding the importance of pressure relief related to the pressure ulcer. The LN said the nurses were concerned and offered and tried to lay the resident down during down times and educated the family.	F 314		

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F 314	<p>Continued From page 29</p> <p>Documented evidence was requested. When asked why the pressure ulcer deteriorated to an unstageable pressure ulcer and acquired an infection, the LN said it was general condition decline and incontinence of bowel.</p> <p>Note: No documentation from the birthday weekend was provided.</p> <p>On 5/8/14 at 11:00 a.m., LN #4 provided a Physician's Order from May 2013 for Resident #9 which included an order for the roho cushion in the wheelchair. She also said prior to the development of the stage 2 pressure ulcer the resident was using a foam based mattress. The LN was asked if there was any additional documentation from the night of 3/27/14 and 3/28/14 which might provide clarity on the situation. After the LN reviewed the clinical record, no further documentation was provided regarding the night the pressure ulcer developed.</p> <p>Resident #9 acquired a stage 2 pressure ulcer to the coccyx; documentation shows the resident was not turned the night prior to the pressure ulcer's development, and no documentation the resident was toileted or checked and changed. The wound declined to an unstageable pressure ulcer after the resident spent extended periods of time in the wheelchair over the course of a weekend; the clinical record did not contain documentation the facility attempted measures to reduce the time spent in the wheelchair, or to offload pressure from her coccyx. In addition, the unstageable pressure ulcer developed an infection; there was no documentation the resident was toileted or checked and changed to prevent fecal contamination of the wound.</p> <p>2. Resident #1 was admitted to the facility on</p>	F 314			

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F 314	<p>Continued From page 30</p> <p>10/3/2005 with multiple diagnoses. The most current diagnoses include peptic ulcer, depression, and osteoarthritis.</p> <p>Resident #1 annual MDS assessment, dated 3/4/14, coded: *BIMS of 13, indicating the resident was cognitively intact; *No behavioral symptoms; and *Extensive assistance of one for bed mobility; extensive assistance of two for transfers, dressing, personal hygiene, and toileting.</p> <p>On 3/12/14 Resident #1's Care Area Assessment (CAA) for pressure ulcers form documented. "Pressure relief mattress and wheel chair (w/c) cushion in use. [Note: It was unclear what specific mattress or cushion were in place or what the pressure relieving characteristics were]. Staff assist resident with toileting and perianal cares to keep skin clean and dry. Daily skin screening during cares and baths. Weekly head to toe skin checks by license nurse (LN). She is at risk for skin breakdown related to dx/meds, decreased mobility, exposure to moisture, and poor cognitive status."</p> <p>Facility documentation regarding the wound included. Skin assessment weekly (SAW), Skin Ulcer Non-Pressure Weekly (SUNPW), Skin Pressure Ulcer (SPU), Weekly Interdisciplinary Team Skin Review Weekly Update (WITSRWU), Pressure Ulcer Prevention Policy, Care Plans (CP), Physician's Telephone Orders (PTOs), facility physician's notification form, Resident Incident form (I/As) Progress Notes (MD PN's), Nurses's Progress Notes (PN's), Physician's Orders, Daily Ulcer Observation Record (DUOR), MARs, Physician Visit Communication Record (PVCR)MDS, CAAs, Behavior Monthly Flow</p>	F 314			

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F 314	<p>Continued From page 31</p> <p>Sheet MARs and TARs. The time line of the wound was documented as:</p> <p>On 4/2/14, a Skin Assessment Weekly (SAW) for the resident documented her skin was warm, dry, and fragile with lower extremities discolored. Edema was noted on her lower extremities.</p> <p>On 4/7/14 at 5:00 PM, an Incident Report (I/A) documented, "Certified Nursing Assistant (CNA) called the LPN in to assess...skin issue to left hip. Area is 6 centimeter (cm) by (x) 5 cm round with 1.5 x 1 cm black/discolored open area to center. No drainage or odor noted, Res denies pain to area. Res lays on left side at night. Issue is located on a bony prominence." The I/A documented the plan for the resident was to have foam Tegaderm placed and changed every 3 days and as needed, repositioned every two hours while in bed and in wheel chair (WC), use bath blanket folded to relieve pressure when in WC [Note: "A folded blanket does not provide pressure relief"], covered her toilet screws, nuts, and bolts with sheep skin, and check the resident's left hip more than every two hours. The form further documented, "CNA's said no skin issue was reported to them and they found area while toileting [resident] around dinner time." On 4/8/14, Resident #1's care plan was documented:</p> <p>*Focus-"Has actual skin impairment related to pressure ulcer to left posterior hip. [Patient] is at high risk for poor or delayed wound healing due to poor intake of calories and protein, anemia, thyroid disease, incontinence, use of diuretic and anticoagulation therapy and increased ADL dependence."</p> <p>*Goal-"To be free of slough and signs/symptoms of infection by next review.</p>	F 314		

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F 314	<p>Continued From page 32</p> <p>*Interventions-"Hydration, wound care, education, daily ulcer observation and documentation, keep wound dry, patient off left hip, monitor labs, encourage good nutrition, toileting or change briefs every 2 hours and as needed, off loading pressure from left hip, use airbed, and roho cushion."</p> <p>[Note: Other facility documentation did not identify wound as a pressure ulcer was not initiated until 4/18/14.]</p> <p>On 4/8/14, a Nurse Progress Notes (PN) documented, "Assessed area to left hip. Area continues with non-blanchable redness to outer area with middle hard black tissue. No c/o pain. No drainage noted. Foam dressing changed. resident repositioned. Fax sent to [physician] for airbed and roho cushion."</p> <p>On 4/8/14, a MD order documented, "Change foam dressing to left hip every three hours and and as needed until resolved. Every 72 hours."</p> <p>On 4/9/14, a MD order documented, "May have air bed and roho cushion for WC..."</p> <p>On 4/10/14, a PVCR documented, "Suspected deep tissue injury to left hip-Foam [dressing] in place for protection (no drainage), denies pain with palpation. Need order for wound nurse/specialist consultation."</p> <p>On 4/10/14 at 5:05 PM, a PN documented, "Patient returned from wound care clinic with verbal report from [employee] physical therapist (PT)...stating to keep pt (patient) off left ischeal when laying, very limited time up sitting each day for meals, keep area dry, no debridement at this time, cover with foam dressing as ordered. Roho wheelchair cushion has been placed to wheelchair seat for additional pressure</p>	F 314			

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F 314	<p>Continued From page 33 reduction."</p> <p>On 4/10/14, a MD order documented, "Keep patient off left hip 100% of the time. Every shift for wound to left hip."</p> <p>On 4/11/14, MD order documented, "May X-ray left hip."</p> <p>On 4/11/14 a Skin Ulcer Non-Pressure Weekly (SUNPW) form documented, "Requesting consult with Wound Ostomy Certified Nurse (WOCN) and x-ray of left hip ordered to r/o (rule out) previous hip repair hardware issues. Wound may be reclassified following further follow up with MD, WOCN and x-ray."</p> <p>On 4/11/14, a SUNPW documented, "Wound on left hip with black dry eschar, leathery to touch, portioned skin blanchable, bright red oval shape, and purple discoloration with no drainage. Wound measured at 1.5 cm x 1.5 cm, depth was unable to determine, tunneling unable to determine, and undermining was unable to determine." *The SUNPW narrative documented on 4/11/14, stated, "New wound to left posterior hip presented 4/8/14 with rapid onset. Cause at this time is being fully determined. Wound is 100% covered with black dry eschar, leathery to touch."</p> <p>On 4/11/14 at 12:20 PM, an Interdisciplinary Team Skin Review Weekly Update (ITSRW) documented, "The resident's wound to the left posterior hip. Resident was provided a Panacea AirAdvance airbed and a roho cushion for additional pressure reduction, assisted with turning and reposition every 2 hours and as needed. Resident also assisted with toileting every 3 hours and as needed. Foam dressing to</p>	F 314		

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F 314	<p>Continued From page 34</p> <p>left hip change every 3 days and as needed. X-ray ordered on 4/14/2014 to rule out hardware malfunctions. "As part of the ITSR, the dietician completed a consultation and recommended protein powder twice daily, contact physician and request consult with the WOCN, Multivitamin (MVI) with minerals, and prealbumin lab. ITSR documented, "Patient (Pt) is at risk for poor or delayed wound healing due to inadequate intake of protein and calories, anemia, thyroid disease, incontinence, use of diuretic and anticoagulant therapy."</p> <p>On 4/12/14 at 10:37 AM, a PN regarding the wound documented, "No drainage noted, tolerates well. Also dressing to left hip intact...did well without laying on left side. did lay down on airbed directly after meals...change foam dressing to left hip every 3 days and as needed until resolved."</p> <p>On 4/14/14, Daily Ulcer Observation Record (DUOR) documented tracking of wound through 4/17/14. *Note: There was no DUOR documented from 4/18/14 through 4/21/14, or 4/26 through 5/3/14.</p> <p>On 4/16/14, Resident #1's quarterly MDS documented: *High risk pressure ulcer; *No Pressure ulcers present; *Pressure at stage one or higher; * 1 unstageable; * Zero pressure ulcers at stage 2, 3, or 4; * Pressure ulcer was documented at 1.5cm x 1.5cm</p> <p>On 4/16/14, Skin Pressure Ulcer Weekly (SPUW) for the resident documented her "pressure ulcer to be unstageable with slough and</p>	F 314			

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F 314	<p>Continued From page 35</p> <p>eschar...wound to left posterior hip is unchanged in size, continues to be covered with dry black eschar 100% of wound...X-ray to left hip completed with normal findings." [Note: On 4/11/14 the ITSRW documented new wound on left hip and recommendations. The DUOR did not document daily skin checks prior to 4/14/14, and the next Skin Pressure Ulcer weekly was completed on 4/16/14, at which time the pressure ulcer was documented as unstageable].</p> <p>On 4/18/14, a MD order documented, "May have wound care specialist referral for decubitus left hip. Keep her off of her left hip 100% of the time. Toilet and change attends every 2 hours while awake."</p> <p>On 4/23/14, a SPUW for Resident #1 documented the pressure ulcer as 1.3 cm x 1.3 cm with the edges lifting, scant serosanguinous drainage, no signs or symptoms of infection and continues to be unstageable. Narrative stated, "Due to patient dementia [and] safety challenged to keep [patient] with pressure off loaded from hip 100% of the time."</p> <p>On 4/25/14, a Physician Visit Communication Record (PVCR) documented, "Wound on [left] hip-Debrided hip today with sterile conservative sharp debridement...peri wound abrasion that is sealed. The wound is now 100% . Use Decoderm paste...agree that [patient] should be off of this area as much as possible. Will have staff call if not continuing to progress."</p> <p>On 4/30/14, a SPUW for Resident #1 documented the pressure ulcer as 1 cm x 1.2 cm. The wound was documented with serous</p>	F 314			

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F 314	<p>Continued From page 36</p> <p>drainage, small with no odor, and continues to be unstageable with slough/eschar.</p> <p>On 5/3/14, a MD order, "May be on left hip for 5 minutes at most, four times a day...as needed, sharp debridement only by MD or wound specialist."</p> <p>On 5/5/14 at 3:10 PM, Resident #1 was observed sitting next to the nurses station. This surveyor asked the resident how she was doing. Resident stated, "Feeling good, sitting mostly. Listening to whatever comes my way."</p> <p>*3:20 PM, RN #1 asked resident #1 if she was ready to take a rest. Resident #1 stated, "No, I really don't." The RN walked away after informing the resident she would check back later.</p> <p>*3:25 PM, RN #1 escorted resident #1 to her room.</p> <p>*3:35 PM, Resident #1 was in bed, positioned on her right side, and appeared to be asleep.</p> <p>On 5/6/14, a SPUW for Resident #1 documented no changes in size, shape, or color. The narrative stated, "Pt. was positioned onto right hip with positioning pillows placed to help keep pt. onto right side."</p> <p>On 5/6/14 at 10:30 AM, Resident #1 was observed in her bed, sleeping on her right side.</p> <p>*11:15 AM, Resident #1 was laying in her awake and was positioned on her right side. The Surveyor asked her how she was doing. Resident stated, "I'm okay, as long as I stay on my right side."</p> <p>*3:55 PM, Resident #1 was in her room in bed, positioned on her back, leaning towards her right side with her knees bent and leaned to her right side.</p>	F 314			

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F 314	<p>Continued From page 37</p> <p>On 5/7/14 at 3:17 PM, the surveyor discussed skin integrity with the ADON and DNS. The ADON stated, "Initially, when we identified her wound we were not convinced of pressure. Because it had not been there at lunch [Note: Lunch is served at 12:15 PM and dinner is served at 6:15 PM]. But then when they got her up for supper, it was there... we investigated, removed the wing nuts from the toilet seat, padded the commode, examined the environment. We requested an x-ray due to the history of surgical repair on her. The physician felt it was pressure.</p> <p>*The surveyors asked about skin protection plan prior to pressure ulcer. ADON stated, "Toileting, barrier cream, mat cushion, and pressure reducing mattress on bed." [Note: Pressure reducing mattress is a lesser level of protection than the air mattress provided after the pressure ulcer developed].</p> <p>*Asked how often Resident #1 is toileted. ADON stated, "Can't tell you right off the bat. Resident specifics are in her CP."</p> <p>[Note: The facility was unable to state if Resident #1 was moved, repositioned, or toileted approximately five hours before her skin breakdown was discovered.</p> <p>On 5/8/14 at 9:00 AM, the surveyors discussed Resident #1 with Medical Director. The Surveyor informed him the resident had been put to bed after lunch according to the ADON. [Note: Resident #1's I/A report on 4/8/14 documented skin as, " no skin breakdown]. Approximately five hours later, she got up for dinner and had a skin breakdown, and the facility could not state when she was repositioned or toileted. The Surveyor asked, "Is five hours long enough for skin to breakdown?" Physician stated, "Yes."</p>	F 314			

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F 314	<p>Continued From page 38</p> <p>On 5/8/14 at 9:45 AM, the surveyor observed dressing change on Residents #1 left hip wound. The wound measured 1.1 cm x 1.0 cm, but the depth could not be measured. There was no drainage, with induration to the posterior end of the wound. Upon palpation RN #4 stated, it was hard to the touch. The wound was white with a creamy tone presenting towards the center of the wound. There was a small black crescent moon shaped area on the upper right lateral aspect of the wound, which RN #4 identified as eschar. Upon palpation the white area of her wound was described as soft. The wound bed could not be visualized, therefore the wound could not be staged.</p> <p>On 5/9/14 at 9:45 AM, the Administrator and the DNS were informed of the surveyor's findings. The facility offered no further information.</p> <p>3. Resident #4 was admitted to the facility on 12/6/13 with multiple diagnoses including rehabilitation related to a left hip fracture, difficulty in walking, and muscle weakness.</p> <p>The facility's Pressure Ulcer Prevention Policy dated 6/12/13 documented: "ON-GOING RISK ASSESSMENT: 1. All residents will be assessed weekly and prn by the licensed nurse for any skin issues... IMPLEMENTATION OF CARE PLAN: 1. Facility staff will be responsible for implementing the care plan for prevention and treatment of pressure ulcers..."</p> <p>Resident #4's Admission MDS dated 12/12/13, documented the resident: * Had one stage I pressure ulcer and one</p>	F 314			

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F 314	<p>Continued From page 39</p> <p>unstageable pressure ulcer;</p> <ul style="list-style-type: none"> * Was severely cognitively impaired; * Was frequently incontinent of bladder; * Was occasionally incontinent of bowel; * Required extensive two person assist with bed mobility; and * Required extensive two person assist with transfers. <p>The resident's LN-Admission Assessment Comprehensive dated 12/6/13 documented, the resident had a stage I pressure ulcer to the right gluteal fold and an unstageable pressure ulcer to the left heel.</p> <p>The resident's LN-Braden Scale for Predicting Pressure Sore documented: *12/6/13-"Low Risk" with a score of 15, and *12/19/13-"High Risk" with a score of 11.</p> <p>The resident's Care Plan dated 12/7/13, documented: "Focus: Has actual impairment to skin integrity r/t [related to] Abrasion, Fragile skin, Abrasion to right and left buttock and coccyx... Interventions: Follow facility protocols for treatment of injury. Identify/document potential causative factors and eliminate/resolve where possible..., Encourage good nutrition and hydration in order to promote healthier skin. Focus: Has pressure ulcer stage 1 right buttock... Interventions: Educate rresident [sic], family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning..., Needs monitoring/reminding/assistance to</p>	F 314			

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F 314	<p>Continued From page 40</p> <p>turn/reposition at least every 2 hours, more often as needed or requested..., Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care..., Weekly head to toe skin at risk assessment." Note: The care plan did not include an intervention for a pressure relieving device for the resident's wheelchair or bed.</p> <p>The resident's December 2013 TAR documented an order on 12/6/13 for, "High Risk for skin breakdown skin checks Q [every] week." The space for 12/13/13 was blank on the TAR, indicating the skin check was missed that day.</p> <p>The following documentation was gathered from Resident #4's LN-Skin Pressure Ulcer Weekly assessment (SAW), Physician's Progress Notes (MDPN), Physician's Orders (MD orders), and care plan (CP): 12/11/13- MD Orders, "Apply foam dressings to ulcers on buttocks, change q3 days and prn until resolved." 12/18/13- CP revision, "Focus: Has pressure ulcer to...coccyx." 12/18/13- MD Orders, "Apply foam dressings to ulcer to coccyx, change q3 days and prn until resolved." 12/19/13-SAW, "Date of Onset: 12/17/2013, Site: Coccyx, Stage: Unstageable, Size: 3 cm x[by] 1 cm, Comments: Pressure ulcer to coccyx with new onset this week. Mention made in previous nursing assessments of abrasion to coccyx, but now presents as an unstageable ulcer. Wound bed is 100% covered with yellow slough, unable to determine full depth d/t [due to] slough. Periwound skin is blanchable, but reddened extending out 2 cm from wound bed. Wound with</p>	F 314			

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F 314	Continued From page 41 only scant serous drainage and no foul odor...Wound cleansed with NS (normal saline), no sting barrier applied to periwound skin and foam dressing was applied per aseptic technique. Pt.[patient] tolerated wound assessment and dressing changes well without s/s [signs and symptoms] of pain. Pt. was assisted to position off buttocks into side lying position with extensive assistance..." 12/19/13- MDPN, "Coccyx-small ulcer." 12/19/13- CP revision, "Interventions: Monitor nutritional status. Serve diet as ordered, monitor intake and record. (nutritionally enhanced meals, ice cream BID with lunch and dinner and high protein snacks BID added 12/19/13); Requires pressure relieving/reducing device on panacea mattress to bed and geomat to w/c [wheelchair] seat; Requires the bed as flat as possible to reduce shear." 12/23/13- SAW, "Site: Coccyx, Size: 1.5 cm x .5 cm, Comments: Pressure ulcer to coccyx is improved over past week measuring smaller in size and now presents as stage 2 ulcer with wound bed red and granular, superficially open with scant serous drainage. No s/s of infection and no periwound redness. Periwound skin is pink, blanchable and intact..." 12/23/13- MDPN, "Some breakdown to coccyx. Has had some improvement." 12/23/13- MD Orders, "Air bed, RoHo cushion to W/C until Pressure issues clear-Complex." 1/2/14- SAW, "Site: Coccyx, Size: 4 cm x 3.5 cm, Comments: Pressure ulcer present to coccyx has increased in size over past week and is now unstageable. Wound is 40% dark purple at out edges of wound, 40% yellow slough to center and 20% red granular. Due to presence of slough at center wound, is now unstageable as unable to	F 314			

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F 314	<p>Continued From page 42</p> <p>visualize full depth of wound d/t slough. Periwound skin is bright red, blanchable and extends out 4 cm from wound edges. No s/s of infection is evident. Serosanguinous drainage present...Dr. [Physician Name] was contacted with wound assessment and request change of treatment orders & possible WOCN [wound ostomy certified nurse] consult. Pt. denies pain with dressing changes..." Note: This was bigger than the original onset size.</p> <p>1/8/14- SAW, "Site Coccyx, Size: 3.5 cm x 3.5 cm, Comments: Pressure ulcer to coccyx is smaller in length this week compared to last week, however, wound presents this week as an unstageable pressure ulcer due to presence of black eschar over 100% of wound bed, firmly adhered. Moderate amount of serosanguinous drainage present with slight foul odor. Periwound skin is pink and blanchable, redness present last week is resolved..."</p> <p>1/8/14- MD Orders, "Duoderm paste to wound bed coccyx wound with foam dressing cover, change q2 days and prn..." and "WCLN [wound clinic licensed nurse] to consult on coccyx wound-Complex."</p> <p>Note: On 1/13/14, the resident was sent to a local hospital for 4 days for an unrelated surgery.</p> <p>On 5/7/14 at 4:50 PM, RN #4 was interviewed regarding the pressure ulcer. She said they did not know how the unstageable pressure ulcer to the resident's coccyx occurred, but they thought it could have been from laying on the operating table at a local hospital for too long, prior to her admission on 12/6/13. However, since the ulcer was discovered 11 days after admission, RN #4 stated, "We took it as an ulcer in house."</p> <p>On 5/7/14 at 5:35 PM, RN #4 was asked for a clarification regarding the SAW documentation</p>	F 314		

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F 314	Continued From page 43 from 12/23/13, where it documented the unstageable ulcer became a stage II. She said they were not trying to back stage the original ulcer, but rather explain what the ulcer looked liked at the time of observation. She also said after initial improvement the ulcer worsened, but they did not know how that happened. Despite having been admitted with a stage I pressure ulcer to the buttocks and an abrasion to the coccyx, the resident did not receive appropriate prevention measures such as a pressure relieving device to her wheelchair or bed until after the development of an avoidable unstageable ulcer to her coccyx. Also, the facility failed to assess the resident's skin as ordered when a skin check was missed 4 days prior to the onset of the coccyx ulcer. On 5/8/14 at 4:50 p.m., the Administrator and DON were informed of the pressure ulcer issues. No further documentation was provided.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined	F 323	F323 (D) Free of Accidents Hazards 1) Resident #1's call light mat was completely re-secured to the floor. 2) Other residents with call light mats have the potential to be affected by this practice. All were checked and secured completely. 3) The staff were inserviced to watch for loose tape on the call light mats and notify maintenance immediately. The maintenance staff are checking each mat daily for security and functionality. 4) Beginning on 6-13-14 the administrator or designee will conduct audits to ensure		

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F 323	<p>Continued From page 44</p> <p>the facility failed to ensure adequate supervision to prevent falls, and to provide an environment as free as possible from accident hazards. This was true for 1 of 8 residents (Resident #1) sampled for environmental safety. The deficient practice had the potential to cause more than minimal harm if a resident tripped over an exposed cord in her room.. Findings included:</p> <p>Resident #1 was admitted to the facility on 10/3/2005 with multiple diagnoses. the most current diagnoses include peptic ulcer, depression and osteoarthritis.</p> <p>Resident # 1 annual MDS assessment, dated 3/14/14, coded: *BIMS of 13, indicating the resident was cognitively intact: *Extensive assistance of one for bed mobility, extensive assistance of two for transfers, dressing, personal hygiene, and toileting.</p> <p>On 3/6/14, a FSI documented Resident #1 was found on the floor. Resident informed CNA she was reaching for her colored pencils.</p> <p>On 4/22/14, a FSI documented Resident #1 was found on the floor next to her bed. Resident informed investigating party she was tired of laying in bed and was trying to get her in her W/C parked next to bed when legs got weak and she slid to ground. PN documented interventions which included repositioning of the call light mat from a horizontal position to vertical.</p> <p>On 5/5/14 at 3:10 PM, the surveyor observed Resident # 1's call light mat taped to the floor with duct tape. The cord attached to the call light mat was not fully secured with the tape.</p>	F 323	<p>call light mats are fully secured weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5) Date of compliance is on <u>6-18-14</u>.</p>		

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F 323	Continued From page 45	F 323		
F 327 SS=D	<p>On 5/9/14 at 9:45 AM, the Administrator and DNS were informed of the surveyor's findings and of the potential safety concerns regarding the risk of fall.</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, it was determined the facility failed to have water in the residents room or within the residents' reach, 2 of the 5 days during survey. This was true for 2 of 7 residents (Resident #1 and Resident #3) sampled for hydration. The deficient practice had the potential to cause more than minimal harm if residents became dehydrated. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 10/3/05 with multiple diagnoses. The most current diagnoses included peptic ulcer, depression, and osteoarthritis.</p> <p>Resident #1's Annual MDS assessment, dated 3/4/14, coded: *BIMS of 13, indicating the resident was cognitively intact; *No behavioral symptoms; *Extensive assistance of one for bed mobility; extensive assistance of two for transfers; and supervision with setup help only, for eating.</p>	F 327	<p>F327(D): Hydration</p> <p>1) Resident #1 and #3 had water pitcher placed with in reach as soon as facility was made aware.</p> <p>2) Residents without fluid restriction, thickened liquids, npo, etc. orders have the potential to be affected by this practice. All nursing staff were in-serviced on the importance of availability and accessibility of fluids as required.</p> <p>3) Staff on each shift will ensure fluids are available & accessible to residents as needed. LN's will be in-serviced on the need to document Q shift that hydration was available & accessible to residents without fluid restrictions as required.</p> <p>4) Beginning on <u>6-6-14</u> the administrator or designee will conduct audits to ensure residents without fluid restriction, etc. have availability & accessibility to fluids as required weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5) Date of compliance is on <u>6-12-14</u></p>	

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FACILITY STANDARDS

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F 327	<p>Continued From page 46</p> <p>Resident # 1's Care Plan documented: *Focus-"Has actual skin impairment related to pressure ulcer...[patient] is at high risk for poor or delayed wound healing due to poor intake of calories and protein," revisited on 4/8/14. *Intervention-"Encourage good nutrition and hydration on 4/30/14." *Focus-"At risk for falls related to intermittent confusion," revised on 4/30/14. *Intervention-"Keep needed items, water, etc in reach." [Note: Resident #1 does not have a focus area for hydration.]</p> <p>The surveyor made the following observations regarding Resident #1:</p> <p>On 5/5/14 at 3:25 PM, the resident was escorted to her room by staff and placed in bed. Resident #1 did not have any water within reach, nor was any water in the room.</p> <p>On 5/6/14 at 10:30 AM, the resident was in her room sleeping. There was no water container available in her room.</p> <p>*On 5/6/14 at 11:15 AM, the resident was laying on her bed awake. The surveyor observed water had not been placed in her room. The surveyor discussed the lack of water in the room. Resident #1 stated, "I get water brought to me."</p> <p>*On 5/6/14 at 3:55 PM, Resident #1 was sleeping in her room. The surveyor noticed two glasses containing water on the sink, approximately six feet away from the resident.</p> <p>On 5/7/14 at 9:30 AM, the DON and ADON were</p>	F 327			

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F 327	<p>Continued From page 47</p> <p>interviewed about hydration for Resident #1. When asked if resident should be provided with water in her room the DON and ADON stated, "Yes." The surveyor asked the ADON if she would be surprised to discover resident #1 had not had water in her room. DNS stated, "Yes, water should be provided every shift."</p> <p>On 5/9/14 at 9:45 AM, the Administrator and DON were informed of the Surveyor's concerns. The facility provided no further information.</p> <p>2. Resident #3 was admitted to the facility on 11/18/11 with multiple diagnoses which included dementia and ischemic cerebrovascular disease.</p> <p>The most recent significant change MDS assessment for Resident #3, dated 4/14/14, documented:</p> <ul style="list-style-type: none"> * Severely impaired cognition with a BIMS of 2; * Extensive assistance required with 1 person for bed mobility, transfers and eating; * Range of motion impairment on one side of the upper and lower extremities; and, * Frequently incontinent of bladder. <p>Resident #3's Care Plan documented:</p> <ul style="list-style-type: none"> * Focus - "Has potential/actual impairment to skin integrity r/t [related to] Abrasion right hip," date initiated 4/27/14; * Interventions - "Encourage good nutrition and hydration in order to promote healthier skin;" * Focus - "Has bladder incontinence r/t history of incontinence and large inguinal hernia Dx [diagnosis]-stress incontinence," date initiated 8/11/13; * Interventions - "Encourage fluids during the day 	F 327			

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F 327	<p>Continued From page 48</p> <p>to promote prompted voiding responses;"</p> <p>* Focus - "At risk for falls r/t Unaware of safety needs, Poor communication/comprehension, Psychoactive drug use, Vision/hearing problems, balance problems," date initiated 8/11/13; and,</p> <p>* Interventions - "Keep needed items, water, etc, in reach."</p> <p>The following observations were made by the surveyor of Resident #3 and his room:</p> <p>* 5/5/14 at 3:05 p.m., the resident was lying on top of his bed. There was no water pitcher and no cups were observed in the resident's room;</p> <p>* 5/5/14 at 3:40 p.m., the resident was lying on top of his bed with no water pitcher or cups with or without fluids in his room;</p> <p>* 5/6/14 at 8:15 a.m., the resident was not in his room. There were no cups with or without fluids and no water pitcher observed in the room;</p> <p>* 5/6/14 at 9:11 a.m., the resident was not in his room. There was an empty, upside down plastic cup next to the sink;</p> <p>* 5/6/14 at 10:05 a.m., the resident was sitting in his wheelchair in his room working on a yarn project. No fluids were observed in the room;</p> <p>* 5/6/14 at 11:38 a.m., the resident was sitting in the wheelchair in his room looking inside his closet. No fluids were observed in the room;</p> <p>* 5/6/14 at 1:43 p.m., the resident was lying on his bed covered with blankets. A water pitcher was observed on the right side of the sink, out of reach of the resident;</p> <p>* 5/6/14 at 2:10 p.m., the resident was lying on his bed and a visitor was present. The water pitcher was beside the sink, out of reach of the resident; and,</p> <p>* 5/6/14 at 3:40 p.m., the resident was lying on his bed with the water pitcher beside the sink and out of reach.</p>	F 327			

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F 327	Continued From page 49 On 5/7/14 at 3:05 p.m., LN #2 and the Social Worker (SW) were interviewed about hydration for Resident #3. When asked if the resident was on a fluid restriction the SW stated, "No." They were asked how the resident was encouraged to have good hydration and the SW said they offer fluids with meals and cares and have water at the bedside. When asked if there would be any reason Resident #3 would not have fluids available in his room, the SW said the resident should have fluid in his room and that the CNA's pass water every shift. LN #2 and the SW were informed of the observations of the resident without fluids available in his room, and when there was a water pitcher in his room, it was out of reach. On 5/7/14 at 6:50 p.m., the Administrator and DON were informed of the hydration issues. No further information was provided. On 5/8/14 at 2:45 p.m., Resident #3 was lying in bed with the water pitcher on the bedside table which was across the room and out of reach.	F 327		
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F329 (E) Unnecessary Drugs 1) Residents #1, 2, 4, 5 and 10 care plans were updated as needed, behavior monitors were updated, and diagnosis were corrected on all forms. 2) All other residents on anti-psychotic medication have been reviewed for appropriate diagnosis, target behaviors, justification for use, GDR, and risk vs. benefits. The licensed nursing staff were inserviced regarding the conditions in which anti-psychotics can be used in	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/09/2014
NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318		
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F 329	<p>Continued From page 50</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 observation, staff and resident interview, and record review it was determined the facility failed to: *Ensure medication regimens were evaluated for the need for duplicate therapies; *Ensure appropriate indications and monitoring for the use of anti-psychotic medications; *Ensure medication regimens were evaluated for possible adverse reactions or drug interactions; and *Had identified non-pharmacological interventions prior to initiating or increasing psychotropic medications, or the administration of "as needed" medications for anxiety and/or sleep. This was true for 5 of 6 residents (Resident #s 1, 2, 4, 5, and 10) sampled for the use of psychotropic medication use. The deficient practice had the potential for more than minimal harm from receiving duplicate therapy and/or medications without adequate indication or monitoring. Findings included:</p>	F 329	<p>residents with dementia, as well as, behavior documentation, not giving multiple prn medications at the same time, but administering one to see if it is effective prior to further intervention. Duplicate therapy of medications for residents #4 & #5 have been reviewed by the IDT, including the physician, and found to be clinically necessary.</p> <p>3) The psychotropic drug committee will review monthly residents on anti-psychotic drugs for upcoming GDR, risks vs. benefits, justification, behavior monitoring and diagnosis. The IDT will be responsible for ensuring residents with dementia meet all criteria for treatment with antipsychotic medications and that non-pharmacological interventions have been attempted and appropriate behavior documentation is in place. In cases of duplicate therapy the IDT, including the physician, will meet to review the clinical justification of multiple medications in the same category.</p> <p>4) Beginning on <u>6-9-14</u> the DNS or RN designee will audit new psychoactive med orders for the above weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5) Date of compliance is on 6-18-14</p>		

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F 329	<p>Continued From page 51</p> <p>1. Resident #5 was admitted to the facility on 6/20/12. Her multiple diagnoses included CHF, dementia, depression and anxiety. She was re-admitted on 12/29/13 with a new diagnosis of a right wrist fracture.</p> <p>Resident #5's most recent annual MDS, dated 6/24/13, coded: *BIMS of 6, indicating severely impaired cognition; *No hallucinations or delusions; *No behaviors affecting others; *Extensive assistance of 1 person for transfers, bed mobility, and hygiene; *Extensive assistance of 2 persons for dressing, toilet use, and bed mobility; *Rare pain, characterized as mild, not impacting sleep or daily activities; *Received scheduled and PRN pain medications; and *No non-medication interventions in place for pain; and *Anti-anxiety medication received each day for the past 7 days.</p> <p>Documentation was gathered from Resident #5's Physician's Progress Notes (MD PN), Nurse's Progress Notes (PN), Physician's Orders (MD orders), care plan (CP), Behavior Monthly Flow Sheets (BMFS), MAR, TAR, Pain Management Flow Sheet (PMFS), BM (bowel movement) report, Psychotropic Drug Review Forms (PDRF), Consent for Psychotropic Medication Forms (CPMF), Social Services Communication Forms (SSCF), MDS, and Fall Scene Investigation Reports (FSI).</p> <p>Resident #5's medication orders, listed on her</p>	F 329			

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F 329	Continued From page 52 December 2013, documented: *Xanax 0.25 mg every 4 hours PRN, starting 6/20/12, for anxiety; *Xanax 0.25 mg daily, starting 6/20/12, for anxiety [NOTE: The resident did not have a care plan documented for anxiety until 9/30/13]; *Norco 10-325 mg three times daily, starting 6/24/13, for pain; *Tramadol HCl 50 mg twice daily, starting 6/29/13, for pain [NOTE: The resident did not have a care plan documented for pain until 12/5/13]; *Lactulose 20 gm/30 ml, 30ccs twice daily, starting 6/20/12, for constipation; *Colace 100 mg twice daily, starting 6/20/12, for constipation; *Miralax 17 gm daily, starting 6/26/12, for a diagnosis of regularity [NOTE: The resident did not have a care plan for the potential for constipation or the use of bowel medications]; *Ambien 10 mg at bedtime, starting 4/12/13, for insomnia. [NOTE: The resident did not have a care plan for insomnia.] *The resident's order for Ambien was changed from 10 mg routinely at bedtime, to 5 mg PRN at bedtime, on 12/12/13. *Seroquel 12.5 mg at bedtime, starting 9/4/13, for depressive disorder. [NOTE: Per the guidance in the SOM, depressive disorder is not an indication for use for an anti-psychotic medication used in an elderly resident with a diagnosis of dementia.] *A space for the nurse to document s/sx of pain twice daily, starting 10/1/12. [NOTE: This documentation contained only the nurse's initials. It did not include whether or not pain was actually present. If pain was present, there was nowhere to document the quality, severity, location, onset, duration, aggravating factors, or relieving factors. If pain had been noted, the resident did not have	F 329			

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F 329	<p>Continued From page 53 orders for "as needed" pain medications.]</p> <p>On 8/22/13, a PDRF for Resident #5 documented the diagnoses for the resident's psychotropic medications as, "dementing illness with behavior symptoms," "insomnia," and, "depression."</p> <p>Resident #5's December 2013 MAR documented an order for Seroquel 12.5 mg at bedtime daily, starting 9/4/13, for depressive disorder.</p> <p>On 9/19/13, a PDRF for Resident #5 documented the diagnoses for the use of psychotropic medications as "depression," "increased behaviors," "anxiety," and, "insomnia." [NOTE: There was no explanation as to why the diagnosis of "dementing illness with behavioral symptoms" was no longer present.]</p> <p>On 9/30/13, Resident #5's CP was updated with a focus area of, "Antidepressant medication use r/t Depression: Antihypnotic [sic] medication use r/t insomnia Antianxiety use r/t anxiety [sic]." Goal was documented as, "Will be free from discomfort or adverse reactions related to antidepressant therapy through the review date." Interventions included: -"Monitor/document/report to MD prn [sic] ongoing s/sx of depression unaltered by antidepressant meds..." 24 possible symptoms of depression were then listed on the care plan, with no indication as to which were pertinent to this resident. -"Observe for s/sx of following..." A list of 26 possible symptoms wre documented, including, "Confusion, mood change, change in normal behavior, hallucinations/delusions, social isolation, withdrawal, decline in ability to help with/do [ADLs], continence...cognitive function,</p>	F 329			

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F 329	<p>Continued From page 54</p> <p>constipation...diff[iculty] am[ulating], Balance [problems], accidents, dizziness/vertigo, falls...Diarrhea, fatigue, insomnia..." [NOTE: There was no documented history of the resident experiencing many of these symptoms. Even though hypnotic and anti-anxiety medication were identified in the focus area, there were no goals pertaining to the use of those medications.]</p> <p>On 9/30/13, Resident #5's CP was updated with a focus area of, "At risk for falls r/t Psychoactive drug use, Vision/hearing problems, incontinence." Goal was documented as, "Will be free of falls through the review date." Interventions included, "Anticipate and meet needs," "Educate resident/family/caregivers about safety reminders and what to do if a fall occurs," "Encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility," "Keep needed items, water, etc, in reach," "Keep noise in hallway at a minimum," "Monitor for s/s of pain. Treat routinely as needed per nursing assessment of pain...Resident displays pain with s/s of anxiety at times." [NOTE: There were no interventions for the resident to have increased supervision related to the use of after PRN Xanax or Ambien had been administered, even though Xanax individually, and when used in conjunction with Ambien, was identified in the SOM as increasing fall risk.]</p> <p>On 9/30/13, Resident #5's CP was updated with a focus area of, "Has bowel/bladder incontinence r/t Confusion, Dementia." The interventions documented the resident was to wear a disposable brief, and be checked, "as required for incontinence." There was an intervention of prompted toileting 4 times daily, which was discontinued on 11/6/13. [NOTE: This was the</p>	F 329			

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F 329	<p>Continued From page 55</p> <p>only part of the resident's care plan referring to bowel and bladder function. There was no documentation regarding risk for constipation, or interventions to prevent constipation. There were no interventions for the resident to be offered, prompted, or assisted to use the toilet after 11/6/13. There were no interventions to address the use of multiple bowel medications, or the possible adverse effects of those medications, including abdominal pain, urgency, or diarrhea.]</p> <p>On 11/19/13, Resident #5's Activities CP was updated with a Focus of, "Has little activity involvement r/t Resident wishes not to participate most of the time." Goal was documented as, "Will attend 2-3 group activities per week as resident can tolerate..." Interventions included, "Invite...to scheduled activities. Remind her that she doesn't have to stay the whole time...", and, "...needs reminders and encouragement to go to events. She will often times say no, but...will sometimes agree..."</p> <p>On 11/21/13, a PDRF for Resident #5 documented the diagnoses for her psychotropic medications as, "depression," "anxiety," "increased behaviors," and, "insomnia." The resident was documented to have no restless, agitation, anxiety, continuous crying, or extreme fear in the past 30 days. However, the form documented the resident had received 2 doses of "as needed" medication in that period of time. [NOTE: The form did not make it clear which medication had been used "as needed", nor which behavior the medication had been used to treat.] The "Committee Recommendations" were documented as, "Consider decreasing Seroquel 25 mg...to 12.5 mg for adjunct to antidepressant for major depressive disorder. Observe for any</p>	F 329		

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F 329	<p>Continued From page 56</p> <p>change in mental status or increase in depression." The line next to the statement, "Physician agrees with committee recommendations," was checked. The document also contained hand-written check boxes for the physician to mark a diagnosis of either, "Adjunct to antidepressant for major depressive disorder," or, "other." The box next to the option including major depressive disorder was checked. The physician signed the form on 11/25/13, 4 days after the committee's recommendations were documented.</p> <p>Resident #5's BMFS for December 2013 documented behaviors tracked as, "Agitated," "Anxiety," "Continuous crying," "Extreme Fear," "Restless," and, "Ref[usal] of cares." The form documented Seroquel was used for a diagnosis of, "increased behaviors."</p> <p>Resident #5's MAR for December 2013 documented her Ambien order was changed from 10 mg routinely to 5 mg at bedtime as needed on 12/12/13 [NOTE: The resident did not have a care plan for insomnia];</p> <p>On 12/5/13, Resident #5's CP was updated with a focus of, "Has chronic pain related to decreased mobility - right shoulder pain -[right] wrist pain r/t previous [fracture]." [NOTE: This was the first care plan for pain documented for this resident, even though she had been on the same pain medication regimen since 6/29/12.] The goal was documented as, "Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date." Interventions included, "Monitor/document for probable cause of each pain episode. Remove/limit causes where possible," "Monitor/record pain characteristics:</p>	F 329			

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F 329	<p>Continued From page 57</p> <p>Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset; Duration (e.g., continuous, intermittent); Aggravating factors; Relieving factors," "Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decreased ROM, withdrawal or resistance to care," "Monitor/record/report to Nurse any s/sx of non-verbal pain: Changes in breathing...Vocalizations (...yelling out...); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open, narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing); Body (tense, rigid, rocking, curled up, thrashing)."</p> <p>On 12/19/13, an MD PN for resident #6 documented, regarding medications, "...2. Osteoarthritis. 3. Insomnia. She is now on 5 mg." [NOTE: The MD PN did not document regarding pain or pain management, bowel function or medications, or the indication for use of an anti-psychotic and an anti-anxiety agent in addition to the hypnotic medication. The PN did not document which medication was now being administered at 5 mg.]</p> <p>On 12/19/13, a PDRF for Resident #5 documented the resident was receiving Cymbalta, Seroquel, Xanax, and Ambien. The form documented in the past 30 days, the resident had no episodes of restlessness, agitation, anxiety, or extreme fear. The resident was documented with 3 episodes of continuous pacing. The "Committee Recommendations" area of the form documented, "Stable and doing well on current regimen, any change or reduction may result in return of behaviors," and that the current medications be maintained. The line next</p>	F 329			

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F 329	<p>Continued From page 58</p> <p>to the statement, " Physician agrees with committee recommendations," was checked. The physician signed the form on 12/30/13. [NOTE: The date the physician signed the form was 11 days after the committee recommendations were documented, and 3 days after the resident fell, sustained a wrist fracture, and was admitted to the hospital. There was no documentation the physician considered possible adverse effects of the medications, or medication interactions, as a contributing factor to the resident's fall. There was no documentation the committee had considered other medications, such as pain or bowel medications, as a concern when used in conjunction with the psychotropic medications. There was no documentation of other factors, such as pain, constipation, or urgency from multiple bowel medications, as a possible contributing factor to the resident's history of restlessness, agitation, anxiety, fear, or pacing. There was no documentation of non-pharmacological interventions attempted, or the effectiveness of those interventions, when recommending the medications for the resident be continued.]</p> <p>On 12/26/13, Resident #5's MAR documented she received the following medications: *7:00 PM -Tramadol HCl 50 mg; -Lactulose 20 gm/30 ml, 30ccs given; -Colace 100 mg; -Miralax 17 gm; and -Ambien 5 mg. [NOTE: The order for the resident's Ambien was for bedtime.] *8:00 PM -Hydrocodone 10-325 mg; and -Seroquel 12.5 mg.</p>	F 329			

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F 329	<p>Continued From page 59</p> <p>On 12/27/13 at 12:15 AM, an FSI for Resident #5 documented the resident fell in her room and sustained a right wrist fracture. "Attachment #1" to the FSI documented, "...She takes multiple medications including Ambien, Norco, Seroquel, Coreg, insulin, and Xanax...[NOTE: The FSI did not include any evaluation of the use of the identified medications together, The FSI did not address the multiple bowel medications in use, or whether or not bathroom needs were a factor in the fall.]</p> <p>Resident #5's record contained a document identified as her, "Initial Care Plan, dated 6/21/12. On 12/29/13, re-admission information was added, including:</p> <p>*Chemical Restraints in use (psychotropic meds) were identified as Xanax for anxiety, Ambien for insomnia, Cymbalta for Depression, and Seroquel, with no diagnosis noted.</p> <p>*Behaviors to monitor were documented as, "[Decreased] mood [increased] anxiety." [NOTE: There was no indication of how, specifically, a decreased mood state or increased anxiety presented for this resident.]</p> <p>*Behavior interventions/approaches were documented as, "encourage her to do some activities outside of her room [and] let her call her family." [NOTE: There were no indications as to what activities the resident might find enjoyable. Even though she had a number of pain and bowel medications ordered, addressing pain and toileting needs was not listed as an intervention. There was no clear indication as to why the resident required an anti-psychotic medication.]</p> <p>*Medication side effects to monitor for were documented as, "Refer to PDR [Physician's Desk Reference] book."</p>	F 329			

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F 329	<p>Continued From page 60</p> <p>Resident #5's BMFS for January 2014 documented behaviors tracked as, "Anxiety," "Agitated," "Continuous crying," "Extreme Fear," "[Refusal] of care," and, "Self transfers." [NOTE: It was not possible to determine the frequency of any of these behaviors being tracked, due to the number of blanks on the BMFS. Please see F 514 as it pertains to accuracy and completion of clinical records.]</p> <p>Resident #5's most recent quarterly MDS, dated 1/24/14, coded: *BIMS of 7, indicating severely impaired cognition; *No hallucinations or delusions; *Behaviors affecting others 1 to 3 days out of the past 7 days; *Extensive assistance of 2 persons for transfers, dressing, bed mobility, and toilet use; *Extensive assistance of 1 person for hygiene; *Occasional pain, rated as a 7 out of 10, not impacting sleep or daily activities; and *No non-medication interventions in place for pain. *Had received anti-anxiety, anti-psychotic, and anti-depressant medication each day for the past 7 days. *Had received hypnotic medication 3 days out of the past 7 days.</p> <p>Resident #5's BMFS for February 2014 documented behaviors tracked as, "Anxiety," "Agitated," "Continuous crying," "Insomnia," "Extreme Fear," and, "Mood Changes."</p> <p>On 2/2/14, Resident #5's CP documented the addition of a Focus area for, "Potential for mood problem r/t insomnia." Goal was documented as, "Will have improved sleep pattern by reporting</p>	F 329			

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F 329	<p>Continued From page 61</p> <p>adequate rest or documented episodes of insomnia less than weekly..." Interventions included, "Assure that environment is quiet," "Encourage [Resident #5] to attend activities during the day, " "Encourage [Resident #5] to remain awake more during the day to enable sleep at night," and, "Medication as ordered by MD." [NOTE: This care plan had not been initiated at the time of the resident's fall on 12/27/13, when she had received a hypnotic medication 5 hours prior to falling. A period of 37 days had passed.]</p> <p>On 2/2/14, Resident #5's CP documented the addition of a Focus area for, "Potential for a behavior problem r/t anxiety/depression." Goal was documented as, "Will have fewer episodes of anxiety/crying/extreme fear/mood changes/agitation out by review date." Interventions included, "Alter...environment during episodes of anxiety, depression, take a walk, take to an activity or other area," "Attempt to find out the reason or cause of anxiety/depressed mood," "Encourage...to attend activities of choice," "Encourage...to express her feelings of sadness, anger, frustration - provide support and reassurance," and, "Listen attentively...to resolve or discuss area of upset. " [NOTE: The above CP additions do not address the resident's preference to decline invitations to activities, as outlined in the care plan addition from 11/19/13.]</p> <p>On 2/10/14, a SSCF documented, "Res grabbed CNA by scrub collar and refused to let go. Res had crying outburst X 4 [plus]. Res becoming harder to redirect." "Anxiety/Agitation," and, "Belligerent/Combative" were checked under the "Problem Noted" column. [NOTE: There was no assessment documented as to the potential root</p>	F 329			

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F 329	<p>Continued From page 62</p> <p>cause of this behavioral change for the resident, no non-pharmacological interventions attempted, or the results of those interventions. At the time this note was written, the resident was required to wear a brace on her right wrist, which was bothersome to her.]</p> <p>Resident #5's BMFS for 2/10/14 documented 4 episodes of agitation, 2 episodes of continuous crying, and 4 episodes of mood changes. "Redirection" was the only documented intervention, although it was not clear what "redirection" entailed. A hand-written notation on the BMFS documented, "2/10/14. I told resident we should fix her sling and she became upset and grabbed my shirt and would not let go. I called the nurse for help." [NOTE: There was no information on how the resident was approached, and no assessment as to whether or not pain was a factor in the resident's mood or behavioral changes.] A further hand-written notation on the BMFS documented, "Res has self-transferred [twice.]"</p> <p>On 2/16/14, a SSCF for Resident #5 documented, "Res threatening to hit staff and threatening to hit other res were [sic] difficult to redirect res when in emotional state. Res behavior disturbs other res eating dinner." "Depression," "Anxiety/Agitation," "Belligerent/combative," and "Mood swings/change," were all checked under the "Problem Noted" column of the form. [NOTE: There was no assessment documented as to the potential root causes of this behavioral change for the resident, no non-pharmacological interventions attempted, or the results of those interventions.]</p>	F 329			

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F 329	<p>Continued From page 63</p> <p>Resident #5's BMFS for 2/16/14 documented 1 episode of continuous crying and 5 episodes of mood changes. "Redirect" was the only documented intervention. A hand-written notation on the BMFS documented, "Res was crying in the dining room. She wants to go to bed right after dinner. Also she's trying to hit staff and resident [sic]." [NOTE: There was no documentation the facility offered to assist the resident to bed when she was crying, and stating she wanted to go to bed. There was no documentation as to whether or not the resident had been assessed for pain or toileting needs when requesting to go to her room and go to bed.]</p> <p>On 2/17/14 at 3:02 AM, Resident #5's PNs documented, "Res had several emotional outbursts throughout this shift. Res disrupted dinner with yelling through the halls and crying uncontrollably. Unable to talk res through the crying, when other res tried to talk to her she stated [sic] "don't touch me or I'm gonna hit ya." Res did accept Xanax and pain pill, effective within the hour..." [NOTE: There was no documentation of assessment of the root cause of the behavioral changes when first noted by staff. It was not clear from the documentation if the Xanax or the pain pill was effective, since they were given at the same time.]</p> <p>On 2/18/14 at 12:22 AM, Resident #5's PNs documented, "Res did have emotional outbursts [twice] this shift. Did give Xanax and pain pill effective within the hour." [NOTE: It was not clear how it was determined if it was the Xanax or the pain pill that was effective, since they were administered at the same time.]</p>	F 329			

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F 329	<p>Continued From page 64</p> <p>On 2/20/14 at 10:42 AM, Resident #5's PNs documented, "[Physician] in to see resident and new order to [discontinue] Seroquel..."</p> <p>On 2/21/14 at 3:03 AM, Resident #5's PNs documented, "Res had several emotional outbursts after she was finished eating...refused to wait until meal time was over to be assisted to bed...attempted self transfers 4 times through the night...was redirected back to bed for rest. Res did use call light [three times] after assisted to bed and stated [sic] 'there's a little girl in my room keeping me awake'..." [NOTE: The next entries in Resident #5's PNs regarding behavioral issues was on 2/25/14 (a period of 4 days), 3/10/13 (16 days after later), 3/16/14 (6 days later).]</p> <p>On 3/18/14, a SSCF documented Seroquel 12.5 mg at bedtime was started, due to anxiety/agitation, sleep/restlessness, and mood swings/changes.</p> <p>On 3/20/14, a PDRF documented Resident #5 received Seroquel, Ambien, Cymbalta, and Alazopram (Xanax). Diagnoses were listed as tearfulness, increased behaviors, sleep, depression, and anxiety. The form documented in the past 30 days, the resident had 3 episodes of agitation, 14 episodes of anxiety, 40 episodes of continuous crying, 2 episodes of extreme fear, and 5 episodes of insomnia. [NOTE: Of the 40 episodes of continuous crying, 21 were noted on evening shift on 3/16/14, and 10 on evening shift 3/19/14. The remaining 9 episodes were noted sporadically on evening and night shift throughout the month.] The "Committee Recommendations" were to maintain the current doses of medications, with the comment, "Trial discontinuation of Seroquel resulted in increased</p>	F 329		

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F 329	<p>Continued From page 65</p> <p>depressive symptoms, crying, agitation, and fear...may we clarify diagnosis major depressive disorder adjunct to antidepressant therapy..."</p> <p>The line next to the statement, "Physician agrees with committee recommendations" was checked, and the physician signed the form on 3/25/14.</p> <p>[NOTE: This was the first documented review of the resident's psychotropic medications and behaviors since her re-admission on 12/31/13 with a right wrist fracture. At the time this note was written, the resident had an active care plan for acute pain related to her wrist fracture. An assessment of whether or not the resident's pain was a factor in terms of her behavior was not documented on the form. There was no documentation of other medical, environmental, psychosocial, or emotional stressors being considered and ruled out in terms of her behavioral changes, and the need to re-start an antipsychotic medication for this resident.]</p> <p>On 3/28/14, a SSCF documented, "diagnosis major depressive disorder adjunct to anti-depressant therapy," with a new medication order of, "Ambien PRN."</p> <p>On 3/28/14, a CPMF documented the resident received Seroquel 25 mg at bedtime for, "Dementing illness [with] hallucinations, delusions, risk to self harm." [NOTE: The form did not specify the characteristics of the resident's hallucinations or delusions, nor how the resident was at risk of harming herself. No other diagnosis was documented regarding the use of Seroquel.]</p> <p>On 3/30/14, a CPMF for Resident #5 documented the resident received Seroquel 12.5 mg at bedtime, increased to 25 mg on 3/28/14. The form documented, " Your physician has</p>	F 329			

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F 329	<p>Continued From page 66</p> <p>recommended that you receive the medicine identified for the treatment of: " The facility filled in the space provided with, "major depressive disorder adjunct to anti-depressant."</p> <p>Resident #5's BMFS for April 2014 documented behaviors tracked as, "Anxiety," "Agitated," "Continuous Crying," "Insomnia," "Extreme Fear," and, "Mood Changes."</p> <p>Resident #5's BMFS for May 2014 documented behaviors tracked as, "Agitated," "Anxiety," "Continuous Crying," "Danger to Self," "Depressed Withdrawn," "Extreme Fear," "Hallucinations/Paranoia/Delusions," and, "Insomnia."</p> <p>On 5/2/14, Resident #5's care plan documented the addition of a Focus of, "Psychotropic medications use [sic] r/t crying/yelling/physically abusive to staff." Goal was documented as, "Will be/refrain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date." Interventions included, "Monitor/record occurrence of for [sic] target behavior symptoms (SPECIFY: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol." There was a triangular symbol next to this intervention. On 5/8/14 the DNS identified the symbol as an indicator that the particular intervention in question was a generic, pre-printed care plan, and had not yet been individualized for a specific resident. [NOTE: The resident had been on psychotropic medications at the time of her original admission on 6/20/12, and</p>	F 329		

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F 329	<p>Continued From page 67</p> <p>since re-admitted from the acute care hospital on 12/29/13, yet this care plan was not initiated until 5/2/14.]</p> <p>[NOTE: The facility provided narrative PNs with similar entries as the behavioral entries noted above for 3/20/14, 3/22/14, 3/23/14, 3/25/14, 3/26/14, 3/28/14, 3/31/14, 4/1/14, 4/5/14, 4/9/14, 4/25/14, and 4/28/14. Only one of those progress notes, on 3/26/14 at 6:36 PM, documented non-pharmacological interventions. The progress note made at that time indicated the behavioral symptoms were successfully altered. However, there was no documentation those interventions were incorporated into the resident's care plan, or duplicated in any way so as to be monitored for their effectiveness over time.]</p> <p>On 5/7/14 at 11:45 AM, the SDC and LSW were interviewed about Resident #5's behaviors, medications, and her fall in December 2013 which resulted in a wrist fracture. They stated: *When Resident #5 first came to the facility in June of 2012, she would become tearful and upset, and "would put herself on the floor. She couldn't focus. The Xanax helps with that." [NOTE: The resident putting herself on the floor, and having difficulty concentrating, were not target behavioral symptoms being monitored for this resident.] *When asked about Seroquel use, the LSW stated the resident would start talking to someone not there and become anxious. The LSW did not describe how the resident's "anxious" behavior presented. The LSW was unable to clarify how often that behavior occurred, how persistent the behavior was, if the facility had been able to identify an antecedent to the behavior, such as pain, environmental factors, adverse effects to</p>	F 329			

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F 329	Continued From page 68 medications, or medication interactions. *The LSW attempted to give a timeline regarding the specific diagnosis and target behavioral symptoms for the use of the Seroquel for this resident. The LSW stated the MD had diagnosed the resident with major depressive disorder. The LSW was uncertain when or how that diagnosis had come about, and unaware of any previous psychiatric history. The LSW stated there had not been any kind of psychiatric practitioner involved in that diagnosis, or in the resident's care plan development, until the previous week. The LSW stated, "As of last week, we have a psychiatric nurse practitioner coming in. The medical director asked for that, because he needs help with the diagnoses for these medications." *The LSW and SDC were asked if the use of an anti-depressant, anti-anxiety, anti-psychotic, hypnotic and narcotic pain medication in conjunction with one another had ever been evaluated as possible contributing factors to the resident's confusion, depression, or fall risk. The LSW stated, "The pharmacist attends our (Psychotropic Medication Review) meetings, but he has never said anything. It would be in the doctor's progress notes." *The LSW stated the resident required Ambien "to help her rest." The LSW stated the staff would try a calm, relaxing environment, then give the resident Ambien if that did not help her sleep. The LSW was asked if the facility had ever attempted other non-pharmacological interventions, or sleep hygiene techniques, for the resident. The LSW stated the facility had not. *The SDC stated if a hypnotic medication, such as Ambien, was ordered at bedtime, it should be given between 9:00 PM and 10:00 PM. *Regarding the night the resident fell and broke her wrist (12/26/14-12/17/14), the SDC stated:	F 329			

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F 329	<p>Continued From page 69</p> <p>*She stated the resident received her Ambien at 7:00 on 12/26/14, approximately 5 hours before she fell, because, "she asked for it." When asked if non-pharmacological interventions had been attempted before the Ambien was given at that time, the SDC stated, "I don't know." The SDC was unable to explain why the medication would have been given at 7:00, when she had earlier stated it should be given no between 9:00 and 10:00 PM.</p> <p>*The SDC was asked if the resident needing to have a bowel movement was a factor in her fall, given that she had been given multiple bowel medications in the hours leading up to the fall, and had been retrieving her underwear when she fell. The SDC stated, "The nurse took her to the toilet at [9:30 PM]." [NOTE: The resident fell at 12:15 AM, more than two hours later.] "I'm not sure what the results were. I'll look into it. I don't think we considered that as a factor."</p> <p>On 5/8/14, the facility requested the surveyors meet with the Medical Director, so he could hear the surveyor's concerns. After hearing the surveyor's concerns for F 329, the physician stated the resident's family requested she have enough medication on board to make sure she was sleeping. The physician stated he had not really talked with them about the potential for adverse reactions or medication interactions, as they were fairly insistent the resident needed the medications to help her sleep. While the Medical Director acknowledged the resident had a lengthy medication list, he stated, "It's a lot shorter than it used to be."</p>	F 329			

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F 329	Continued From page 70 2. Resident #4 was readmitted to the facility on 1/17/14 with multiple diagnoses including dementia with behavioral disturbances and depression. a. The resident's quarterly MDS assessment, dated 2/14/14, documented the resident did not have any physical, verbal, or other behavioral symptoms directed towards others. The resident's Psychotropic Drug Review, dated 3/20/14, documented, "DC [discontinue] Risperdal 3/4/14." The form did not document harm to self or others. A Fax Request for Physician Response form dated 3/24/14, documented, "In regards to Risperidone use. Is Dx [Diagnosis] of Dementing illness with psychosis r/t combativeness, self-harm Acceptable? Please advise." The physician documented under the section New Orders, "Yes, as above." The resident's April and May 2014 MAR documented an order dated 3/24/14 for, "Risperidone Tablet 1 MG Give 1 tablet by mouth at bedtime related to Dementing illness with psychosis r/t [related to] combativeness, and self harm." The resident's March and April 2014 Monthly Behavior Summary were reviewed and the facility did not monitor 'Danger to others' and only	F 329			

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F 329	<p>Continued From page 71</p> <p>started to document 'Danger to self' on 3/24/14. There were zero episodes of 'Danger to self' documented for March or April 2014.</p> <p>On 5/8/14 at 10:50 AM, the Social Worker was interviewed regarding why the resident was placed on the antipsychotic. She said she would find out.</p> <p>On 5/8/14 at 1:35 PM, the Social Worker provided several resident progress notes regarding the resident's anxiety and attempts to self transfer, but did not have supporting documentation which addressed harm to self or others.</p> <p>The facility failed to provide an adequate indication for the use of an antipsychotic medication.</p> <p>b. Resident #4's quarterly MDS assessments, dated 2/14/14 and 4/21/14, documented a depressive score of 2, which indicated minimum depression.</p> <p>The resident's All Active Orders (recapitulation) dated 1/31/14, documented orders on 1/17/14 for 50 MG of Celexa a day for depression and 50 MG of Trazodone a day for depression. The February, March, April and May 2014 MARs indicated the resident received the orders as prescribed.</p> <p>The resident's Psychotropic Drug Reviews, dated 3/20 and 4/17/14 documented zero episodes of 'Depressed withdrawn' behaviors.</p> <p>The resident's March and April 2014 Monthly Behavior Summary were reviewed and there were zero episodes of 'Depressed withdrawn' behaviors documented.</p>	F 329			

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F 329	<p>Continued From page 72</p> <p>On 5/7/14 at 4:50 PM, the Social Worker was interviewed regarding the duplicate anti-depressant medications. When asked what the rationale was for the resident to be on two anti-depressants, she said she would check into it.</p> <p>On 5/8/14 at 1:35 PM, the Social Worker informed the surveyor she could not find why the resident had received duplicate anti-depressant medications.</p> <p>3. Resident #2 was readmitted to the facility on 10/10/13 with multiple diagnoses including Bipolar disorder and hypertension.</p> <p>A Physician's Progress Note dated 12/9/13, documented, "Sleep Continues to be an issue with Trazodone 100 mg. Discussed Augmentation [with] Klonopin." Note: The resident also had an order for 100 MG of Trazodone for insomnia with an order date of 11/26/13.</p> <p>A Physician's order dated 12/9/13, documented, "Klonopin 1 MG TAB[let]S take 1 by mouth every evening (insomnia) with Trazodone."</p> <p>A Physician's Progress Note dated 2/26/14, documented, "Reports sleep, appetite to be stable."</p> <p>The resident's April and May 2014 MARs indicated the resident received the orders as prescribed.</p> <p>The Nursing 2014 Drug Handbook documented, the medication Klonopin was used for seizures, panic disorder, bipolar disorder, and tic disorders. It also documented an adverse reaction (side</p>	F 329			

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F 329	<p>Continued From page 73 effect) was insomnia.</p> <p>On 5/7/14 at 5:48 PM, the Social Worker and RN #1 were interviewed regarding the justification for Klonopin for insomnia. They said they would find out.</p> <p>On 5/7/14 at 6:25 PM, RN #1 provided the two physician notes documented above and said they had no other justification or rationale for the use of Klonopin for insomnia.</p> <p>4. Resident #10 was admitted to the facility on 3/11/14 and readmitted on 4/18/14 with multiple diagnoses which included insomnia, anxiety and dementia without behavioral disturbances.</p> <p>The most recent admission MDS assessment for Resident #10, dated 4/25/14, documented: * Severe cognitive impairment with a BIMS of 3; * No depression with a mood score of 0; * No psychosis evidenced by hallucinations or delusions; * No physical or verbal behavioral symptoms directed toward others, and no other behavioral symptoms not directed toward others; * Rejection of care not exhibited; and, * Received an antipsychotic medication each day for the past 7 days.</p> <p>The Care Area Assessments (CAAs) triggered and care planned for Resident #10 from the annual MDS assessment, dated 4/25/14, included cognitive loss/Dementia and psychotropic drug use. Psychosocial well-being, mood state and behavioral symptoms did not trigger.</p> <p>Resident #10's Care Plan, initiated on 4/18/14, documented: * Focus - "Psychotropic medications use r/t</p>	F 329			

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F 329	<p>Continued From page 74</p> <p>[related to] Disease process: Dementia with Psychosis;" and,</p> <p>* Interventions - "Administer medications as ordered. Monitor/document for side effects and effectiveness; Consult with pharmacy, MD [Medical Doctor] to consider dosage reduction when clinically appropriate; Discuss with MD, family re[garding] ongoing need for use of medication; Monitor/record/report to MD prn [as needed] side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS [Extrapyramidal Symptoms] (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person."</p> <p>The May 2014 Physician's Orders (recapitulation orders) for Resident #10 documented, "SEROquel Tablet (QUETiapine Fumarate) Give 50 mg [milligrams] by mouth at bedtime for dementia." The date ordered was 4/18/14.</p> <p>A Physician's Orders sheet, dated 5/6/14 documented, "SEROquel tablet 25 MG (QUETiapine Fumarate)...Give 1 tablet by mouth at bedtime for Dementia Dose reduction."</p> <p>Resident #10's MAR included both aforementioned orders for Seroquel. The medications were administered per Physician's Orders.</p> <p>Note: The Seroquel 50 MG for dementia order was discontinued from the MAR when the Seroquel 25 MG for dementia dose reduction was ordered.</p>	F 329			

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F 329	Continued From page 75 The April 2014 Behavior Monthly Flow Sheet for Resident #10 documented the behaviors monitored were, "Agitated," "Anxiety" and "Insomnia." There were no episodes of anxiety or insomnia documented. More than 13 episodes of agitation were documented on the 4/27/14 evening shift. Note: The current (May 2014) Behavior Monthly Flow Sheet for Resident #10 was requested but not provided. On 5/8/14 at 10:26 a.m., the DON was interviewed regarding Resident #10 and the use of the antipsychotic Seroquel. She said during a previous stay in the facility the medication was not used for dementia. When asked if the resident exhibited behaviors, the DON said Resident #10 "Becomes very resistive to care," has verbal outbursts from time to time and was, "Verbally abusive to staff." The DON was asked if the resident exhibited hallucinations at which she replied she thinks the resident will see people that aren't there, which could be due to poor vision. Later that day on 5/8/14 the DON provided a Physician's Progress Notes sheet, dated 5/8/14 at 11:20 a.m. which documented, "Seroquel DX [diagnosis]: Dementia with psychosis..." On 5/8/14 at 4:40 p.m., the Administrator and DON were informed of the antipsychotic medication issue. No further information was provided.	F 329			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332	F332(D): Medication Errors 1) Resident #17 medication error report completed: physician notified and LN		

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F 332	<p>Continued From page 76</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</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 residents received morning medications in a timely manner. This was true for 10 of 25 medications (40%) and it affected 1 of 11 residents (#17) during medication pass observations. Failure to ensure timely medication delivery created the potential for residents to receive less than optimum benefit from their prescribed medications. Findings included:</p> <p>The facility's Policy and Procedure for Medication Administration, with a revision date of 10/2007, documented, "Duration of med[ication] pass: A. You are allowed a "2 hour window" to pass meds at routine med times. This means you can start an hour before the scheduled time, but must end no later than an hour after it."</p> <p>Resident #17 was admitted to the facility on 6/4/07 with multiple diagnoses which included diabetes, esophageal reflux and depression.</p> <p>May 2014 Physician recapitulation orders for Resident #17 documented: * Aspirin tablet 81 MG (Milligrams) by mouth (PO) every day for prophylaxis; * Colace capsule 100 MG by mouth twice a day for constipation; * Glucotrol tablet 5 MG by mouth twice a day for diabetes mellitus; * GlycoLax powder 17 GM (Grams) by mouth</p>	F 332	<p>counseled. The resident was not adversely affected by receiving the meds later than scheduled & no orders were changed.</p> <p>2) All residents have the potential to be affected by this practice. Medications were reassessed and pass time changed as needed.</p> <p>3) LN's were in-serviced on timeliness of medication administration per physician orders.</p> <p>4) Beginning on <u>6-5-14</u> the DNS or LN designee will audit timeliness of medication administration weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5) Date of compliance is on <u>6-12-14</u></p>		

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F 332	<p>Continued From page 77</p> <p>every day for constipation; * Lasix tablet 40 MG by mouth twice a day for edema; * Lexapro tablet 20 MG by mouth every day for depression; * Megestrol Acetate 40MG per ML [milliliters] 4 tsp (teaspoons) by mouth every day for poor appetite; * Methadone 5 MG by mouth twice a day for pain; * Multivitamin/Minerals 1 tablet by mouth every day for wound healing; and, * Omeprazole capsule delayed release 20 MG by mouth every day for GI (gastrointestinal) reflux.</p> <p>The May 2014 MAR (Medication Administration Record) for Resident #17 documented Lexapro, Megestrol Acetate, Glucotrol and Lasix were to be administered at 7:00 a.m. Aspirin, Glycolax, Multivitamin, Omeprazole, Colace and Methadone were to be administered at 8:00 a.m.</p> <p>On 5/8/14 at 9:20 a.m., LN #3 was observed during the morning medication pass for Resident #17. The LN dispensed multiple medications which included Aspirin, Glycolax, Lexapro, Megestrol Acetate, Multivitamin, Omeprazole, Colace, Glucotrol, Lasix, and Methadone. The LN was asked if she was administering 7:00 and 8:00 a.m. medications at which she stated, "Uh huh." The LN entered Resident #17's room, administered the medications to the resident, came back to the medication cart and charted the medications as administered.</p> <p>On 5/8/14 at 10:30 a.m., the DON was asked what time frame was appropriate to administer medications due at 8:00 a.m. She stated, "An hour before and an hour after." The DON was informed of the medication pass observations.</p>	F 332			

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F 332	Continued From page 78	F 332			
F 364 SS=E	<p>The Policy and Procedure for medication administration was requested and provided.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the Resident Group Interview, resident interviews, test tray evaluation and staff interview, it was determined the facility failed to prepare palatable food. This affected 7 of 11 residents who attended the Resident Group Interview, 12 of 12 sampled residents (#'s 1-12) and had the potential to affect other residents who dined in the facility. This failed practice created the potential to negatively affect the resident's nutrition status and psychosocial well-being related to unpalatable food. Findings included:</p> <p>On 5/5/14, during an interview with a resident who wished to remain anonymous, the resident voiced a concern regarding the food served in the facility. The resident stated most of the food did not taste good and most of the vegetables were, "mushy."</p> <p>On 5/6/14 at 2:40 PM, during the Resident Group Interview, 7 out of 11 residents said the food in general was, "Rotten...Horrible", lukewarm and had no flavor.</p>	F 364	<p>F-364 (E):</p> <ol style="list-style-type: none"> Residents from the group interview were not identified but Dietary department was notified of the deficiency and inserviced regarding food presentation, importance of following recipes and appropriate food temperatures for hot and cold foods at time of service. Outside contractor was contacted to take over food preparation to improve quality. New food service contractor began 6/16/14. All residents dining in the facility have the potential to be affected by this practice. Dietary staff will be inserviced regarding food presentation and food temperatures at least quarterly by CDM and or RD. Resident council to meet monthly with CDM and social services to voice concerns about meals. Change menu items as needed. Provide resident choice meal at least once a month. 		

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F 364	Continued From page 79 On 5/7/14 at 1:00 PM, a lunch meal test tray was evaluated by the survey team and the facility RD. The test tray included cornflake baked chicken, California blend vegetables (cauliflower, broccoli, and carrots), Creole potatoes, and a pork chop (alternative meat). The chicken was determined to be too crunchy on the outside and tough on the inside. The vegetables were determined to be unpalatable, mushy, broken, and tasteless, indicating the vegetables were overcooked. The Creole potatoes were determined to be flavorless. The pork chop appeared to be a formed pork like patty product and was determined to be tough and chewy. On 5/7/14 at approximately 1:10 PM, the DM was asked what she thought about the chicken and she stated the, "cauliflower was broken up, but in the mouth it was fine." When asked about the chicken she said it had, "inconsistencies." On 5/7/14 at 6:50 PM, the Administrator, DON, AIT, and Quality Improvement Resources were informed of the issue. No other information was provided by the facility.	F 364	4. Beginning on <u>6-6-14</u> the Administrator or designee will audit a test tray weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective. 5. Date of Compliance is on 6/18/14		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F441(D): Infection control 1) Resident #16 was given a new privacy bag and properly secured and positioned off the floor. 2) Residents with catheter bags were reviewed to ensure proper placement off the floor. 3) Nursing staff in-serviced on proper placement of privacy bags to ensure they are secured and positioned off the floor for infection control purposes.		

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F 441	<p>Continued From page 80 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not maintain an infection control program to help prevent the development and transmission of infection. This was true for 1 Random Resident (#16) and had the potential to cause an infection from his catheter bag not being maintained properly. Findings included: On 5/7/14 R 6:20 PM, Random Resident #16 was</p>	F 441	<p>4) Beginning on <u>6-5-14</u> administrator or designee will conduct audits to ensure catheter bags are secured and properly positioned off the floor weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5) Date of compliance is on <u>6-12-14</u>.</p>		

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F 441	Continued From page 81 observed to remove himself from the East dining room. He propelled his wheelchair approximately 50 feet down the East hallway, then was approached by a visitor, who turned his wheelchair around and returned him to the dining room. Throughout this observation, Random Resident #16's catheter privacy bag was observed dragging on the floor.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents' medical records were complete. This was true for 2 of 7 sample residents (#1 and #5).	F 514	F514(D): Clinical Records 1) Residents #1 and #5 behavior monitoring trackers have been updated as needed to reflect the actual behaviors the staff need to track. 2) All residents needing behavior monitoring have the potential to be affected by this practice. Residents needing behavior monitoring will have the monitoring sheets located at each nurses station in a binder and will be reviewed daily for completion. 3) Nursing staff will be in-serviced on Behavior monitoring documentation requirements. 4) Beginning on 6-6-14 the administrator or management designee will audit the Behavior Monitoring sheets to ensure documentation is completed as required weekly X's 4 weeks, then every 2 weeks X's 4 weeks, then monthly X's 3. The audits will	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 82</p> <p>This failure created the potential for medical decisions to be made based on incomplete information. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 10/3/05 with multiple diagnoses. the most current diagnoses included peptic ulcer, depression, and osteoarthritis.</p> <p>Resident # 1's record contained Behavior Monthly flow Sheets for November 2013, and December 2013. The flow sheets documented several behaviors which included angry, false beliefs, mood changes, and refusal of cares. The flow sheets monitored the number of incidents, outcome, interventions, and the nurse's initials. No information was recorded for the following:</p> <p>*November 2013 -17 of 93 opportunities to document angry; -15 of 93 opportunities to document anxiety; -33 of 93 opportunities to document mood change; -35 of 93 opportunities to document [refusal] of cares;</p> <p>2. Resident #5's record contained Behavior Monthly Flow Sheets for December 2013, and January of 2014. The flow sheets contained a space for the nurse to document the number of identified behaviors that had occurred, if any interventions were attempted, whether or not those interventions were effective, and the nurse's initials. No information was recorded for the following:</p> <p>*December 2013 - 9 of 86 opportunities to document agitation, anxiety, continuous crying, extreme fear, restlessness, and refusal of cares.</p>	F 514	<p>be reviewed monthly by the QAA committee until it has been determined by the committee that the systems are effective.</p> <p>5) Date of compliance is on 6-18-14.</p>		

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

PRINTED: 06/05/2014
FORM APPROVED
OMB NO. 0938-0391

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F 514	<p>Continued From page 83</p> <p>[NOTE: The omissions in the December 2013 documentation included the day shift for 12/22/13 through 12/24/13.]</p> <p>*January 2014</p> <ul style="list-style-type: none"> - 14 of 93 opportunities to document anxiety; - 12 of 93 opportunities to document agitation; - 11 of 93 opportunities to document continuous crying; - 17 of 93 opportunities to document extreme fear; - 17 of 93 opportunities to document refusal of cares; and - 17 of 93 opportunities to document self-transfers. <p>On 5/8/14 at 2:00 PM, the MDS nurse was asked how the facility determined what had happened on the shifts no information was recorded. The MDS nurse stated, "They forgot to chart." The MDS nurse stated without the charting in place, it was not possible to tell what the resident's behavior had been for that shift.</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER PARKE VIEW REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2303 PARKE AVENUE BURLEY, ID 83318
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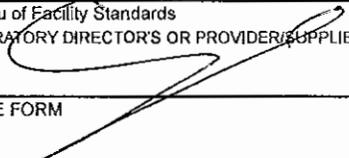
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Lauren Hoard, RN, BSN, Team Coordinator Brad Perry, BSW, LSW Nina Sanderson, BSW, LSW Noel Mathews, MSW</p>	C 000		
C 099	<p>02.009 CRIMINAL HISTORY AND BACKGROUND CHECK REQUIRE</p> <p>01. Criminal History and Background Check. A skilled nursing and intermediate care facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the skilled nursing and intermediate care facility. A Department check conducted under IDAPA 16.05.06, " Criminal History and Background Checks, " satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. (3-26-08)</p> <p>02. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources:</p>	C 099	Please refer to F226-plan of correction	

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

TITLE

(X6) DATE

 *Administrative* **6/18/14**

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C 099	<p>Continued From page 1</p> <p>(3-26-08)</p> <p>a. Federal Bureau of Investigation (FBI); (3-26-08)</p> <p>b. Idaho State Police Bureau of Criminal Identification; (3-26-08)</p> <p>c. Sexual Offender Registry; (3-26-08)</p> <p>d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08)</p> <p>e. Nurse Aide Registry. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. (3-26-08)</p> <p>04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08)</p> <p>05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08)</p> <p>a. Accepting employment with a new employer; and (3-26-08)</p> <p>b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. (3-26-08)</p> <p>06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a</p>	C 099		

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C 099	Continued From page 2 previous criminal history and background check obtained under these rules if: (3-26-08) a. The individual has received a criminal history and background check within three (3) years of his date of hire; (3-26-08) b. The employer has documentation of the criminal history and background check findings; (3-26-08) c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and (3-26-08) d. No disqualifying crimes are found. (3-26-08) 07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08) This Rule is not met as evidenced by: Refer to F226 regarding employee background check not done for a new employee.	C 099		
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please see F 164 as it pertains to resident record privacy and dignity.	C 125	Please refer to F164-plan of correction	

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C 147	Continued From page 3	C 147		
C 147	02.100,05,g Prohibited Uses of Chemical Restraints g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please see F 329 as it pertains to unnecessary medications.	C 147	Please refer to F329- Plan of correction	
C 311	02.107,07 FOOD PREPARATION AND SERVICE 07. Food Preparation and Service. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance, and shall be attractively served at proper temperatures. This Rule is not met as evidenced by: Refer to F364 regarding food palatability issues.	C 311	Please refer to F364- Plan of correction	
C 409	02.120,05,i Required Room Closet Space i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for	C 409	Parke View Rehabilitation & Care Center is requesting to continue the waiver for the closet space requirements on the North wing (rooms 110 through 132)	

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C 409	<p>Continued From page 4</p> <p>prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room.</p> <p>This Rule is not met as evidenced by: Based on observation, resident and staff interview, it was determined 17 of 18 Resident room closets on the North Wing (room #'s 110, 112, 117, 118, 119, 120, 121, 122, 124, 125, 126, 127, 128, 129, 130, 131, and 132), did not meet closet space requirements. Findings included:</p> <p>Observations and various random resident interviews during the initial tour on 5/5/14, revealed the unmet closet requirement did not negatively impact resident's quality of life.</p> <p>On 5/9/14 at 9:45 AM, The Administrator, and DON were informed of the issue. The Administrator indicated the facility would again request a waiver for the closet space requirement. No other information was provided by the facility.</p>	C 409		
C 782	<p>02.200,03,a,iv Reviewed and Revised</p> <p>iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to revising care plans.</p>	C 782	Please refer to F280-Plan of correction	
C 784	<p>02.200,03,b Resident Needs Identified</p> <p>b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to</p>	C 784		

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C 784	Continued From page 5 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 327 as it pertains to hydration. Refer to F309 as it relates to a coordinated plan of care between facility and hospice provide to ensure residents needs are met.	C 784	Please see plans of correction For F327 and F309	
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 regarding pressure sore issues. Please see F 314 as it pertains to pressure ulcers.	C 789	Please refer to F314- Plan of correction	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please see F323 as it pertains to safety in the environment.	C 790	Please refer to F323- Plan of correction	
C 811	02.200,04,g,vii Medication Errors Reported to Physician vii. Medication errors (which shall be reported to the charge nurse and attending physician. This Rule is not met as evidenced by:	C 811	Please refer to F332- Plan of correction	

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C 811	Continued From page 6 Refer to F332 as it relates to a medication error rate of greater than 5%.	C 811		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please see F 514 as it pertains to accurate and complete medical records.	C 881	Please refer to F514- Plan of correction	