



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
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CERTIFIED MAIL: 7007 3020 0001 4044 7144

May 22, 2013

Donna L. Lant, Administrator
Karcher Estates
1127 Caldwell Boulevard
Nampa, ID 83651

Provider #: 135110

Dear Ms. Lant:

On **May 10, 2013**, a Recertification and State Licensure survey was conducted at Karcher Estates by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 4, 2013**. Failure to submit an acceptable PoC by **June 4, 2013**, may result in the imposition of civil monetary penalties by **June 24, 2013**.

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

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

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

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- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **June 14, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 14, 2013**. A change in the seriousness of the deficiencies on **June 14, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 14, 2013** includes the following:

Denial of payment for new admissions effective **August 10, 2013**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 10, 2013**, if substantial compliance is not achieved by that time.

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

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

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If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 10, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **June 4, 2013**. If your request for informal dispute resolution is received after **June 4, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LKK/dmj
Enclosures

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

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/10/2013
NAME OF PROVIDER OR SUPPLIER KARCHER ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification survey of your facility. The surveyors conducting the survey were: Linda Kelly, RN - Team Coordinator Sherri Case, LSW, QMRP Lorraine Hutton, RN Survey Definitions: ADL = Activities of Daily Living BFS = Bureau of Facility Standards CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PO = Orally PRN = As needed SNF/NF = Skilled Nursing Facility/Nursing Facility	F 000	Preparation or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and /or executed solely because it is required by law.		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 225	RECEIVED JUN 25 2013 FACILITY STANDARDS F 225 -Resident #14 will be assessed for current s/s of abuse. The DON at the time of the accusation is no longer employed at the facility. The LN #5 and the CNA were suspended pending investigation. The LN #5 was found to be following the directives of the former DON.		

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

Emma R. Kant

TITLE

Executive Director

(X6) DATE

6/25/13

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 225	<p>Continued From page 1</p> <p>involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's abuse policy, review of investigations, review of personnel files, record review, and staff interviews, it was determined the facility failed to ensure all allegations of abuse were immediately reported, residents were immediately protected, allegations were thoroughly investigated, all allegations of abuse were reported to BFS and appropriate corrective action was taken. This failure directly impacted 1 of 1 residents (Resident #14) involved in significant incidents and 1 of 7 sample residents (#7) residents reviewed for accidents. Findings include:</p>	F 225	<p>Continued F 225</p> <p>-Due to the findings of the investigation the CNA #4 was terminated. LN #5 has been educated about abuse reporting and the investigation policy and procedure. All staff have been educated about the process for reporting allegations of abuse to the Bureau of Facility Standards. This training was completed on June 19, 2013 by Social Services, Administrator and Director of Nursing.</p> <p>-Resident #7 will be assessed for current s/s of abuse. LN will do head to toe assessment to identify bruises, all care giver staff will be inserviced on Resident #7 care plan and the need to report new bruises to LN, start date June 25, 2013.</p> <p>-All residents and staff could be potentially affected. All staff have been trained on the abuse reporting and investigation policies and procedures on June 19, 2013.</p> <p>- LN will monitor Resident #7 for geri sleeves or long sleeve shirt daily x 1 week, weekly x 4, start date June 25, 2013.</p>		

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F 225	<p>Continued From page 2</p> <p>1. The facility's Abuse, Mistreatment, & Neglect, undated, (in place on 2/5/13, but revised 4/24/13, defined physical abuse in the Procedure, Section 1, as, "physical contact with harm or that which is likely to harm the resident/patient." Verbal abuse was defined as, "statements or actions made that cause unsure or likely harm to a resident or patient." Section 4 included:</p> <p>a. The case of suspected abuse will be reported to the Department of Health by the executive director or the director of nursing within 24 hours.</p> <p>d. An incident report will be completed at the time of occurrence.</p> <p>e. Notify the resident's/patient's physician and family, local (sic) ombudsman, and police (if applicable).</p> <p>f. Any associate suspected of resident/patient abuse, mistreatment, or neglect will be promptly relieved of duty until the director of nursing or executive director completes an investigation.</p> <p>h. Any and all protective and/or remedial actions to prevent further harm to the resident/patient who has suffered physical or psychological harm from abuse, mistreatment or neglect will be taken.</p> <p>An "Incident Data Questionnaire" (IDQ) documented an incident had occurred on 2/5/13 at 9:30 p.m. (a question mark was by the time). The incident was documented to have occurred in Resident #14's room and documented "Resident was striking out and [CNA #4] grabbed wrists and attempted to hold resident arms to not strike other CNAs." The IDQ documented a family member and the physician were notified on 2/7/13 at 2:00 p.m., almost 2 days after the alleged incident. The form identified, "?"</p>	F 225	<p>Continued F 225</p> <p>-LN will ensure that all residents are monitored daily during routine cares for new skin issues, including bruises, by the CNA's giving care. A skin care alert sheet will be filled out for any new skin issues/bruises by the CNA's or LN's. RN Supervisor will monitor Daily x 1 week, Weekly x 4, then monthly x3, start date June 25, 2013.</p> <p>-All bruises of unknown origin will be investigated to rule out abuse by Social Services and the Administrator. BFS will be notified of all cases of suspected abuse.</p> <p>-Daily review of 24 hour report by RN Supervisors. An Incident Report will be completed for all bruises of unknown origin. The Incident Report form has been revised to ensure accuracy in completion of such form. All allegations of abuse will be reviewed by the Administrator and Social Services daily to ensure proper investigation and reporting has been initiated.</p>	
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F 225	<p>Continued From page 3</p> <p>questionable physical abuse" and the immediate supervisor was notified (date or time not documented). Verbal abuse was not identified on the form. The IDQ documented the facility was unable to substantiate abuse and was signed by the Administrator and the previous DON on 2/7/13. However, the "Actions Taken" section of the IDQ stated that, "due to statements by CNAs who witnessed incident....[CNA #4] was suspended on 2/9/13 and 2/10/13 and was terminated on 2/11/13."</p> <p>The IDQ included written statements from CNA #2 and CNA #3. CNA #2's statement, undated, documented three CNAs were trying to change Resident #14. CNA #2's statement documented the resident was "irritated" and asked what the CNAs were doing to him, the resident's arms were up and CNA #4 grabbed the resident's "wrists very aggressively and forced his arm down on his chest. [Resident #14] did try to bring his arm up when they were pressed down." CNA #2 stated the resident called CNA #4 a "son of a ..." (SOB) and CNA #4 called the resident an SOB. CNA #3 informed CNA #4, "she could not do that to a resident and that if residents act out she needs to step back." CNA #2 stated she informed the supervisor of the incident and was told the supervisor would take care of the situation.</p> <p>CNA #3's written statement, dated 2/7/13, documented Resident #14 was upset and put both his hands in the air, CNA #3 stated she backed off but CNA #4 grabbed the resident's wrists "hard and pushed them against his chest so [Resident #14] got more upset and started yelling to [CNA #4] you son of a ... 3x [times] and</p>	F 225	<p>Continued F 225</p> <p>-The Administrator will direct the abuse investigation process. Social Services, Administrator, DON and RN Managers responsible for follow up will be asked to give a daily status report on their assignments related to the abuse investigation. Abuse allegations will be monitored by QA Committee monthly.</p> <p>-Completion Date July 26, 2013</p>		

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F 225	<p>Continued From page 4</p> <p>[CNA #4] yelled back oh yeah son of a ... 2 x." CNA #3 documented she told CNA #4 to leave and come back but CNA #4 refused to leave. CNA #3 stated when CNA #4 was told not to grab the resident CNA #4 stated, "she wasn't gonna let him hit her and [CNA #2] said well that's why you just have to back off."</p> <p>CNA #4's written statement, undated, documented Resident #14 was swinging his arms in all directions and she was fearful he would hurt the other CNAs or himself. The statement included "I thought I was doing my best holding the resident's hands and trying to talk to him." The statement did not include that the resident had called her an SOB or that she had called him an SOB.</p> <p>An untitled typed paper, included with the IDQ, had the facility's name at the top and documented there had been an incident on 2/5/13 at approximately 10:00 p.m. The document included LN #5 had "reported to me" (me not identified) CNA #2 had "told her" CNA #4 was "rough with a resident." The date or time the incident was reported was not documented. The document stated CNA #4 had been contacted and said she had held on to Resident #14's wrists because she was afraid the resident would hurt himself or the other CNA. The document included that CNA #2 had not been contacted until 2/7/13 at about 2:30 p.m. CNA #2 identified another witness to the abuse. The document included, "I spoke to both CNA's independently about the incident and they both had the very same facts." The last typed statement on the document was, "I suspended [CNA #4] pending my investigation. [CNA #4] was terminated on Feb. 11, 2013." The only signature</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>on the document was the former DON's and was dated 2/26/13. The signature was by the following handwritten statements at the bottom of the document "Copy of CP (care plan), as worked schedule and daily sheet added." There was no other date, signature or name as to who had written the other information.</p> <p>The Administrator and the current DON were shown that above document was not dated or signed. The current DON pointed to the signature dated 2/26/13 (21 days after incident) and agreed it appeared to be for the handwritten statements. The current DON and Administrator were asked why CNA #4 was not suspended on 2/6/13 as there was documentation the former DON did speak to CNA #4 on that date. Neither the current DON or Administrator were able to provide a reason. The current DON and Administrator were informed it was unclear if the investigation had been completed within 5 days as the document only contained the 2/26/13 date.</p> <p>CNA #4's time card was reviewed and documented that she worked until 10:45 p.m. on 2/5/13 and a full shift on 2/6/13 and was terminated for abuse on 2/11/13.</p> <p>On 5/9/13 at 4:30 p.m. the Administrator was informed the CNA finished working her shift on the day of the alleged abuse (2/5/13) and also worked a full shift on 2/6/13, prior to the investigation being completed. The Administrator stated CNA #4 should have been suspended immediately. When told the investigation did not include an interview with Resident #14, the Administrator stated the resident would not have been able to respond accurately if interviewed.</p>	F 225		

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F 225	<p>Continued From page 6</p> <p>On 5/9/13 at 2:45 p.m., the Social Worker stated he spoke to the resident and it was documented in Resident #14's medical record. Resident #14's medical record documented the social worker spoke to him about the alleged abuse on 2/8/13. Resident #14 stated no one had called him names or grabbed his wrists.</p> <p>On 5/10/13 at about 10:30 a.m. the current DON was informed the IDQ did not include a written statement or incident report from LN #5 about the alleged abuse. The current DON stated the previous DON told her LN #5 had put a note under the door of the previous DON's office at about 10:45 p.m. on 2/5/13. The previous DON did not find the note until 2/6/13 when she reported to work. The Administrator was present and stated she thought the previous DON had reported the incident to BFS timely. The current DON and the Administrator were informed the incident was not reported until 2/8/13. The current DON acknowledged the incident was not reported within the required 24 hours.</p> <p>2. Resident #7 was admitted to the facility on 10/18/10 with multiple diagnoses which included failure to thrive, right sided weakness suggestive of transient ischemic attack, mild mental changes, and anxiety disorder.</p> <p>The resident's most recent quarterly and significant change MDS assessments, dated 1/4/13 and 2/17/13 respectively, both coded, in part:</p> <ul style="list-style-type: none"> * Moderate cognitive impairment with short and long-term memory problems; * Extensive 2 person assistance for bed mobility, 	F 225		

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F 225	<p>Continued From page 7</p> <p>transfers, toilet use, and bathing; * Extensive 1 person assistance for ambulation on/off the unit, dressing, eating, and personal hygiene; and * Wheelchair (w/c) use.</p> <p>Resident #7's Care Plan, dated 3/5/13, included the problems: * "I have an alteration in mobility with risk for falls and pressure ulcers..." Approaches included, "My primary mode of locomotion is w/c and the staff propels it[;] My transfers are with using a sit-to-stand lift and -2 person assist[;] FYI [for your information]--I receive bruises frequently. Please put on long sleeved clothing and derma savers/gerigloves each morning to protect me..." * "I frequently have bruises on my arms (I tend to hold my forearms really tight with my fingers)." Approaches were, "I wear dermasavers or geri-gloves to both of my arms--I refuse to wear them at times[;] I may self-propel in my wh/ch [wheelchair] at times, and I get stuck on the railings[;] Sometimes I wrings [sic] my hands when I am angry and this may cause bruises too[;] I often grab the hooks with 2 fingers when using the Sabina [type of mechanical lift] lift. Remind me not to."</p> <p>On 5/7/13 at 7:55 a.m., CNA #6 and CNA #8 were observed as they provided morning care for Resident #7. When CNA #6 uncovered the resident, a reddish purple bruise, approximately 3 inches by 3 inches, was noted on the top of resident's right mid forearm; and, a dark purple bruise, approximately 1 inch long by 1/2 inch wide, was noted on the top of the resident's right middle finger near the joint closest to the hand. No other bruises were observed on the resident's</p>	F 225		

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F 225	<p>Continued From page 8</p> <p>arms. The CNA's dressed the resident in a short sleeved pull-over shirt and applied geri-sleeves to both arms.</p> <p>On multiple occasions during the survey week, Resident #7 was observed wearing long-sleeved clothing or geri-sleeves.</p> <p>Resident #7's Interdisciplinary Progress Notes (IPN) included the following documentation: * 3/20/13 at 10:30 a.m. - "...red bruises to LFA [left forearm] [and] (R) [right] wrist area. [No] c/o [complaint of] pain. Origin unknown. RN Unit Manager aware." Note: There were no other entries regarding the LFA and (R) wrist bruises. * 5/5/13 at 2:10 a.m. - "Lg [large] 3" [inch] [by] 3" red [and] purple bruise noted to (R) fore arm and (Rt) [right] hand middle finger [with] purple bruise noted - report by CNA - Alert charting Started [sic] - Cont[inue] to monitor." * 5/7/13 at 2:00 p.m. - "...bruise on (R) forearm remains purple, but beginning to fade...Deep purple bruise on (R) middle finger - Denies pain."</p> <p>Review of the facility's Incident Reports (IR) for December 2012 through May 6, 2013, revealed there were no IR for Resident #7 regarding the bruises of unknown origin noted on 3/20/12 or the bruises reported by a CNA on 5/5/13.</p> <p>On 5/9/13 at 10:10 a.m., LN #9 was asked about the bruises noted in Resident #7's IPN on 3/20/13 and 5/5/13. The LN reviewed the IPN then stated she wrote the 3/20/13 entry. She stated, "I would have done an incident report." The LN said another nurse wrote the 5/5/13 entry. LN #9 said she would look for the IR for both dates and get</p>	F 225			

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F 225	Continued From page 9 back with the surveyor. At 12:00 p.m. that day, LN #9 stated she could not find any IR of bruises noted on Resident #7's arms on 3/20/13 and 5/5/13. The LN stated she remembered doing an incident report on 3/20/13 and indicated she would continue to look for the IR. At 12:15 p.m., LN #9 stated she was unable to find an IR for 3/20/13. The LN stated, "I'm pretty sure I did one and if I did, I gave it to the Unit Manager and that Unit Manager is no longer here." On 5/10/13 at approximately 9:30 a.m., when asked if there were any other IR or investigations, the SW stated, "No." Resident #7 was known to develop bruises on her arms. However, the facility failed to investigate when bruises of unknown origin were discovered on the resident's arms on 3/20/13 and 5/5/13 which placed the resident at risk for harm related to potential abuse. On 5/10/13 at about 5:40 p.m., the Administrator and DON were informed of the issue. However, no other information or documentation was received from the facility that resolved the issue.	F 225			
F 226 SS=E	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.	F 226			

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F 226	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to clearly and adequately direct how investigations would be accomplished to prevent abuse or neglect. This had the potential to result in harm to residents if incidents of possible abuse, neglect, mistreatment or misappropriation of property were not adequately investigated. This had the potential to affect 11 of 11 sampled residents (#s 1-11) and any resident reporting an allegation of abuse/neglect. Findings include: The facility's abuse policy, revised 4/24/13, was reviewed. The policy was not sufficient to ensure residents were protected from mistreatment, neglect, abuse, and misappropriation of their property as follows: The Procedure section, 2 c. "Resident injuries of unknown injuries" states, "...Minor bruising and/or skin tears on the extremities need not be reported." NOTE: The policy stated minor injuries would not be reported or investigated. All injuries of unknown injury including a pattern or trend for minor injuries (bruising/skin tears) to extremities should be reported and investigated by the facility as possible abuse/neglect in accordance with the BFS Informational Letter #2005-1 (Resident Abuse Reporting in SNF/NFs). Minor injuries such as bruising/skin tears need not be reported to the police or the BFS.	F 226	F 226 -Guidelines for reporting abuse have been added to the abuse policy and procedure. Information instructing family/visitors on who to report suspected abuse to was posted on both units and added to the admission packets during the week of survey. -This has the potential to affect all residents. -The abuse policy was updated May 31, 2013 and given to all staff on June 10, 2013 and reviewed in an all staff in-service on June 19, 2013. -The Administrator will assure that the current abuse policy is available in each department and updated as appropriate and necessary. The Administrator will monitor to assure there are copies of the abuse policy in each department weekly x 4, then monthly x 3, beginning June 24, 2013. -Completion Date July 26, 2013		

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F 226	<p>Continued From page 11</p> <p>The Reporting Guidelines section, 2 states that when an incident of suspected resident abuse, mistreatment, or neglect was reported to the director of nursing or the executive director, the following will occur:</p> <p>"e. An incident report will be completed at the time of occurrence.</p> <p>f. Notify the resident's/patient's physician and family, local ombudsman and police (if applicable).</p> <p>g. Any associate suspected of resident/patient abuse, mistreatment, or neglect will be promptly relieved of duty until the director of nursing or executive director completes an investigation.</p> <p>i. Any and all protective and/or remedial actions to prevent further harm to the resident/patient who has suffered physical or psychological harm from abuse, mistreatment, or neglect will be taken."</p> <p>NOTE: The Reporting Guidelines did not include the following:</p> <p>*That the allegation would be "immediately" reported to the DON or the executive director. The policy did not include how to immediately notify the DON or Administrator if they were not at the facility.</p> <p>*Who was responsible to notify the Administrator/ DON or if staff were to report the incident to their immediate supervisor who would notify the DON or Administrator.</p> <p>*Who was to complete the incident report.</p> <p>*The incident report would include the date and time of the incident.</p> <p>*When the family member/ physician would be notified.</p> <p>*Who was authorized to make the decision to relieve the accused staff of their duties until the</p>	F 226		

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F 226	<p>Continued From page 12 investigation was completed.</p> <p>*The facility would ensure the resident's safety if the allegation was a family member or friend.</p> <p>*The investigation would be completed within 5 days.</p> <p>*How family members or visitor were to report concerns, incidents and grievances.</p> <p>The Responsibilities section stated:</p> <p>a. All associates will report suspected abuse to the executive director and /or immediate supervisors.</p> <p>b. All associates will be available for an interview to provide a statement and/or written report to and in the abuse investigation.</p> <p>NOTE: The Responsibilities section not include:</p> <p>*To report suspected abuse to the DON or executive director as the policy previously identified, and the following in accordance with BFS Informational Letter #2005-1:</p> <p>*Any witness to the abuse, including residents or family members present when the abuse occurred, would write a statement.</p> <p>*All visible injuries must be measured and described in detail.</p> <p>*In cases of unknown injury all staff having possible contact with the resident for 24 hours prior to the discovery of the injury must be interviewed.</p> <p>*Any staff accused of abuse must be interviewed and the interview documented.</p> <p>*The accused staff must provide a written statement. If the staff refuses the facility will document the refusal.</p> <p>On 5/8/13 at 1:50 p.m., the Administrator agreed that the abuse policy did not include the need to</p>	F 226		

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F 226	Continued From page 13 interview the resident. When asked how family members were informed about how to report abuse/neglect, the Administrator stated she would need to refer to the Marketing Director. Later the Marketing Director stated there was no information in the admit pack regarding who family members were to report allegations of abuse to but it did provide information on how to file grievances.	F 226			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility failed to ensure policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property were sufficiently developed and operationalized. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to enhance residents' dignity during dining. This was true for 1 random resident (#13) when an LN stood while feeding the resident. The failure created the potential for a negative effect on the resident's psycho-social well being. Findings included: On 5/8/13 from 12:40 p.m. to 12:45 p.m., LN #10 was observed as she stood to the right of Random Resident #13 and leaned over the table while she fed the resident several bites of a	F 241	F 241 -LN will review to ensure that resident #13 is seated at a table conducive for feeding assistant. -All staff will be educated about the expectation that staff will sit next to and converse with residents during feeding, in service date June 11, 2013. -All residents requiring feeding assistance could be affected. All residents requiring feeding will be assessed to ensure they are sitting at tables conducive for feeding assistance. All care givers and nurses will be educated about the expectation that staff will sit next to and converse with all residents during feeding.		

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F 241	Continued From page 14 pureed substance with a spoon. At 12:45 p.m., CNA #8 rolled a stool over to LN #10. The LN sat on the stool and continued to feed the resident. On 5/8/13 at 2:35 p.m., LN #10 was interviewed. The LN acknowledged she had been standing when she fed Resident #13 during the lunch meal service that day. On 5/10/13 at 5:45 p.m., the Administrator and DON were informed of the dignity issue. However, no other information was received from the facility.	F 241	Continued F 241 -The plan for getting trays out in order to accommodate feeding will be reviewed and revised as needed. -LN will monitor dining rooms to ensure staff is sitting next to residents requiring feeding assistance, weekly x4 weeks, monthly x3 months, start date 6/24/2013. DON or designee will monitor dining rooms randomly. A report will be given at the monthly Quality Improvement meeting x3 months and then quarterly thereafter. -Completion Date July 26, 2013		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' call lights were accessible. This was true for 2 of 11 sample residents (#1 and #7). The failed practice created the potential for physical and emotional harm for residents whose call light was not accessible when assistance was needed or wanted. Findings included:	F 246			

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F 246	<p>Continued From page 15</p> <p>1. Resident #1 was admitted to the facility on 8/18/06, and readmitted on 12/30/08 with multiple diagnoses which included uncomplicated senile dementia, generalized muscle weakness, and benign prostatic hypertrophy (BPH).</p> <p>Resident #1's most recent quarterly MDS assessment, dated 3/2/13, coded, in part:</p> <ul style="list-style-type: none"> * Moderate cognitive impairment with short and long-term memory problems; * Total assistance of 2 people for bed mobility, transfers, and toileting; * Total assistance of 1 person for dressing and personal hygiene; * Functional limitation in range of motion in both upper extremities; and, * Frequent bowel and bladder incontinence. <p>On 5/7/13 at 7:10 a.m., Resident #1 was observed asleep in a low bed. The resident's call light was clipped to the privacy curtain. The call light was about 2 1/2 feet above the bed and about 2 feet away from the bed. The call light was not within the resident's reach.</p> <p>At 7:30 a.m. and 7:52 a.m., there was no change.</p> <p>At about 7:55 a.m., LN #11 stated she was going to "check on" Resident #1. When asked if the resident was able to use his call light, the LN stated, "Sometimes he can." When LN #11 and the surveyor entered the resident's room, the LN was asked if the resident could reach his call light. LN #11 stated, "No he can't!" The LN moved the call light onto the bed within the resident's reach. LN #11 stated, "They probably hooked it up there when they turned him and forgot to put it back."</p>	F 246	<p>F 246</p> <ul style="list-style-type: none"> -Residents #1 and #7 will be checked to ensure that their call lights are placed where they can reach them. -All residents could be affected. All residents will be checked to ensure that their call lights are placed where they can reach them. -All staff will be educated about the placement of call lights by July 26, 2013. -LN will make weekly rounds x1 month, monthly x3 to ensure call lights are placed appropriately, start date 6/24/2013. Staff will be educated/reminded immediately, if call lights found not to be in place. -DON or designee will monitor call lights Q2 weeks x4, monthly x3. A report will be given at the monthly Quality Improvement meeting x 3 months and then quarterly thereafter. -Completion Date July 26, 2013 		

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F 246	<p>Continued From page 16</p> <p>On 5/10/13 at approximately 5:45 p.m., the Administrator and DON were informed of the call light issue. No other information or documentation was received from the facility.</p> <p>2. Resident #7 was admitted to the facility on 10/18/10 with multiple diagnoses which included failure to thrive, right sided weakness suggestive of transient ischemic attack, mild mental changes, and anxiety disorder.</p> <p>The resident's most recent quarterly MDS assessment, dated 1/4/13, coded, in part:</p> <ul style="list-style-type: none"> * Moderate cognitive impairment with short and long-term memory problems; * Extensive 2 person assistance for bed mobility, transfers, and toileting; * Extensive 1 person assistance for dressing, eating, and personal hygiene; and, * Frequent bowel and bladder incontinence. <p>On 5/9/13 at 9:25 a.m., Resident #7 was observed dozing in her high back wheelchair (w/c). The w/c was parked by the end of the resident's bed. The resident was facing the window, away from the bed. The resident's call light was by the pillow at the head of the bed. The call light was at least 3 feet behind the resident and outside the resident's reach.</p> <p>At 9:30 a.m., when CNA #12 walked by Resident #7's room, she was asked if Resident #7 could use her call light. The CNA stated, "Yes." CNA #12 accompanied the surveyor into Resident #7's room. When asked if the resident could use the call light where it was, CNA #12 shook her head no and stated, "When it's clipped to her." The</p>	F 246		

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F 246	<p>Continued From page 17</p> <p>CNA moved the call light to the resident's lap and clipped it onto the resident's clothing. The CNA asked the resident to "push the red button" (on the call light). The resident attempted, but was not able to activate the call light. CNA #12 then attempted to activate the call light but was not successful. The CNA stated, "Sometimes it gets stuck and won't work." CNA #12 wheeled Resident #7 to her roommate's side of the room (the roommate was not in the room) and asked the resident to press her roommate's touch pad call light. Resident #7 was able to activate the touch pad call light. The CNA left the resident on the roommate's side of the room with the touch pad call light on the resident's lap. CNA #12 said she would request a touch pad call light for Resident #7 then she left the room.</p> <p>At about 9:40 a.m., CNA #12 informed the surveyor she had put in a written request for a touch pad call light and had tried to call the Plant Supervisor (PS). The CNA said she was not successful contacting the PS. LN #9 was present and she said they would call the PS again. The LN also said, "In the meantime," Resident #7 was moved to the Common Area by the Nurses' Station. The resident was observed in the Common Area by the Nurses' Station.</p> <p>At about 10:30 a.m., the PS informed the surveyor Resident #7's call light had been changed to a touch pad call light.</p> <p>On 5/10/13 at approximately 5:45 p.m., the Administrator and DNS were informed of the call light issue. No other information or documentation was received from the facility.</p>	F 246		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=D	<p>Continued From page 18</p> <p>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, record review, and staff interview, it was determined the facility failed to ensure care plans were evaluated and revised as the residents requests, needs, or status changed. This affected 1 of 7 (# 2) sampled residents. This had the potential for staff to not provide appropriate care due to lack of direction in the care plan. Findings include:</p> <p>Resident #2 was admitted to the facility 6/9/10 with diagnoses of congestive heart failure, osteoporosis, chronic kidney disease, and atrial</p>	F 280	<p>F 280</p> <p>-Resident #2 care plan identified will be reviewed and corrected.</p> <p>-All residents could be affected. All care plans will be reviewed and corrected.</p> <p>-A notification system will be created for staff to review and point out changes needed to RN managers.</p> <p>-Review of plan of care updates will be addressed in weekly plan of care meetings, to include unit managers, MDS nurse, start date 6/26/2013.</p> <p>-Monthly care plan review for staff prior to new MDS to identify changes.</p> <p>-Completion Date July 26, 2013</p>		

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F 280	Continued From page 19 fibrillation. A quarterly MDS assessment, dated 4/27/13, documented the resident: *Was moderately cognitively impaired, *Required limited assistance of one staff for bed mobility and transfers. The resident's care plan for Risk for Falls, dated 5/7/13, stated the motion alarm was to be turned on "so staff can know when I go in and out of the bathroom." During an observation on 5/7/13 at 8:50 a.m. Resident #2 was observed to return from the toilet to her room. The motion alarm did not sound. At that time CNA #7 was asked if Resident #2 required assistance to transfer. CNA #7 stated that she could transfer independently but if she needed help she would ask. On 5/9/13 at 9:30 a.m. the infection control nurse stated the motion alarm should have been discontinued in the care plan.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure staff adhered to professional standards of care. This was true for 1 of 9 residents (#15) observed receiving medications when Resident	F 281			

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F 281	<p>Continued From page 20</p> <p>#15's proton pump inhibitor (PPI) medication was administered right after breakfast rather than before the meal. This failure created the potential for the resident to experience less than optimal control of gastric acidity. Findings included:</p> <p>During a medication pass observation on 4/7/13 at 9:00 am, LN #1 administered omeprazole by mouth to Resident #15 in the dining room after the resident had just finished her breakfast.</p> <p>Federal guidelines issued through letter S&C:13-02-NH on November 2, 2012 documented, "PPIs such as lansoprazole (Prevacid) and omeprazole (Prilosec), are routinely used in nursing homes settings. For optimal therapeutic benefit, most PPIs should be administered on an empty stomach, ideally 30 - 60 minutes before eating. The rationale is that in order for the medication to provide the maximum benefit it needs to be present in the system before food activates the acid pump so that the peak concentration of PPI will coincide with maximal acid secretion..."</p> <p>The Nursing 2013 Drug Handbook (NDH 2013), page 1011, under the drug omeprazole, documented, "Give drug at least 1 hour before meals." The NDH 2013 documented the onset time for the drug to start working was 1 hour, the peak time 30 minutes to 2 hours, and half-life was 30 - 60 minutes.</p> <p>Resident #15's May 2013 Physician Orders (Recapitulation) listed, "Omeprazole 20 mg take by mouth once daily for gastroesophageal reflux disease."</p>	F 281	<p>F 281</p> <ul style="list-style-type: none"> -Review resident #15's orders for Omeprazole with the pharmacist. Get appropriate directives from pharmacist on how it is to be given, seek clarification order from MD for this resident. - All residents could be affected. All residents on proton pump inhibitors will be reviewed to ensure that they comply with the directives received from the pharmacist for resident #15. Seek clarification orders for all residents needed, start date 6/4/2013. -Pharmacy will review all medication orders each month and alert DON of any directives that need clarification by MD. Pharmacy will identify other medications with specific delivery needs as well. -The monthly pharmacy reports will be reviewed by the licensed nurses. Follow up on recommendations will be presented at Quality Improvement meeting on a monthly basis x 3 months, then quarterly. -Completion Date July 26, 2013 		

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F 281	Continued From page 21 On 5/8/13 at 3:00 pm, the DON was interviewed about the administration time of the omeprazole. The DON stated the omeprazole should have been given with the 7:00 am medications. The DON was then asked to provide a copy of their policy for administering PPIs and other medications with specific recommendations for administration in regards to food. The DON later provided a copy of a medication policy did not address the administration of PPIs. Please refer to F425 for additional information.	F 281			
F 286 SS=C	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure MDS assessments were available to all professional staff members and consultants who may need to review the information. This was true for 11 of 11 sample residents (#s 1 through 11) and all other residents who resided in the facility. Findings included: Note: Interpretive guidelines at F286 state, "... MDS assessments must be kept in the resident's active clinical record for 15 months following the final completion date for all assessments and correction requests... The information, regardless of form of storage (i.e., hard copy or electronic), must be kept in a centralized location and must	F 286	F 286 -15 months of MDS will be placed on a computer that will be available to all professional staff members and consultants who may need to review for information at station D nurse's station. Unit managers and charge nurses will have access to the password to give to those needing the MDS information. This information will be available 24 hours a day. There will be a policy and procedure placed in every chart under the MDS section directing professional staff and consultants to the computer to view the MDS and CAA. The initial tracking assessment and care screening will be kept in the hard chart in the MDS section. -This has the potential to affect all residents. -Medical Records will monitor weekly x 4, then monthly x 3; outside Medical Records Consultant will monitor quarterly x 4, start date June 25, 2013. -Completion Date July 26, 2013		

*June 25, 2013 @ 9:30
DON & Adminstr
Pr I Change
Adminstrator will
Audit monthly
then monthly &
JC*

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F 286	<p>Continued From page 22</p> <p>be readily and easily accessible. This information must be available to all professional staff members (including consultants) who need to review the information in order to provide care to the resident. ..."</p> <p>On 5/7/13, an untitled document, dated 10/1/11, was found in the active clinical records/charts for Resident #1 and #7. The document, stated, "Policy for Obtaining MDS Data -All MDS data will ne stored electronically and secured ...according to CMS requirements... Procedure-All MDS data will be printed upon request - all signature pages will be placed in the clinical records for a period of 15 months -Hard copies of the signed and dated CAA completion; correction completion and assessment completion will be stored within the resident's active clinical record."</p> <p>On 5/7/13 at 11:00 a.m., when asked where MDS assessments were kept, the MDS nurse stated, "The only place we keep MDSs are in the E-MDS [electronic MDS]." When asked if MDS assessments were available to any professional who may need to review them, the MDS nurse stated, "Management staff have access but other staff, such as med [medication] nurses, would have to be set-up to access E-MDS."</p> <p>At 11:20 a.m., when asked if she had access to E-MDS assessments, the Infection Control/Quality Assurance Nurse (IC/QAN) stated, "Me and [MDS nurse's name] are the only ones who have access to MDSs and care plans."</p> <p>At 11:23 a.m., when asked if she had access to E-MDS, LN #13 stated, "No."</p>	F 286			

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F 286	Continued From page 23 At 11:25 a.m., when asked if she had access to E-MDS, LN #11 stated, "No." At about 11:40 a.m., regarding access to E-MDS, the IC/QAN stated, "They [LN staff] don't have a password, they are not password eligible." When asked if an LN would have access to MDS assessments when she and the MDS nurse were not available, the IC/QAN stated, "No, Corporate wouldn't let that happen." At 1:00 p.m., the Medical Records Supervisor said she could view MDS assessments on the computer but she could not print them. She stated she was aware of the "view only" possibility "about 2 weeks ago." On 5/10/13 at about 5:45 p.m., the Administrator and DON were informed of the issue. No other information or documentation was received from the facility.	F 286			
F 309 SS=D	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, resident and staff interview and observation, it was determined the facility failed to ensure that physician's orders and	F 309	F 309 -Resident #1, #2 and #5 care plans will be reviewed, all care giver staff will be in-serviced on Residents #1, #2 and #5 care plans on June 25, 2013. -All residents could be affected. All care plans will be reviewed with care giver staff by LN. -All care giver staff will be required to have a working knowledge of resident plan of cares. -RN Supervisor or designee will monitor that care giver staff has reviewed care plan daily x 1 week, weekly x 4, monthly x 3, starting June 25, 2013. -Completion Date July 26, 2013		

*Plan done
June 28, 2013
DON or RN will monitor to ensure
Care Plans are implemented
JC*

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F 309	<p>Continued From page 24</p> <p>resident care plans were consistently followed. This was true for 3 of 7 sampled residents reviewed (#s 1, 2, & 5) and had the potential to affect residents' health status. Findings include:</p> <p>1. Resident #2 was admitted to the facility 6/9/10 with diagnoses of congestive heart failure, osteoporosis, chronic kidney disease, and atrial fibrillation.</p> <p>A quarterly MDS assessment, dated 4/27/13, documented the resident: *Was moderately cognitively impaired, *Required limited assistance of one staff for bed mobility and transfers.</p> <p>Resident #2's medical record included a 4/25/13 physician order to elevate her right leg when she was in her wheelchair. The resident's 5/1/13 recapitulation physician orders included "Encourage resident to elevate legs as needed to reduce edema."</p> <p>Resident #2's 5/7/13 Care Plan (CP) for falls included an approach section to, "...sit in my wheelchair for long periods of time. Encourage me to lie down and elevate my legs several times a day."</p> <p>Resident #2's 5/7/13 CP for for "Cardiovascular/Respiratory Function" included an approach to elevate her legs several times a day.</p> <p>Resident #2 was observed in her wheelchair and did not have her right leg elevated during observations on 5/6/13 at 11:50 a.m., 1:08 p.m., 2:05 p.m., and 2:30 p.m., on</p>	F 309			

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F 309	<p>Continued From page 25</p> <p>5/7/13 at 7:15 a.m., 7:40 a.m., 8:00 a.m., 8:50 a.m., 10:30 a.m., 1:05 p.m., 2:12 p.m. and 3:15 p.m. Resident #2 was not observed to lay down at any time during observations on 5/6/13 through 5/9/13.</p> <p>The resident's medical record did not include documentation the resident had refused to elevate her right leg.</p> <p>On 5/9/13 at 9:25 a.m. the infection control nurse stated Resident #2 should have had her leg elevated or there should be documentation she refused to elevate her right leg or to lay down.</p> <p>2. Resident #5 was admitted to the facility 1/12/12 with diagnoses that included aftercare fracture, pain, hypertension, and dementia.</p> <p>A significant change MDS assessment, dated 4/28/13, documented the resident: *Was moderately cognitively impaired, *Required limited assistance of one staff for bed mobility and transfers.</p> <p>Resident #5's CP for Alteration in Skin Integrity, dated 5/7/13, included an approach to avoid sitting with her legs in a dependent position for extended periods of time. Staff were to assist her to lie down and elevate "affected areas several times..." NOTE: Several times was not defined.</p> <p>Resident #5 was observed sitting in her wheelchair or in her recliner with her feet on the floor on 5/6/13 at 12:10 p.m., 1:40 p.m., 2:25 p.m., on 5/7/13 at 7:40 a.m., 8:00 a.m., 8:45 a.m., 9:18 a.m., 1:15 p.m., and 3:15 p.m.</p>	F 309		

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F 309	<p>Continued From page 26</p> <p>The resident's medical record did not include documentation the resident had refused to lie down.</p> <p>On 5/9/13 at 9:25 a.m. the infection control nurse stated Resident #5 should have been assisted to lie down or there should be documentation she refused.</p> <p>3. Resident #1 was admitted to the facility on 8/18/06, and readmitted on 12/30/08 with multiple diagnoses which included uncomplicated senile dementia and generalized muscle weakness.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 3/2/13, coded, in part: * Moderate cognitive impairment with short and long-term memory problems; * Total assistance of 1 person for dressing; and, * Functional limitation in range of motion in both upper extremities.</p> <p>Resident #1's Care Plan identified the problem, "I am at risk for...impaired skin integrity..." Approaches included, "I may wear geri-gloves to help protect my skin. I am very prone to skin tears and bruises. I often knock my arms against the equipment when I am being transferred" and "FYI [for your information]—Ensure my nails are trimmed and that I have my geri gloves on each day."</p> <p>Resident #1 was not wearing geri-gloves, as care planned, when he was observed on: * 5/6/13 from 1:10 to 1:20 p.m. - In wheelchair (w/c) in the "Cafe" dining room; * 5/6/13 at 2:25 p.m. - Asleep in bed; * 5/7/13 at 8:35 a.m. - In bed and being fed</p>	F 309			

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F 309	<p>Continued From page 27</p> <p>breakfast;</p> <ul style="list-style-type: none"> * 5/7/13 at 10:00 a.m. - Asleep in bed; * 5/7/13 at about 1:20 p.m. - In w/c in Common Area by Nurses' Station D; * 5/7/13 at 2:10 p.m. - Asleep in bed; * 5/8/13 at 9:25 a.m. and 10:00 a.m. - Asleep in bed; * 5/8/13 at 11:10 to 11:25 a.m. - Awake in bed during skin assessment by Wound Nurse; * 5/8/13 at 12:30 p.m. - Dozing in w/c by his bed; * 5/8/13 at 2:30 p.m. - Asleep in bed; and * 5/9/13 at 9:35 a.m., 10:30 a.m., and 11:30 a.m. - Asleep in bed. <p>CNA #6 was present when the Wound Nurse assessed the resident's skin on 5/8/13 from 11:10 a.m. to 11:25 a.m. At the end of that time frame, when asked if Resident #1 was care planned to wear geri-gloves, CNA #6 nodded "Yes" and stated, "They're in the laundry. We are waiting for them to come back."</p> <p>On 5/10/13 at about 5:45 p.m., the Administrator and DON were informed of the issue. No other information or documentation was received from the facility.</p>	F 309		
F 314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p>	F 314		

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F 314	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident who was at risk for pressure ulcers (PU) and had a history of PU did not develop avoidable PU. This was true for 1 of 3 sample residents (#1) reviewed for PU. Resident #1 was harmed when he developed recurrent stage II PU on his left buttock, left upper buttock, and coccyx; and, a stage III PU on the left buttock. Findings included: Resident #1 was admitted to the facility on 8/18/06, and readmitted on 12/30/08 with multiple diagnoses which included uncomplicated senile dementia, generalized muscle weakness, difficulty walking, diabetes mellitus, and benign prostatic hypertrophy (BPH). The resident's significant change MDS assessment and two most recent quarterly MDS assessments, dated 9/13/12, 12/7/12, and 3/2/13 respectively, coded, in part: * Moderate cognitive impairment with short and long-term memory problems; * Total assistance of 2 people for bed mobility, transfers, and bathing; * Total assistance of 1 person for dressing and personal hygiene; * Functional limitation in range of motion in both upper extremities; * Frequent incontinence of bowel and bladder; * No healed or unhealed PU/venous or arterial ulcers; and * Moisture associated skin damage (MASD).	F 314	F 314 -The wound care nurse responsible for resident skin care prevention, obtaining MD orders, and initiating nursing interventions was put on probationary status and terminated. -Assessment, chart and care plan review has been conducted for resident #1 to ensure all preventative measures and documentation are in place. -All residents with current skin concerns will have assessment, chart and care plan review/update and corrective action taken as needed. -The wound care nurse now responsible for wound care and skin care prevention has been trained on pressure ulcer prevention and wound care policies, effective June 25, 2013. - LN responsible for wound care and skin care prevention will assess, care plan and document wound trending and notify MD or Wound Care Nurse Practitioner for additional orders as needed.		

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F 314	<p>Continued From page 29</p> <p>The aforementioned 9/13/12 and 3/2/13 MDS assessments also coded total assistance of 2 people for toileting while the 12/7/12 MDS assessment coded total assistance of 1 person for toileting.</p> <p>Resident #1's PU CAA, dated 9/13/12, documented, in part, extrinsic risk factors - pressure, needs special mattress or seat cushion, friction and shear, and maceration; intrinsic risk factors - immobility, altered mental status, and incontinence; and, history of healed PU. The analysis of findings documented, "...multiple risk factors for development of pressure areas. He will remain at risk."</p> <p>The resident's recapitulation (recap) of Physicians Orders for May 2013 included the following orders and the order date for each: * Multi vitamin 1 by mouth (PO) daily as a supplement - 12/30/08; * Magic cups 2 times daily inbetween meals as a supplement - 11/16/12; * Three-in-one vitamin, once daily PO as a supplement and for wound healing - 3/1/13; * Barrier cream to peri area and buttocks as needed for protection - 9/20/12; and * Zinc oxide topical ointment to open areas on coccyx and gluteal folds every shift and as needed until healed - 3/15/13.</p> <p>Resident #1's Care Plan Problem List, dated 3/12/13, included: * "I am at risk for...pressure ulcers and impaired skin integrity R/T [related to] my incontinence..." and "5/1 open area on compromised (L) [left] buttocks [sic]..." Approaches included, "Tx</p>	F 314	<p>Continued F 314</p> <p>-The pressure ulcer prevention and wound care policies will be reviewed with all LN and care giver staff at an in-service on June 27, 2013.</p> <p>-The facility has contracted with a Wound Care Specialist, Nurse Practitioner for one year to ensure optimum wound care and skin care prevention for all residents. Start date June 11, 2013.</p> <p>-The facility will hold weekly skin at risk meetings and will review residents with skin related concerns, start date June 26, 2013. A weekly skin report will be prepared by LN and presented to leadership team. LN will give a report at the monthly Quality Improvement meeting x 3 months and then quarterly thereafter.</p> <p>-Completion Date July 26, 2013</p>		

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F 314	Continued From page 30 [treatment] as ordered...monitor me after meals for toileting needs and need to lay down...assist me to reposition Q 2 hrs [every 2 hours] PRN [as needed] when in bed. Be aware: I likes [sic] to lay on my back. Encourage me to stay on my sides to take pressure off my buttocks. I have an air overlay [and] pressure reducing cushion in my w/ch [wheelchair]...I need barrier cr[eam] to my buttocks PRN for protection/report redness to LN...I have a tendency to get open areas on my buttocks because of previous injury to skin-use Xenaderm or sacral Alleevyn or barrier PRN to encourage healing, and keep my buttocks [open] to air at night..." * "I have a self care concern...I require assistance with my ADLs, mobility and transfers." One approach was, "I need peri care after each incont[inent] episode [and] PRN. 2/28 Not a candidate for a toileting program..." * "I have an alteration in elimination - I am incontinent of B&B [bowel and bladder]..." Approaches included, "I wear adult sized incont[inence] products. Assist me w/ [with] changing and peri care PRN...I have barrier cr[eam] to my buttocks PRN for protection..." Resident #1's medical record included the following: * A Braden Scale (tool for predicting pressure ulcer risk) which documented the resident's PU risk as 14, or moderate risk, on 12/7/12 and 3/7/13. Both Braden Scales included: sensory perception = 3, slightly limited; moisture = 3, occasionally moist; activity = 2, chairfast; mobility = 2, very limited; nutrition = 3, adequate; and, friction and shear = 1, problem. * A Wound/Skin Record with a stage II PU at the left inner buttock and a stage II PU at the left	F 314			

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F 314	<p>Continued From page 31</p> <p>upper/inner buttock, both on 3/14/12. Both of these were documented as healed on 3/28/12. This Wound/Skin Record also included a stage II PU on the coccyx on 4/30/12 which was documented as healed on 5/7/12.</p> <p>* A Wound/Skin Record with a stage II PU on the coccyx and a stage II PU on the left upper buttock, both on 9/20/12. The coccyx PU measured 0.5 centimeters (cm) by 0.6 cm by less than 0.1 cm. The left upper buttock PU measured 0.8 cm by 0.8 cm by less than 0.1 cm. Both of these PU were documented as healed on 10/4/12. This Wound/Skin Record also documented a stage II PU on the left buttock that measured 3.6 cm by 2.6 cm by less than 0.1 cm on 10/8/12, it was noted as healed on "10/2." (The date "10/2" may have been incomplete, or an error).</p> <p>* Another Wound/Skin Record documented a stage III PU on the left buttock that measured 3.6 cm by 2.6 by "unknown" depth on 10/5/13. This PU was documented as healed on 10/23/12.</p> <p>* A Wound/Skin Record with a stage II PU on the left inner upper buttock that measured 2.6 cm by 1.1 cm by less than 0.1 cm on 5/1/13.</p> <p>NOTE: It was unclear why there was documentation on 10/5/13 of a stage III left buttock PU and on 10/8/13 of a stage II left buttock PU. In addition, all of the Wound/Skin Records included 4 body diagrams in which to note the location of PU on the body. The diagrams represented the anterior (front), posterior (back), and lateral (left and right sides) perspectives of the body. However, only the 3/14/12 Wound/Skin Record documented the location of the PUs on the posterior body diagram. All of the other aforementioned</p>	F 314			

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F 314	<p>Continued From page 32</p> <p>Wound/Skin Record body diagrams were blank.</p> <p>Resident #1 was observed in bed on his back on an air mattress on:</p> <ul style="list-style-type: none"> * 5/7/13 at 8:35 a.m., the head of the resident's bed was at about 40 degrees elevation, while CNA #7 fed him; and, * 5/9/13 at 9:35 a.m., 10:30 a.m., and 11:30 a.m. <p>On 5/8/13 at 11:10 a.m., Resident #1 was observed lying on an air mattress on his right side. With CNA #6's assistance, the Wound Nurse (WN) turned the resident farther onto his side and examined the resident's buttocks and peri area. Two superficial open areas were noted on the resident's left inner buttock. Both of the open areas, one superior (above) the other, were about 1.0 cm in diameter. When asked about the open areas, the WN stated the superior wound was related to moisture and the inferior (lower) wound was related to moisture and pressure. The WN pointed out that the inferior wound was over the ischium (hip bone). She stated, "Stage II pressure ulcers come and go about every other month."</p> <p>On 5/9/13 at 12:10 p.m., when asked what treatments and interventions were implemented regarding the recurrent PU to Resident #1's buttock and coccyx areas, the WN stated she alternated between barrier cream and Calmoseptine and different types of dressings, such as Mepilex, Xenaderm, and Allevyn.</p> <p>At 3:20 p.m. that day, the WN was also asked about the aforementioned conflicting documentation on 10/5/12 regarding a stage III PU and 10/8/12 regarding a stage II PU, both on</p>	F 314		
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F 314	Continued From page 33 the left buttock. The WN only stated, "I'm not sure why I documented that way." When asked if the resident's voiding pattern had been monitored, such as a 3 day voiding diary, to determine when the resident may be wet and if more frequent incontinence brief changes were needed, the WN stated, "No." When asked if turning the resident more often than every 2 hours had been considered, the WN indicated, "No." When asked if the physician had documented that any of the PU were unavoidable, the WN stated, "No." Resident #1, who had a history of PU to the left buttock and coccyx areas, was harmed when a stage II PU reoccurred to the left upper buttock area and a stage II PU reoccurred to the coccyx on 9/20/13; when a stage II or III PU occurred on the left buttock area on 10/5/12 or 10/8/12; and when a stage II PU reoccurred on the left upper inner buttock on 5/1/13. On 5/9/13 at 6:10 p.m., the Administrator and DON were informed of the PU issue. On 5/10/13 at about 4:00 p.m., the WN provided more documentation regarding the care and treatment Resident #1 received related to PU; however, the documentation did not resolve the issue.	F 314			
F 329 SS=D	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	F 329			

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F 329	<p>Continued From page 34</p> <p>adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to implement non-pharmacological interventions prior to the use of an antidepressant for insomnia. Additionally, the facility failed to provide physician justification for the continued use of the antidepressant. This affected 1 of 7 sampled residents (#5). Findings include:</p> <p>Resident #5 was admitted to the facility 1/12/12 with diagnoses that included aftercare fracture, pain, hypertension, and dementia.</p> <p>A significant change MDS assessment, dated 4/28/13, documented the resident: *Was moderately cognitively impaired,</p>	F 329	<p>F 329</p> <p>-Resident #5 has been reviewed by Dr. Germano to identify need for Trazadone. A sleep monitor will be completed for Resident #5. Monitor will be sent to MD for review. Care plan will be revised to add non-medication sleep hygiene interventions. LN will request a dose reduction from MD, start date June 25, 2013.</p> <p>-All residents on medications for insomnia will be reviewed. Care plans will be revised. Dose reductions will be requested from MD to ensure GDRs have been attempted. Sleep monitors will be implemented.</p> <p>-Pharmacy will review sleep aids monthly. Recommendations for GDR's will be addressed by the DON and nurses delegated.</p> <p>-The RN Supervisor will follow up on the monthly recommendations from Pharmacy and MD responses. A report will be given at the monthly Quality Improvement meeting x 3 months and then quarterly thereafter.</p> <p>-Completion Date July 26, 2013</p>		

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F 329	<p>Continued From page 35</p> <p>*Required limited assistance of one staff for bed mobility and transfers.</p> <p>Resident #5's Physician Orders (recapitulation), dated 5/1/13, included an order for Trazodone 100 mg at bedtime for dementia with insomnia and to monitor and document the resident's hours of sleep.</p> <p>The resident's 5/7/13 Care Plan (CP) for medical conditions documented, "insomnia." Approaches included for a nurse to monitor medication dose side effects, and the use of a C-PAP at night.</p> <p>NOTE: Federal Guidance at §483.25 (l), states, "...Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medication..." And, "...The use of non-pharmacological interventions...permit use of lowest possible dose..."</p> <p>a. There was no other CP interventions to address the resident's insomnia that included alternative sleep hygiene techniques such as lowering lights, massage, or soft music etc.</p> <p>b. Resident #5's medical record did not include documentation a gradual dose reduction had been attempted or physician justification for the continued use of the Trazodone.</p> <p>On 5/9/13 at approximately 9:30 a.m. the Infection Control nurse stated there was no any documentation a gradual dose reduction had been attempted and the CP did not include nonpharmacological interventions to address the sleep.</p>	F 329			

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F 425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policies, it was determined the facility failed to ensure that procedures and policies were established for the time range for administering protein pump inhibitors (PPIs) and the disposal of used Fentanyl patches after they were removed from residents. This affected 1 of 9 residents (#15) observed during medication pass, and 2 of 2 random residents (#s 16 & 17) who wore a Fentanyl patch. This failed practice had the potential to interfere with the proper absorption and effectiveness of medications that should be</p>	F 425	<p>F 425</p> <p>-For residents #15, #16 and # 17 the policy for timing of medications has been requested from pharmacy, MARS updated and initiated on June 11, 2013.</p> <p>-Policy for removal/disposal of Fentanyl and other controlled patches has been received by pharmacy, in serviced to LN staff on June 11, 2013.</p> <p>-All residents on medications with special delivery requirements or controlled patches could be affected. The policies received from pharmacy have been reviewed by the pharmacist on June 11, 2013 and new directives have been initiated.</p> <p>-Pharmacy has done an in-service on the administration of medications (ie- Omeprazole) and the removal/disposal of controlled patch medications for all licensed staff on June 11, 2013.</p> <p>-MAR's will be reviewed by LN's prior to the end of month change over to ensure all medications with special delivery requirements have appropriate directives for nurses.</p>		

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F 425	<p>Continued From page 37</p> <p>administered on an empty stomach and posed a danger in the facility and local community if the unused portions of discarded Fentanyl patches were to fall into a confused resident's hands or be diverted into the community. Findings included:</p> <p>1. During a medication pass observation on 5/7/13 at 9:00 am, LN #1 administered omeprazole by mouth to Resident #15 in the dining room after the resident had just finished her breakfast.</p> <p>Resident #15's May 2013 Physician Orders (Recapitulation) listed, "Omeprazole 20 mg take by mouth once daily for gastroesophageal reflux disease."</p> <p>The Nursing 2013 Drug Handbook (NDH 2013), page 1011, under the drug omeprazole, documented, "Give drug at least 1 hour before meals." The NDH 2013 documented the onset time for the drug to start working was 1 hour, the peak time 30 minutes to 2 hours, and half-life was 30 - 60 minutes.</p> <p>The Center for Clinical Standards and Quality/Survey & Certification Group Ref. S&C: 13-02-NH, November 2, 2012 letter documented, "Section 483.60(a), Pharmacy Services, requires the facility to establish procedures that assure the accurate administration of medications to meet the needs of each resident. The facility must have policies that address the timing for medications that are required to be administered with regard to food intake (for example, with food or on an empty stomach). PPIs, such as lansoprazole (Prevacid) and omeprazole (Prilosec)..."</p>	F 425	Continued F 425		
			<p>-Pharmacy will continue to monitor orders and MARs on a monthly basis, start date June 11, 2013. DON or RN Supervisor will report concerns at the monthly Quality Improvement meeting monthly x 1 month and then quarterly.</p> <p>-Completion Date July 26, 2013</p>		

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F 425	<p>Continued From page 38</p> <p>On 5/8/13 at 3:00 pm, the DON was interviewed about the administration time of the omeprazole. The DON stated the omeprazole should have been given with the 7:00 am medications. The DON was then asked to provide a copy of their policy for administering PPIs and other medications with specific recommendations for administration in regards to food. The DON later provided a copy of a medication policy that did not address the administration of PPIs. It stated:</p> <p>"Policy for Medication times. All medication will have a time range rather than specific times. There will be certain medication that will need to be given at specific times, thyroid medications, osteoporosis medications, anticoagulation medications are a few examples. The ranges are as follows: AM - Range is from 7:30 AM to 10:30 AM MIDDAY - Range is from 11:30 AM to 1:30 PM PM - Range is from 3:30 PM to 6:30 PM HS - Range is from 7:00 PM to 10:30 PM There could be adjustments to the above times for certain residents when based on resident choice." Meal times were hand written onto this form as breakfast at 8:00 AM, lunch at 12:30 PM, and dinner at 6:00 PM.</p> <p>2. The Center for Clinical Standards and Quality/Survey & Certification Group Ref: S&C: 13-02-NH, November 2, 2012 letter documented, "Service Consultation requires a licensed pharmacist, who is employed by or provides services to a facility, to establish a system of records of receipt and disposition of all controlled medications. The system should enable periodic, accurate reconciliation and accounting of all</p>	F 425			

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F 425	<p>Continued From page 39</p> <p>controlled drugs. Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for abuse, misuse and diversion, and the substantial amount of Fentanyl remaining in the patch after use... Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized."</p> <p>During an interview on 5/9/13 at 2:25 pm LN #s 9 and 15 were asked if they had any residents who wore Fentanyl patches. The LNs stated "Yes" and they were asked about the facility's procedure and policy for the destruction/disposition of used Fentanyl patches. Both nurses were asked if two nurses witnessed the destruction of used Fentanyl patches and if the destruction/disposition of the patches was documented. Both LNs stated, "No," regarding the witness by two nurses and "No," regarding documentation of the destruction/disposition of used patches. The LNs stated one nurse, usually on the evening shift, would remove the old patch, replace it with the new patch and discard the old patch in a sharps container. Both LNs stated that the destruction of unused patches required the witness of two nurses to destroy them and that it was documented on the controlled drug log.</p> <p>On 5/9/13 at 3:30 pm, the DON was asked if there was a policy that covered the destruction/disposition of used Fentanyl patches. The DON stated she would look for a policy. Later that day the DON stated she was not able to locate a policy that covered the destruction/disposition of used patches.</p>	F 425			

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F 425	Continued From page 40 On 5/10/13 at 5:30 pm, the Administrator and the DON was asked to provide a list of residents in the facility that used Fentanyl patches. On 5/14/13 the facility provided a list of two residents who used Fentanyl patches, Random Residents #s 16 and 17. A Drug Disposition log for Resident #17, obtained during the survey documented Resident #17 had an order for Duragesic *Fentanyl 50 mcg patch topically every 72 hours. The log documented that the resident's patch was changed on the evening shift of 5/1/13, 5/5/13, and 5/7/13. The log did not document the disposition of the used patch that was removed from the resident on those dates.	F 425			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	F 431 -Central Supply where medications are stored will have a locked cabinet where CNA staff do not have access. LN will only have access to medication cabinets, carts and refrigerators. -The medication room where expired medications were located will be checked for other medications that have expired. Medications will be destroyed, as needed, per facility policy. -All licensed nurses and CNAs will be educated about the facility expectation that medication cabinet/cart keys will be kept on the person of the licensed nurses responsible for medication cabinet administration on June 27, 2013. CNAs are not to have access to the medication cabinets, carts and refrigerator.		

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F 431	<p>Continued From page 41 controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure outdated multi-dose flu vaccine and lactose liquid were discarded. This was true for the flu vaccine in 1 of 2 medication room refrigerators and 2 of 2 bottles of Lactulose observed in the unit D medication room. The outdated flu vaccine had the potential to provide ineffective immunity for any resident receiving flu vaccine from the outdated vial. The outdated Lactulose had the potential to affect Resident #1's health status by not working effectively to resolve the resident's constipation. In addition, the facility failed to ensure that only authorized individuals could access rooms where medications were stored and not locked. This was true for 2 of 3 rooms observed. Findings include:</p> <p>1. During an observation of the facility's two medication rooms on 5/10/13 at 3:45 pm, an</p>	F 431	<p>Continued F 431</p> <p>-All other medication storage areas; rooms, medication carts, individual resident rooms (if self-medication), will be checked for properly labeled and dated medications. If expired medications are found, they will be destroyed per facility policy.</p> <p>-Licensed nurses are assigned to check carts, cabinets and refrigerator for expired or improperly labeled/dated medications monthly. LN will sign monthly audit sheet, start date June 25, 2013.</p> <p>-LN completes a medication room audit on a monthly basis. DON will receive audit results and report findings at the Quality Improvement meeting monthly x1 month and quarterly thereafter.</p> <p>-Completion Date July 26, 2013.</p>		

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F 431	<p>Continued From page 42</p> <p>outdated vial of flu vaccine was found in the refrigerator of the unit D medication room. The vial was partially used, dated as opened on 12/4/12 , and remained in the box that it came in. According to the manufacturer's insert in the box, "Once entered [the seal was punctured], a multi-dose vial, and any residual contents, should be discarded after 28 days." The vial should have been discarded on December 31, 2012.</p> <p>2. During the same observation, of the medication room on the D unit, two 450 cc bottles of liquid Lactulose were observed. Both bottles were labeled for Resident #1. One of the bottles had an expiration date of 3/11/13 and the other 4/16/13.</p> <p>Resident #1 was admitted to the facility on 8/18/06, and readmitted on 12/30/08, with diagnoses including uncomplicated senile dementia, generalized muscle weakness, difficulty walking, diabetes mellitus, and benign prostatic hypertrophy (BPH).</p> <p>The resident's most recent quarterly MDS assessment, dated 3/2/13, coded: * Moderate cognitive impairment with short and long-term memory problems; * Functional limitation in range of motion in both upper extremities; * Frequent incontinence of bowel and bladder.</p> <p>The resident's most recent Bowel and Bladder screen, dated 2/28/13, documented the resident needed a laxative or enema two or more times per week. Resident #1's 4/30/13 Physicians Orders (Recapitulation) included an order for Lactulose</p>	F 431			

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F 431	<p>Continued From page 43</p> <p>30 CC (cubic centimeters) by mouth once daily as needed for constipation. The start date for the order was 4/12/12.</p> <p>On 5/10/13 at 4:00 pm the DON was notified of the expired medications. The DON immediately discarded the medications.</p> <p>3. During observations of the medication rooms on the D and C units on 5/10/13 at 3:30 pm the following was observed:</p> <p>a. Three shelves of over the counter medications such as ibuprofen, milk of magnesia, tylenol, and stool softners were stored, unlocked, in the central supply room on the D unit. The key for the central supply room was hanging by the door to the nurses station and could be accessed by anyone. Immediately prior to the observation a C.N.A. was observed entering and exiting the room.</p> <p>b. When asked for assistance to enter the medication room on the C unit, a male C.N.A. went to the nurses station and accessed the key hanging at the entrance, then unlocked the door for the surveyor. An unlocked refrigerator in the medication room contained 5 bottle of novolog insulin and several suppositories. The Unit Manager (UM) for the C unit was asked to accompany the surveyor into the medication room and asked what the refrigerator was used for. The UM pointed to the insulins, suppositories, flu vaccines and an opened metal lock box which she said generally contained Ativan. The the Ativan was currently in use by the hall nurse and nothing was in the box. The UM also stated that resident's IV medications may be stored in the</p>	F 431		

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F 431	Continued From page 44 refrigerator as well. The easy access to the refrigerator by all staff was discussed with the UM, who acknowledged that the key to the room was generally hanging at the nurses station and accessible to all staff. Guidelines at 42 CFR 483.60(b)(2)(3)(d)(e), F431, document, "Storage areas may include, but are not limited to, drawers, cabinets, medication rooms, refrigerators, and carts. Depending on how the facility locks and stores medications, access to a medication room may not necessarily provide access to the medications (for example, medications stored in a locked cart, locked cabinets, a locked refrigerator, or locked drawers within the medication room). When medications are not stored in separately locked compartments within a storage area, only appropriately authorized staff may have access to the storage area."	F 431		
F 441 SS=E	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 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F 441 -All Department Leaders will complete environmental rounds in their departments to ensure items are not stored directly on the floor. Monitoring will be done weekly x 4, then monthly x 3 beginning June 24, 2013. -This has the potential to affect all residents. -Administrator and Environmental Services Director will do rounds monthly x 3, beginning June 12, 2013. Administrator will address this issue at the Quality Assurance meeting x3 months and then quarterly thereafter. -Completion Date July 26, 2013	

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F 441	<p>Continued From page 45</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff adhered to standard infection control measures. This was true when foam cushions were found on the floor in a Therapy Department closet. This failure had the potential to affect 8 residents who needed a foam cushion to sit on and could lead to the spread of infections in the facility. Findings included:</p> <p>On 5/9/13 at 2:35 p.m., during an inspection of the main Therapy Department, 14 foam cushions, each about 2 inches thick and the size of a standard w/c seat, were observed stored in a</p>	F 441			

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F 441	<p>Continued From page 46</p> <p>closet with the hydroculator. Eight of the foam cushions were in contact with the floor. Two cushions were flat on the floor in front of the hydroculator and 6 cushions were on their sides (vertical) next to the hydroculator. One edge of each of the 6 vertical cushions was in contact with the floor. All but 2 of the cushions were in a clear, thin plastic sleeve. Both of the unsleeved cushions were in contact with the floor. One of them was flat on the floor, the other was vertical with 1 edge on the floor. Six other foam cushions were stacked on top of the vertical cushions.</p> <p>At approximately 2:40 p.m., when asked about the cushions on the closet floor, Physical Therapist (PT) #14 looked in the closet and stated, "Not usually that many in here."</p> <p>At 2:50 p.m., the Rehab Director was interviewed. When asked about the cushions on the floor in the closet, the Rehab Director stated, "Usually we only have a few of them in here. I don't know why we have so many now." When asked how the cushions were used, the Rehab Director stated the plastic would be left on and the cushions would be placed in residents' wheelchairs or other chair seats. PT #14 added that the unsleeved cushions would be cut into pieces and used to pad resident equipment when needed. The Rehab Director acknowledged the cushions in contact with the floor was an infection control issue and he immediately moved the cushions to shelves in another storage area in the department.</p> <p>On 5/10/13 at about 5:50 p.m., the Administrator and DON were informed of the infection control issue. No other information or documentation was</p>	F 441			

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F 441	Continued From page 47 received from the facility.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure the flooring in the food preparation area of the kitchen was maintained in a cleanable condition. This affected 7 of 7 (#s 1-7) sampled residents and all residents who dined in the facility. This practice created the potential to expose residents' food to disease causing pathogens. Findings included: On 5/9/13 at 11:45 a.m., the floor in the food preparation area of the facility's kitchen was noted to be an industrial type non skid material. There were more than 50 dents, dings, cuts, and indentations in the floor surface. The floor seams between the baker's room and the stove area, the stove area and the food preparation sink, the serving line and the employee's utility entrance, and the floor seam in the dry storage rooms had gaps ranging from 3 inches long to 4 feet long and 1/4 inch wide to 3/4 inch wide. The gaps were filled with dirt and debris. There were also 3 gaps and loose areas in the gray rubber base board under the steam table plus a missing piece of base board 10 inches long and 1 inch wide. Each of the gaps and loose area were filled with dark gray debris.	F 465	F 465 -Kitchen floor will be replaced. -Maintenance and Executive Director to do rounds and identify other floor concerns. Estimates will be collected on repair costs and repairs will be scheduled on any floors needing to be replaced or repaired. -Department leaders will assess environmental needs in their departments and give a written report to the Executive Director and Maintenance Director every month. Areas of concern will be addressed and fixed. -Executive Director will report findings from monthly reports received from Department Managers at Quality Assurance meeting monthly x 3, then quarterly thereafter. -Completion Date July 26, 2013	

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F 465	Continued From page 48 On 5/9/13 at 11:50 a.m., the surveyor informed the DDS and consulting Registered Dietician about the condition of the floor in the kitchen. The DDS stated, "We clean the kitchen floor every night." The DDS agreed that the multiple dings, dents, cuts, and gaps in the floor seams and rubber base boards, made it difficult to clean and maintain the kitchen floor. The 2009 FDA Food Code Chapter 4, subpart 202.16 Nonfood-Contact Surfaces indicated, "Nonfood-contact surfaces shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance."	F 465		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all handrails were clear of linen and medication carts and accessible to residents. This was true for the short corridor in front of the nurse's station on the C unit and had the potential to affect 2 of 7 sampled residents (#s 4 & 6) and all other residents who moved about independently in the aforementioned area. The lack of accessible handrails in the corridor area created the potential for residents in wheel chairs to not be able to move independently, using the side rail, or ambulatory residents to stabilize themselves if	F 468	F 468 -All carts have been removed from in front of handrails so that residents #4, #6 and all other residents can move about independently in the short corridor in front of the nurse's station on C unit. -This has the potential to affect all residents. -Maintenance Supervisor to do rounds to identify items blocking access to hand rails/exits, remove items and put in proper place.	

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F 468	Continued From page 49 needed. Findings included: During all days of the survey, from 5/6/13 to 5/9/13, the handrail on the far side of the walk area in front of the C unit nurse's station was observed to be obstructed by a linen cart on one side of the medication room and a nurses medication cart on the other side of the medication room. This left an area of approximately 15 feet, on the one side, where there was no free access to a handrail and the opposite side which was either filled by the desk at the nurse's station or open space. Resident #4 was observed throughout the survey to ambulate without staff assistance up and down the hall way. Resident #6 ambulated with staff assistance but was independently mobile in his wheelchair. On 5/9/13 the RN Unit Manager for the C unit was informed of the handrail issue. The UM stated that the cart was used by every shift as an extra linen cart but could see that it was blocking the handrail in that area. The UM immediately moved the cart from the hallway.	F 468	Continued F 468 -Maintenance will educate staff on 6/19/13 on the expectation to keep hand rails accessible at all times and that work related items cannot be stored in hall ways for more than 15 minutes. -Charge nurses in resident care areas throughout their shifts will monitor hand rails and provide immediate education for staff storing items at handrails in halls. -Maintenance to do rounds weekly x4, then monthly x3 and report to the Administrator. The Administrator will report findings monthly x3 at the Quality Assurance meetings, then quarterly thereafter.		
F 517 SS=E	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on policy review and staff interview, it was	F 517	-Completion Date July 26, 2013		

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/10/2013
NAME OF PROVIDER OR SUPPLIER KARCHER ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
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F 517	Continued From page 50 determined the facility failed to ensure a policy for missing resident(s) was in place. This had the potential to affect 1 of 1 sample residents (#3) and 1 of 1 random residents (#16) identified as at risk for elopement; and, all other independently mobile residents who could have left the facility without supervision. This failure created the potential for staff to not recognize and/or not know what to do if a resident was missing which increased the risk for injury or harm to any resident who was missing. Findings include: The facility's Emergency Preparedness manual was briefly reviewed in the morning on 5/7/13. The manual did not include a policy regarding missing residents. On 5/7/13 at about 11:30 a.m., the Administrator was asked to provide their policy on missing residents. On 5/7/13 at 3:05 p.m., the Administrator provided an "Elopements" policy and stated, "We did not have one before but we do now."	F 517	F 517 -An elopement policy is in place. All Staff will be in-serviced on June 19, 2013. -This has the potential to affect all residents. -All policies could potentially require updates or changes. The facility will ensure that policies are available to staff and update them as new policies and procedures are received from new management company. -Administrator will conduct an annual review of policies and procedures to ensure policies exist for pertinent issues and changes in regulations. Upon review, the Administrator will report changes to the Quality Assurance committee.		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure staff were trained in	F 518	-Completion Date July 26, 2013		

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F 518	<p>Continued From page 51</p> <p>emergency procedures. This was true for 3 of 3 staff (CNA #s 7 and 8, and LN #15) interviewed about emergency preparedness. The failure had the potential to affect 1 of 1 sample residents (#3) and 1 of 1 random residents (#16) identified as at risk for elopement; and, any other independently mobile resident who may have left the facility without supervision. The failure placed missing residents at risk for injury and harm. Finding included:</p> <p>NOTE: Review of the facility's Emergency Preparedness manual revealed it did not include a policy on missing residents. And on 5/7/13 at 3:05 p.m., the Administrator stated the facility did not have a policy regarding missing residents until then. (Refer to F517, regarding emergency preparedness policies, for the details.)</p> <p>a. On 5/9/13 at 2:05 p.m., when asked about emergency preparedness training regarding missing residents, CNA #8 looked at the back of her name badge for the answers. When asked if she had been trained by the facility regarding missing residents, the CNA stated, "last year."</p> <p>b. On 5/9/13 at 2:40 p.m., when asked about emergency preparedness training regarding missing residents, CNA #7 stated he had been trained at "other places." When asked if he had been trained by the facility regarding missing residents, the CNA stated he received education about missing resident's on 5/7/13.</p> <p>c. On 5/9/13 at 3:00 p.m., when asked about emergency preparedness training regarding missing residents, LN #15 stated "We just got one [policy]."</p>	F 518	<p>F 518</p> <p>-A policy and procedure has been placed in the Emergency Preparedness Manual.</p> <p>-No elopement has occurred in the facility.</p> <p>-All staff will be educated on the Elopement/ Missing Person Policy. The Administrator will report at the policy and procedure review in Quality Assurance Meeting x 3 and then quarterly.</p> <p>-Completion Date July 26, 2013</p>		

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F 518	Continued From page 52 On 5/10/13 at 12:15 p.m., the Staff Development Coordinator stated, "I put it (Elopement policy) out this week for staff after [Administrator's name] handed it out."	F 518			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/10/2013
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NAME OF PROVIDER OR SUPPLIER KARCHER ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651
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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 State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN - Team Coordinator Sherri Case, LSW, QMRP Lorraine Hutton, RN</p>	C 000		
C 123	<p>02.100,03,c,vii Free from Abuse or Restraints</p> <p>vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to himself or to others;</p> <p>This Rule is not met as evidenced by: Please see F225 and F226 as it relates to resident abuse.</p>	C 123	<p>See F225 and F226</p>	
C 125	<p>02.100,03,c,ix Treated with Respect/Dignity</p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;</p> <p>This Rule is not met as evidenced by: Refer to F241 as it related to standing while feeding a resident.</p>	C 125	<p>See F241</p>	

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JUN 25 2013
FACILITY STANDARDS

Bureau of Facility Standards
Monna L Lamb Executive Director
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE, TITLE
 DATE 6/25/13 (X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/10/2013
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C 239	02.106,04 EMERGENCY PLANS PROTECTION & EVACUATION 04. Emergency Plans for Protection and Evacuation of Patients/Residents. In cooperation with the local fire authority, the administrator shall develop a written plan for employee response for protection of patients/residents in case of an emergency. The plan shall include at least the following: This Rule is not met as evidenced by: Refer to F517 as it related to the lack of a policy for missing residents.	C 239	See F517	
C 243	02.106,05 ORIENTATION, TRAINING & DRILLS 05. Orientation, Training and Drills. All employees shall be instructed in basic fire and life safety procedures. This Rule is not met as evidenced by: Refer to F518 as it related to the lack of staff training regarding missing residents.	C 243	See F518	
C 362	02.108,07,a Interior Surfaces Kept Clean & Sanitary a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: Refer to F465.	C 362	See F465	
C 389	02.120,03,d Sturdy Handrails on Both Sides of Halls	C 389	See F389 <i>dy</i>	

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C 389	Continued From page 2 d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/residents. This Rule is not met as evidenced by: Refer to F468.	C 389	See F468	
C 393	02.120,04,b Staff Calling System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F246 as it related to accessibility of call lights.	C 393	See F246	
C 645	02.150,01,a,ii CARE OF EQUIPMENT ii. Care of equipment. This Rule is not met as evidenced by: Refer to F441 as it related foam cushions in contact with the floor that were available for resident use.	C 645	See F 441	

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C 745	Continued From page 3	C 745		
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281.	C 745	See F281	
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please see F 280 as it pertains to care plan revisions.	C 782	See F 280	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please to refer to F 309 as it relates to following the resident care plan. Refer to F329.	C 784	See F309 See F329	
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof,	C 789		

