



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7007 3020 0001 4044 6901

June 18, 2013

Nancy E. Trout, Administrator
Life Care Center of Treasure Valley
502 North Kimball Place
Boise, ID 83704

Provider #: 135123

Dear Ms. Trout:

On **June 7, 2013**, a Recertification and State Licensure survey was conducted at Life Care Center of Treasure Valley 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.) **Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.

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After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 1, 2013**. Failure to submit an acceptable PoC by **July 1, 2013**, may result in the imposition of civil monetary penalties by **July 22, 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 7, 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, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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)

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

This request must be received by **July 1, 2013**. If your request for informal dispute resolution is received after **July 1, 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,

A handwritten signature in cursive script that reads "Loretta Todd".

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

LT/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Karen Marshall, MS, RD, LD, Team Coordinator Arnold Rosling, RN, BSN, QMRP Amy Jensen, RN Karla Gerleve, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CHF = Congestive Heart Failure CNA = Certified Nurse Aide C/O = Complaints of DM = Dietary Manager DNS/DON = Director Nursing Services/Director of Nursing Dx = Diagnosis E-PNs = Electronic Progress Notes FDA = Food and Drug Administration FSM = Food Service Manager Gr = Grains Hx = History IDT = Interdisciplinary Team LN = Licensed Nurse LSW = Licensed Social Worker MD = Medical Doctor MDS = Minimum Data Set assessment MG = Milligram MAR = Medication Administration Record NP = Nurse Practitioner PO = By mouth PRN = As Needed Q = Every</p>	F 000	<p>Submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in this statement of deficiency. This plan of correction is being submitted because it is required by law.</p> <p>F 156 Corrective action for specific residents Residents # 19, 20 & 21 have discharged from the facility.</p> <p>Other residents affected</p> <p>Other residents that have Medicare have the potential to be affected.</p> <p>What measures will be put into place/systemic changes to prevent recurrence</p> <p>Residents with Medicare have been reviewed and will be given a non-coverage letter for signature with change in Medicare coverage.</p> <p>Licensed Social workers have been inserviced of need to provide notice both orally and in writing of changes in Medicare coverage and to provide written notice to resident if the resident chooses to discharge letting them know they still have Medicare days available.</p> <p>LSW was re-inserviced on providing non coverage letters 72 hours in advance when facility makes the determination the residents are no longer benefitting from skilled care.</p>	<p>RECEIVED JUL - 1 2013 FACILITY STANDARDS</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Amy Jensen</i>	TITLE <i>RD</i>	(X6) DATE <i>6/25/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 RDCS = Regional Director of Clinical Services Res = Resident RN = Registered Nurse RNUM = Registered Nurse Unit Manager R/T = Related To ST - Speech Therapist TAR = Treatment Administration Record UTI = Urinary Tract Infection WC = Wheelchair HS = Hour of Sleep/Bedtime NOC = Night Tx = Treatment	F 000	Monitoring to ensure deficiency does not recur Executive Director will audit 2 x per week for 6 weeks, and then 1 x month for 1 month; for residents with changes in Medicare coverage, specifically, residents will be notified that they still have Medicare coverage left in writing if they decide to discharge home prior to end of Medicare coverage.		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	Audits to begin 6/28/13 The Executive Director will bring results of the audits to QA/PI meeting. Ongoing education or audits will be scheduled based on trends. Date of Compliance 07/08/13	07/08/13	

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

PRINTED: 06/07/2013
FORM APPROVED
OMB NO. 0938-0391

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F 156	<p>Continued From page 2</p> <p>inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the</p>	F 156		
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F 156	<p>Continued From page 3</p> <p>facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, it was determined the facility had failed to inform residents of their right to request a review of their medicare coverage. This was true for 3 (#s 19, 20, 21) random closed records reviewed. This had the potential for psychological harm if the residents were not informed of their right to appeal and they were experiencing Medicare billing problems that were not resolved. Findings include:</p> <p>1. Resident #19 was admitted to the facility 1/14/13 with diagnoses of care involving other specified rehabilitation procedure, difficulty walking, and ulcer of other part of lower limb.</p> <p>The resident was on Medicare during his stay. The resident was discharged on 2/3/13 to home. The facility failed to notify the resident about his</p>	F 156			

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F 156	Continued From page 4 right to remain in the facility and the right to appeal facility decisions if he wanted to stay and amount of Medicare days that he had remaining. 2. Resident #20 was admitted to the facility 4/3/13 with diagnoses of care involving other specified rehabilitation procedures, difficulty walking, aftercare of healing traumatic fracture and intracranial injury. The resident was on Medicare during his stay. The resident was discharged on 6/1/13 to home. The facility failed to notify the resident about his right to remain in the facility and the right to appeal facility decisions if he wanted to stay and amount of Medicare days that he had remaining. 3. Resident #21 was admitted to the facility on 2/2/13 with diagnoses of care involving other specified rehabilitation procedure, muscle weakness, aftercare for healing traumatic fracture of lower arm. The resident was on Medicare during her stay. The resident was discharged 3/30/13 to an assisted living facility. The facility failed to notify the resident about his right to remain in the facility and the right to appeal facility decisions if he wanted to stay and amount of Medicare days that he had remaining. The two social workers were interviewed about the failure to provide the Medicare notice on 6/5/13 at 2:00 p.m. They indicated the residents were being discharged and they thought they did not have to provide information. No further information was provided.	F 156	F 176 Corrective action for specific residents Resident # 34 has been discharged. Other residents affected Residents who receive medication have the potential to be affected. They will have their medications administered by licensed staff or have a self-administration of medications assessment completed if medications are at bedside. What measures will be put into place/systemic changes to prevent recurrence	
F 176	483.10(n) RESIDENT SELF-ADMINISTER	F 176		

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F 176 SS=D	Continued From page 5 DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. 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 were assessed by the IDT to determine the resident's safety for self administration of their medications. This was true for 1 of 10 residents (#34) reviewed during medication pass. This had the potential of the resident not taking her medication. Findings included: On 6/5/13 at 11:05 am, during a medication pass, RN #1 provided medication to Random Resident #34. After Resident #34 swallowed the medication provided by the RN#1, RN#1 sat the small cup of water on the over the bed table next to the resident. The RN and surveyor observed two pills on the over the bed table. One pill was white and appeared to be cut in half. The second pill was light green and oblong. RN#1 asked Random Resident #34, "What are these?" The resident stated, "I don't know, I picked them up off the floor." RN#1 removed the pills from the table and walked out of the resident's room. On 6/5/13 at 11:20 am, the surveyor asked Random Resident #34, if she knew where the pills on the table came from. Random Resident #34 replied, "Sometimes I put them in my hand	F 176	Licensed staff, unit managers & SDC have been in-serviced that medications can not be left at bedside unless a self administration of medication is completed and care planned with MD orders. Monitoring to ensure deficiency does not recur Nurse Managers will audit 2 times per week for 8 weeks then 1 time a month for 1 month that there are no medications at bedside unless self administration assessment is in place. Audits will begin 6/21/13. ED/DON to bring results of audits to QA/PI meeting. Ongoing audits to be scheduled based on trends. Date of Compliance 07/08/13	07/08/13
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F 176	Continued From page 6 and they must of fell out and dropped on the floor." During interview with the DON on 6/5/13 at 2:15 pm, the DON stated, "They [staff] told me about the pills. I had them do a look thru on the whole unit to make sure there are no more pills in the residents' rooms." On 6/6/13 at 3:00 pm, Random Resident #34's records were reviewed. There was no documentation which indicated the resident was assessed to safely self administer her medication. On 6/6/13 at 3:00, RN #3 on duty that day for Resident #34 stated, "If she self administered her medication it would be on her care plan, but it's not there because she doesn't." At 3:30 pm, RN #3 provided the surveyor with a blank Medication Self-Administration Review form stating, "If she were assessed to take her own medications, this form would be filled out, but she wasn't assessed." On 6/6/13 at 4:15 pm, the Administrator was notified of the resident's medication on the over the bed table. No documentation or information was received which resolved the issue.	F 176		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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:	F 241	F241 Corrective action for specific residents Resident #4 and #32 are receiving dining service provided with dignity and individual interaction by staff. Resident #3 call light is being answered promptly by staff in a quiet manner. Individual staff involved has been educated.	

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F 241	<p>Continued From page 7</p> <p>Based on observation and staff interview, it was determined the facility failed to enhance residents' dignity during dining, and while responding to a resident's call light. This was true of 2 of 11 (#s 3 & 4) sampled residents and 1 of 22 (#32) random residents observed while dining. This failed practice had the potential to have a negative impact on the residents' self esteem and self worth. Findings included:</p> <p>1. On 6/3/13 at 6:00 pm in the 300 Hall Dining Room during the dinner meal observation, LN #6 was sitting on a stool with wheels, at the corner of a square table. There were 4 residents sitting at the same table. LN #6 was not facing Resident #4 who was to his left or facing Resident #32 who was to his right. LN #6 had a spoon in his left hand and a spoon in his right hand and was assisting both Resident #4 and Resident #32 to eat at the same time. LN #6 did not interact or converse with either resident or engage in face to face contact while assisting the residents to eat. LN #6 was observed conversing with other staff and residents but was not focusing on Resident #4 and Resident #32 as individuals.</p> <p>On 6/6/13 at 2:00 pm the DON was informed of the dignity issue during the dinner meal observation of LN #6 feeding Residents #3 and #32, both at the same time, and without engaging in face to face contact or conversation. The DON stated "So that is a dignity issue too." No information or documentation was provided that resolved the issue.</p> <p>2. Resident #3 was admitted to the facility on 8/13/11 with diagnoses of Diabetes, hypertension, dementia, and recently experienced a left</p>	F 241	<p>Other residents affected</p> <p>Residents who live/dine in 300 hall could be affected by these practices.</p> <p>What measures will be put into place/systemic changes to prevent recurrence</p> <p>Nursing Staff have been in- serviced on dignity, specifically assisting residents at meals individually while interacting one on one with them.</p> <p>Nursing staff also in-serviced to ensure residents dignity is protected when answering call lights to ensure residents do not hear communication about other residents from staff.</p> <p>Monitoring to ensure deficiency does not recur</p> <p>300 hall dining room is being monitored to ensure residents are being assisted by staff with individual interaction and dignity provided.</p> <p>Nurse Managers, Department Managers are assigned to the dining rooms. They will monitor and conduct audits 3 times per week times 6 weeks then weekly times 6 weeks then monthly times 2. Start date 6/28/13</p> <p>300 hall call lights are being monitored by Nurse Managers or Department managers to audit for prompt response without sharing information about residents that other residents could overhear 3 times a week times 6 weeks</p>	

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F 241	Continued From page 8 humorous fracture. Resident #3's most recent Care Plan read in part: Alteration in communication: "[Resident #3] speaks only [a language other than English]" On 6/3/13 at 2:35 pm in the common area of the 300 Hall, Resident #3's call light sounded. Resident #6 was in the common area along with several other 300 Unit residents. LN #6 shouted across the TV room and common area to CNA #7, "You answer it, I don't speak [a language other than English], but you and [another CNA's name] have a good rapport with her." On 6/6/13 at 2:00 pm, the DON was informed of the dignity issue of LN #6 shouting across the TV room and common area over other residents, to CNA #7, regarding Resident #3's spoken language. The DON stated, "Let me write this down as dignity too." No other information or documentation was provided that resolved this issue.	F 241	then weekly times 6 weeks then monthly times 2. The ED/DON will take the results from the audits to the QA/PI meeting monthly. Education and further audits will be based on trends identified. Date of Compliance 07/08/13 F 246 Corrective action for specific residents Resident #1 has call light within reach while #10 has been provided a soft touch quad call light. Other residents affected Other residents have the potential to be affected that use a call light and will have their call lights readily available.	07/08/13
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:	F 246	What measures will be put into place/systemic changes to prevent recurrence Education provided to staff on ensuring call lights are available to residents. Monitoring to ensure deficiency done not recur Department or nurse managers will audit that call lights are within reach 2 times per week for 8 weeks than 1 time per month for 2 months. Start date 6/28/13	

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F 246	<p>Continued From page 9</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to: Ensure a Resident's call light was in reach at all times and a resident without a call light had an alternate means to request assistance. This was true for 2 of 11 (#s 1 & 10) sampled residents. This deficient practice had the potential to cause more than minimal harm when residents did not have a way to alert staff of their needs. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 2/25/2005 with multiple diagnoses including: Macular degeneration, anxiety, depressive disorder, CHF.</p> <p>Resident #1's Quarterly MDS, dated 02/22/13, coded in part: *Vision severely impaired *Ability to make herself understood *Ability to understand others</p> <p>Note: The only dates documented on the Care Plan were the "Onset dates" which indicated the initial date the "Problems" were identified and the "Target Dates" which indicated the date the identified "Goals" should be met. By looking at the Care Plan it could not be determined when the Care Plan Approaches and Problems were reviewed or revised.</p> <p>Resident #1's Vision Care Plan, dated 2/24/05, documented, "Make sure call light available to summon help."</p> <p>On 06/04/13 at 10:00 am, Resident #1 was observed laying in her bed with her call light on her night stand to the left of her bed, inaccessible</p>	F 246	<p>DON to bring audit results to QA/PI. Further audits and education will be based on trends.</p> <p>Date of Compliance 07/08/13</p>	07/08/13	

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F 246	<p>Continued From page 10</p> <p>to her. (The call light was approximately three feet away for the resident). At 11:00 am, she was observed sitting in her wheelchair on the left side of her bed with her call light attached to the siderails, inaccessible to her. (The call light was approximately one and one-half feet away from the resident).</p> <p>On 6/4/13 at 2:30 pm, RNUM #11 was interviewed and said he was unaware Resident #1 had been without her call light. He said he would talk to the CNAs and re-educate them on the importance of residents having their call lights within reach at all times.</p> <p>2. Resident #10 was admitted to the facility on 12/1/11 with multiple diagnoses to include: History of traumatic brain injury (TBI), explosive personality disorder, Type II Diabetes Mellitus, and spastic hemiplegia and hemiparesis.</p> <p>Resident #10's Quarterly MDS, dated 05/5/13, coded in part:</p> <ul style="list-style-type: none"> *Rarely/Never makes self understood *Rarely/Never understands others *Vision is highly impaired *Short-term memory problem *Long-term memory problem *Rarely/Never makes decisions regarding tasks of daily life <p>Resident #10's Fall Care Plan, dated 12/1/11, documented, "FYI (For Your Information): Keep call light out of res[idents] reach d/t [due to] PICA and Frequent checks when res[ident] is in bed."</p> <p>Note: PICA is a pattern of eating non-food materials, such as dirt or paper. Resident #10 did</p>	F 246		
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F 246	Continued From page 11 not have the diagnosis of PICA on admission to the facility. On 6/3/13 at 2:20 pm during an observation the surveyor walked passed Resident #10's room and heard the resident state, "I can't breathe." The surveyor observed the resident did not have a call light or alternate means to notify staff she required assistance. On 06/4/13 at 2:30 pm, RNUM #11 was interviewed about Resident #10 not having a call light. He said she did not have access to a call light because she had a condition called PICA, where "She puts everything in her mouth within her reach." The staff was afraid she would attempt to eat her call light, so she did not have one. The surveyor asked how did the resident alert staff when she needed help. He said the staff checked on her "frequently." He said he did not have documentation that showed it was being done or how often.	F 246		
F 252 SS=B	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide a homelike environment by serving meals to residents on trays. This affected 6 of 7 (#s 22 - 27) random residents and had the potential to	F 252		

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F 252	<p>Continued From page 12</p> <p>affect all residents who dined in the restorative dining room. This practice created the potential to negatively affect the residents' psychosocial well-being related to a comfortable and homelike environment. Findings included:</p> <p>1. On 6/4/13 at 11:28 a.m., 5 residents were observed dining in the Restorative dining room. All 5 residents had plates with food, cups, and eating utensils on their trays while dining. LN #4 and ST #5 were in the dining room with the residents at this time. ST #5 was sitting at a table with Random Residents #s 24 and 25.</p> <p>-At 12:09 a.m., Random Residents #s 22 through 27 were dining in the Restorative dining room with their meals on a tray.</p> <p>-At 5:36 p.m., 5 residents were observed dining in the Restorative dining room. All 5 residents had plates with food, cups, and eating utensils on their trays while dining. LN #8 was in the dining room with the residents at this time.</p> <p>2. On 6/6/13 at 8:16 a.m., Random Residents #s 22, 26, 27 & 31 were observed dining in the Restorative dining room. Random Residents #s 22, 26, & 27 had plates with food, cups, and eating utensils on their trays while dining. LN #4 was in the dining room with the residents at this time.</p> <p>Federal guidance at F252 indicated, Some good practices that serve to decrease the institutional character of the environment include the elimination of: Meal service in the dining room using trays (some residents may wish to eat certain meals in their rooms on trays).</p>	F 252	<p>F252</p> <p>Corrective action for specific residents</p> <p>Resident # 22 & 26 have discharged. Resident # 24,25, 27, & 31 are receiving dining service provided with dignity by having their tray removed at the table.</p> <p>Other residents affected</p> <p>Residents that eat in the restorative dining room have the potential to be affected and will have the tray removed.</p> <p>What measures will be put into place/systemic changes to prevent recurrence</p> <p>Staff has been in-serviced on dignity, specifically having their tray removed at meal time.</p> <p>Monitoring to ensure deficiency does not recur</p> <p>Nurse Managers or Department managers will conduct audits 3 times per week times 6 weeks then weekly times 6 weeks then monthly times 2 months that trays were removed for meal service. Audits to start 6/24/13.</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 252	Continued From page 13 On 6/6/13 at 1:31 p.m., the surveyor informed the DON of the above observations. The DON stated, "Food is to be removed from trays while residents are dining." The DON made annotations on paper and said she would speak with staff about residents not dining with their food on trays.	F 252	ED/DON will bring results to QA/PI. On going education and audits will be done based on trends. Date of Compliance 07/08/13	07/08/13
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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. This REQUIREMENT is not met as evidenced by:	F 280	F280 Corrective action for specific residents Resident # 1, 4, 7, 9, 10, 11& 15 careplans have been reviewed by the IDT and updated as needed. These residents and families, as appropriate, will be invited to care plan conferences when scheduled. Other residents affected Residents (and their responsible parties) that have care plan conferences have the potential to be affected and will be invited to the careplan conference. Care plan conferences will be interdisciplinary. Other residents with changes to their plans of care or interventions changed will have their careplan updated or revised. What measures will be put into place/systemic changes to prevent recurrence Staff in-serviced on the interdisciplinary care plan process. Staff also in-serviced on inviting the resident and family and documenting who was invited and who attended.	

F280 -
7/3/13
ADDED AFTER →
FOLLOW UP WITH
KAREN MARSHALL
VIA TELEPHONE.

Our physicians continue to participate in the care plan process by driving resident care through, telephone conversation, faxes, and face to face interactions with resident, families and staff. Our physicians continue to review the medical record during acute visits and scheduled every 60 day visits.

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F 280	<p>Continued From page 14</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to periodically review and revise care plans for 7 of 18 sampled residents (#s 1, 4, 7, 9, 10, 11 & 15) and failed to ensure the care plans were prepared by the use of an interdisciplinary team process. This had the potential to result in harm if residents did not receive appropriate care due to lack of direction on the care plan. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 2/25/05 with multiple diagnoses including: macular degeneration, anxiety, depressive disorder, and CHF.</p> <p>Resident #'s Quarterly MDS, dated 2/22/13, documented under Bowel and Bladder: * "No" for was the resident on an Urinary Toileting Program and * Resident was always incontinent</p> <p>Note: The only dates documented on the Care Plan were the "Onset dates" which indicated the initial date the "Problems" were identified and the "Target Dates" which indicated the date the identified "Goals" should be met. By looking at the Care Plan, it could not be determined when the Care Plan Approaches and Problems were reviewed or revised.</p> <p>Resident #1's Urinary Care Plan, dated 08/29/2006, documented in the Approach section, "Resident and family have been educated regarding toileting program ... "</p> <p>On 6/6/13 at 3:00 pm RNUM #11 and the DNS were interviewed. The RNUM said he had no idea</p>	F 280	<p>Staff inserviced on the need to update or revise the care plans when changes in the residents care or interventions occur.</p> <p>The Care Plan Conference schedule will be discussed during stand up meetings so the IDT can attend the conference.</p> <p>Social services will use the Care Plan Conference Record to show who was invited, who attended and a summary of the conference.</p> <p>Monitoring to ensure deficiency done not recur</p> <p>Unit Manager will review the Care Plan with the MDS nurse prior to putting in the chart and make any corrections needed.</p> <p>Executive Director to audit the documentation of the scheduled careplan conferences once per week times 8 weeks then monthly times 2 months to ensure the family and resident was invited and the documentation of who attended is there.</p> <p>Audit to begin 6/28/13.</p> <p>Nurse Managers will audit 8 resident's careplans per week times 4 weeks and update and revise as needed. Then will audit 5 residents careplans per week times 8 weeks. Careplan Reviews will continue with the Unit Managers and</p>	
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F 280	<p>Continued From page 15</p> <p>the resident's care plan documented that she was on a toileting program. In addition, the RNUM said the resident was not a candidate for a toileting program because she was always incontinent. The DNS and the RNUM said they would be reviewing residents care plans and updating them as necessary.</p> <p>Resident #1's Physician's Orders for 6/13 did not contain a current order for the resident's pacemaker to be tested.</p> <p>Resident #1's Cardiac Care Plan, dated 02/24/2005, documented in the Approach section, "Test Pacemaker per manufacturer's and physician's orders. Pacemaker checks will be performed during each scheduled visit with the Physician"</p> <p>On 6/6/13 at 3:00 pm, RNUM #11 and the DNS were interviewed. The RNUM said he was unaware the resident's care plan had anything on it about the resident having pacemaker checks. He said he would have to look into it and as far as he knew the resident was not having this done.</p> <p>On 6/7/13 at 10:50 am, RNUM #1 provided the surveyor additional information. He said he spoke with the Physician's office on 6/6/13 and the office staff told him Resident #1 had been an inactive patient since December of 2009.</p> <p>2. Resident #10 was admitted to the facility on 12/1/11 with multiple diagnoses to include: history of traumatic brain injury (TBI), explosive personality disorder, Type II Diabetes Mellitus, and spastic hemiplegia and hemiparesis.</p>	F 280	<p>the MDS nurses per MDS schedule thereafter.</p> <p>Audits to begin 6/25/13.</p> <p>Audits will be brought to QA/PI by the ED/DON. Education and further audits will be done based on trends.</p> <p>Date of Compliance 07/08/13</p>	07/08/13	

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F 280	<p>Continued From page 16</p> <p>Resident #10's Quarterly MDS, dated 05/5/13, coded: *Rarely/Never makes self understood *Rarely/Never understands others *Vision highly impaired *Short-term memory problem *Long-term memory problem *Rarely/Never makes decisions regarding tasks of daily life</p> <p>Resident #10's Physician's Orders (recapitulation) for 6/13 did not contain current orders for Duoneb breathing treatments, the Resident to be on a Restorative Therapy Program, or for her to receive eye drops.</p> <p>Resident #10's Respiratory Care Plan, dated 12/01/2011, documented in the Approach section, "Duoneb Tx (treatments) per current MD order."</p> <p>Resident #10's Self Care Care Plan, dated, 12/01/2011, documented in the Approach section, Resident was on a Restorative program and she received eye drops per current MD order.</p> <p>On 6/6/13 at 3:00 pm RNUM #11 and the DNS were interviewed. The RNUM and the DNS said the RNUM would be reviewing resident care plans and updating them as necessary.</p> <p>3. Resident #4 was admitted to the facility 12/3/12 with diagnoses of dementia, anxiety, depression and congestive heart failure.</p> <p>The resident's care plan had positioning information, dated 4/24/13, documented by the occupational therapist [OT]. The information sheet was for the resident's left arm to be</p>	F 280		
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F 280	<p>Continued From page 17</p> <p>elevated on 1 to 2 pillows when seated in the wheelchair. The OT was interviewed on 6/6/13 at 10:30 a.m. She indicated the information was not current and was for when the resident was ill and having some edema. The OT further discussed the resident's special wheel chair and positioning at a slight tilt to facilitate positioning using gravity.</p> <p>None of the wheelchair positioning information was part of the resident's care plan. The resident was observed frequently from the afternoon of 6/3 through 6/4/13 to be up in her wheel chair leaning to the left side over the arm rest of the wheelchair. This information was relayed to the OT who stated that the resident probably was not in the chair correctly. There was no current care plan for correct positioning of the resident.</p> <p>4. Resident 7 was admitted to the facility on 12/22/11 with diagnoses of decubitus ulcer, depressive disorder and paraplegia.</p> <p>The resident's care plan, dated 12/23/11, for Risk of Pressure Ulcers had an approach which documented, "Monitor sacral decubitus ulcer daily until resolved." There was an x through the approach and documentation of "resolved." The sore had opened up again on 5/8/13 and the care plan was not updated to reflect this.</p> <p>The resident's care plan for Mood, dated 12/22/11, had a hand written entry which documented, "Talks nonstop moving from one subject to another, then can come back into focus and knows exactly what is going on currently." The hand written information was not dated or signed by the author and it was unclear if it was a problem or an approach.</p>	F 280		
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F 280	<p>Continued From page 18</p> <p>The resident was observed from the afternoon of 6/3 until the afternoon of 6/5/13 to periodically have a black eye patch over the right eye. The resident was questioned about it and indicated she was having some visual issues after cataract surgery. The care plan failed to address any issues related to her visual problems.</p> <p>5. On 6/4/13 at 1:00 p.m., 11 residents attended the Resident Group interview. The surveyors asked the group about participating in care plan meetings. Many of the residents were unclear as to what the surveyors meant by care plan meeting. The surveyors explained the facility should invite residents, family members, representatives, or interested parties to meetings in which staff plan nursing care, medical treatment and activities for the resident. Two of 11 residents verbalized they had not been invited to a meeting in which facility staff planned their nursing care, medical treatment and activities.</p> <p>On 6/6/13 at 9:00 a.m., the surveyor spoke with LSW #9 and LSW #10. The surveyor informed the LSWs that 2 residents in the group interview said they were not invited to care plan meetings. Both LSW #9 and LSW #10 stated, "Care plan meetings are documented in electronic Progress Notes [E-PNs] with the name of the resident invited, and did or did not attend. Family member or interested party invited, and did or did not attend." The surveyor asked if members from the interdisciplinary team attended the meetings. LSW #10 stated, "The Dietary Manager will stop by and ask if there are concerns. Also many residents request dietary to be there and the Dietary Manager comes to the conference/meeting. Usually the meetings are</p>	F 280		
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F 280	<p>Continued From page 19 with social services, the resident, and family members or interested parties. I moved care conferences/meetings from Wednesdays to Thursdays for more staff to be available to attend the meetings." The surveyor then requested to review the last 2 care plan conferences/meetings documented in E-PNs for sampled Residents #s 1-11.</p> <p>The following was determined based on review of the E-PNs.</p> <p>*Resident #7, 2/24/13, Late Entry, Care conference was held in January. The documentation did not provide evidence the resident was, "invited and did or did not attend."</p> <p>*Resident #9, 4/24/13, Care Plan Conference held. The documentation did not provide evidence the resident was invited and did or did not attend.</p> <p>*Resident #11, 5/16/13, the E-PNs did not provide evidence the resident was invited and did or did not attend and whether the invited family attended. E-signed by LSW #9.</p> <p>On 6/6/13 at 10:28 a.m., the surveyor informed LSW #10 of the review of the Resident #7's and Resident #9's E-PNs as identified in the above paragraph.</p> <p>*Resident #7, late entry for a care conference January 2013. There was no evidence of a care plan conference since January 2013, a time span of 4 months and 6 days. E-signed by LSW #10. LSW #10 stated, "I am not sure about one of her meetings."</p> <p>*Resident #9, 4/24/13, resident was not invited. E-signed by LSW #9. LSW #10 stated, "Resident #9 was invited and the resident told us, I do not care about that stuff."</p>	F 280		
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F 280	<p>Continued From page 20</p> <p>On 6/6/13 at 10:30 a.m., the surveyor informed LSW #10 the care plan conferences/meetings documented in the E-PNs did not consistently reflect the resident and family member or interested party were invited and who did or did not attend. LSW #10 nodded her head up and down acknowledging understanding.</p> <p>The survey team was unable to verify all residents were informed of care plan conferences/meetings and processes, care plans were prepared using an interdisciplinary team process, and were developed with input from the residents, their families, representative(s), or interested parties.</p> <p>On 6/6/13 at 1:59 p.m., the DON was informed two residents who attended the Resident Group interview stated they had not been invited to care plan meetings and the E-PN documentation of care plan conferences/meetings was inconsistent as to who was invited, who attended and did not attend. The surveyor also informed the DON, the E-PNs did not provide evidence of how the residents' physicians were involved in the process. The DON agreed and stated, "The care plan conference process could be improved. We have been making adjustments."</p>	F 280		
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>	F 312		

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F 312	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide necessary assistance to residents during dining, in order to promote and maintain good nutrition. This was true for 3 of 7 (36, 37, & 38) random residents observed while eating breakfast. This deficient practice had the potential for harm if residents became nutritionally compromised from not receiving adequate assistance at meals. On 6/6/13, between 8:00 am and 9:00 am, the following observations were made in the Ponderosa dining room: * At 8:15 am, Resident #10 was observed sitting in her wheel chair at an assist table. At that time her wheel chair was approximately one and one-half feet away from the table. She had to lean forward to reach her plate and silverware. She attempted to reach her beverage glasses and could not because they were out of her reach. CNA #15 was assisting Resident (#37) at the same table and watched as Resident #10 attempted and failed to reach her milk and water. CNA #15 asked Resident #10 if she needed help. The resident responded, "yes" the CNA handed the resident her milk but did not reposition Resident #10's wheel chair closer to the table. Note: Between 8:15 and 8:45 CNA #15 left the Ponderosa dining room approximately four times to remove other residents from the dining room that had finished eating. This left Resident #10 and Resident #37 without assistance to eat their breakfast. * At 8:15 am, Resident #37 was observed attempting to feed herself some eggs and oatmeal, but every time she raised her spoon	F 312	F312 Corrective action for specific residents Resident # 10, 36, 37, & 38 are receiving dining service provided with dignity by having their w/c positioned close to the table and positioned with plate in front of them. Residents are being assisted or cued as needed. Other residents affected Residents have the potential to be affected that eat in the Ponderosa dining room. What measures will be put into place/systemic changes to prevent recurrence Staff has been in-serviced on providing necessary assistance to residents while dining, specifically helping residents sit close to the table positioned correctly to placement of their plate and drinks.	

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F 312	<p>Continued From page 22</p> <p>towards her mouth some of the egg and/or oatmeal spilled down the front of her blouse. The Resident would then put her fork down and remove the egg and/or oatmeal from of her blouse before she would attempt another bite.</p> <p>*At 8:25 am, Resident #38 was positioned approximately four to six inches to the left of her plate and had only consumed 25% of her breakfast. She was not offered assistance until the Administrator asked Resident #38 if she wanted help out of the dining room.</p> <p>*At 8:30 am, CNA #15 sat down to assist Resident #37 with her breakfast.</p> <p>Note: Resident #10 was over stimulated by all the movement and different things going on in the dining room, as evidenced by watching everything that was going on around her and responding to conversations that other residents and staff were having and did not attend to her meal. She required frequent cueing from staff to eat her breakfast.</p> <p>*At 8:45 am Resident #10 was still approximately one and one-half feet away from the table. LN #2 repositioned Resident #10 six inches closer to the table. She had not eaten any of her breakfast, but she had consumed 840 milliliters of fluid. CNA #15 got up from the table, while assisting Resident #37 with her breakfast, to get Resident #10 more to drink. CNA #15 returned from the kitchen with another 240 milliliters of fluid for Resident #10. LN #2 walked over to Resident #10, and began cueing her to eat. The resident set her spoon down on the table and LN #2 picked the spoon up and began feeding Resident #10 bite after bite of her pureed breakfast without pausing to allow Resident #10 to swallow.</p> <p>Note: Resident #10's "thickened" cream of wheat was so thick, the spoon stood straight up. The</p>	F 312	<p>Nursing staff have been in-serviced on cueing instead of feeding those residents that can feed themselves & assisting promptly those in need of assistance.</p> <p>Monitoring to ensure deficiency does not recur</p> <p>Nurse managers or Department managers will conduct Ponderosa dining room audits looking to ensure residents are pushed up to table and being assisted appropriately 3 times per week times 6 weeks then weekly times 6 weeks then monthly times 2 months.</p> <p>ED/DON will bring results to QA/PI. Education and audits will be done based on trends. Audit started 6/24/13</p> <p>Date of Compliance 07/08/13</p>	07/08/13
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F 312	Continued From page 23 cream of wheat stuck to the spoon when it was removed from the bowel. On 6/6/13 at 8:50 am, LN #13 was interviewed and LN #13 stated Resident #10 should be positioned closer to the table so she can reach her food and fluid without difficulty. She also observed LN #2 feeding Resident #10 and LN #13 stated LN #2 should not be feeding Resident #10 so fast because she had an increased risk of choking. The surveyor asked LN #13 if it was acceptable practice for staff to feed a resident who is capable of feeding herself. LN #13 said it was not acceptable practice because it takes away a resident's independence. On 6/6/13 at 9:00 am, the Dietary Manager was asked if the consistency of Resident #10's cream of wheat was "Nectar" thick in texture. She looked at the cream of wheat and said it was too thick and she would talk to her cook about it. On 6/6/13 at 1:30 pm, the DNS was interviewed about Resident #10. The DNS wrote down the observations made by the surveyor and said she would be looking at staffing in the Ponderosa dining room and the amount of assistance each resident requires.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure that 2 of 15 (#4 and 7) sampled residents did not acquire a new/recurrent pressure ulcer as evidenced by:</p> <ul style="list-style-type: none"> - Resident #7's had a healed Stage IV pressure sore on the coccyx that reopened, and - Resident #4 had boggy soft heels found on admission that returned and formed a Stage II pressure sore of the left heel. <p>Resident #7 was harmed when the healed pressure sore to her coccyx reopened to a stage IV. Findings include:</p> <ol style="list-style-type: none"> 1. Resident #7 was admitted to the facility, on 12/22/11, with diagnoses of decubitus ulcer, depressive disorder, cauda equina syndrome and paraplegia. The resident's decubitus ulcer was a Stage IV ulcer over the coccyx area. <p>The most recent quarterly MDS assessment, dated 2/28/13, documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact, BIMS=15, - required extensive assistance of one staff for dressing, personal hygiene and bathing, - required total assistance of two staff for transfers, - had limited range of motion of the lower extremities, - had a foley catheter, - had a Stage IV pressure sore that measured 0.2 x 1.4 x 0.2 cm deep. <p>The most recent annual MDS assessment, dated</p>	F 314	<p>F314</p> <p>Corrective action for specific residents</p> <p>Resident # 4 &7 have had their care plans reviewed and updated. Interventions related to prevention of pressure ulcers are being followed.</p> <p>Other residents affected</p> <p>Other residents that have had a history of pressure ulcers have the potential to be affected.</p>	
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F 314	<p>Continued From page 25</p> <p>12/4/12, documented the resident: - had a Stage IV pressure sore that measured 0.7 x 1.5 x 0.3 cm deep.</p> <p>The resident's care plan, dated 12/23/11, for "Risk for Pressure Ulcers" documented problems of, "Admitted with Stage IV sacral Decubitus Ulcer. Risk factors include impaired sensation, R [right] foot bunion, decreased strength and mobility with [increased] risk for shearing and friction, likes to stay in bed, incontinence, non ambulatory, chronic pain, rarely eats a complete meal, max assist with moving and complete lifting without sliding is impossible, noncompliant with skin program." There was an undated hand written entry of, "Resident has paraplegia with cauda equina syndrome." Additional hand written entries, dated 4/18/13 and 5/28/13, documented, "Note: resident sacral area will always be a increase risk of breakdown r/t hx of extensive stage IV ulcer here and [decrease] tensile strength of scar tissue" and "Resident refusing to let staff turn her at noc [during night time]. Screams out if they try." The target date for the goal was 6/6/13.</p> <p>The approaches the facility put in place were: [Note: none were dated so unable to determine when they were added to the care plan.] "- Special Protective Devices Used: Air overlay Mattress with bolsters, ROHO cushion to Tilt in space wheelchair for pressure redistribution." "- LN to evaluate weekly with daily heel and coccyx checks." "- Treatment per current MD order." "- Monitor sacral decubitus ulcer daily until resolved." [Note: There was an X through this approach with an undated notation "resolved"]</p>	F 314	<p>What measures will be put into place/systemic changes to prevent recurrence</p> <p>Nursing Staff in-serviced on identifying factors, through the use of the Braden assessment and the resident's history that increase resident's risk for pressure ulcers. Also in-serviced on appropriate interventions and to ensure that factors and interventions are care planned.</p> <p>Nursing Staff educated to the need for increased monitoring of residents who have a change in their physical activity due to illness for skin breakdown paying special attention to the high risk residents.</p> <p>Wound nurse in-serviced on updating care plans when wounds develop and heal and when receiving order changes. Wound nurse in-serviced on more complete documentation ensuring that all the interventions and assessments that she does are documented and care planned as needed.</p> <p>Nursing Staff in-serviced that residents who have a decubitus ulcer will have documented repositioning/off loading. Refusals and the reason for refusal will be documented.</p> <p>Licensed staff in-serviced to immediately notify the wound nurse, DON, or the on call manager and write on the 24 hour report when a decubitus ulcer is found on a resident or one that is closed has declined so</p>		

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F 314	<p>Continued From page 26</p> <p>"- Minimize exposure to moisture and keep skin clean, especially fecal contamination." "- Maintain or improve nutrition and hydration status, where feasible." "- Daily coccyx and heel checks at noc." "- 2/21/? - non compliant with off load." "- Monitor for adverse reactions to medications that may increase risk factors for development of pressure ulcers ie; causing lethargy, anorexia, or creating/increasing confusion." "- Nutritional supplement as ordered for wound healing." "- Be aware: [Resident #7] is not always compliant with skin program/interventions in place, continue to encourage and educate on risks/benefits. [Resident #7] often refuses to turn side to side d/t [increase] c/o leg spasms and shoulder pain. Resident wants bed 45 degrees - elevated but noncompliant." "- 4/19/13 -Prafo boot when [up] in WC to left foot. May velcro strap boot to left foot rest as per request from resident for sense of security." "- Float heels in bed as resident allows."</p> <p>Review of all the areas on the care revealed there was no plan for:</p> <ol style="list-style-type: none"> 1) repositioning to include frequency of turning and off loading the resident's coccyx. 2) the leaky catheter and what staff should do to prevent skin breakdown. 3) a bed bath 3 time a week to keep skin clean and dry. (Refer to MD order of 5/14/13 below.) The ADL care plan documented, "Shower/bath at least 1x/week." 4) addressing what the facility identified as "non-compliance" with positioning. <p>On 6/3/12, 11/28/12, 2/6/13 and 5/22/13 a</p>	F 314	<p>that immediate interventions are put into place. In-serviced that this includes maceration, or increased reddened areas to closed decubitus ulcers.</p> <p>Bathing will be provided per wound nurse recommendations and documented. Wound nurse will communicate the changes to the CNA.</p> <p>Facility will complete a root cause analysis on any newly developed Stage 2-4 decubitus ulcer in the facility over the next 6 months to help identify cause and to ensure systems are functioning.</p> <p>Nursing Staff, MDS, LSW and Therapy in-serviced that a plan of care must be developed for non-compliance behaviors which inhibit wound healing, rubbing of feet on bed resulting in removal of preventative boot, and leaking catheters causing moisture to skin which can interfere with wound healing or cause wounds to develop or decline.</p> <p>Licensed staff in-serviced to document these behaviors on the 24 hour report for appropriate follow up.</p> <p>Turn sheet that addresses non compliance and education of risk and benefits implemented for residents that are appropriate.</p> <p>Wound Nurse or designee to review the care plans of residents who are high risk for skin breakdown per the</p>	
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F 314	<p>Continued From page 27</p> <p>BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK was completed. The resident scored a 12 each time which equals high risk. The risk factors that were identified were: "SENSORY PERCEPTION: Has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.; MOISTURE: Very moist: skin is often, but not always moist. Linen must be changed at least once a shift.; ACTIVITY: Chair fast: Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.; MOBILITY: Very limited.; NUTRITION: Probably inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered...; FRICTION AND SHEAR: Potential problem: Moves feebly or requires minimum assistance. during a move, skin probably slides to some extent against sheets, chair...occasionally slides down."</p> <p>The Braden information did not appear to be used to develop a care plan such as:</p> <ul style="list-style-type: none"> - Pain: There was no plan for the resident's pain issues as it corresponds to positioning in bed. The resident's lower extremity and shoulder pain was not addressed. - Moisture: The leaky catheter was not addressed in the care plan. Bathing more frequently than once a week to decrease skin issues from sweat and urine was not care planned. -Mobility: The resident had limited mobility and positioning; there was no plan for off loading and frequency for turning in bed. - Friction and shear: The resident frequently liked to have the head of the bed elevated to 45 degrees. The facility failed to have a plan to ensure the resident did not slide down in the bed 	F 314	<p>Braden Assessment. The review will be to make sure that the risk factors are identified and that interventions are in place on the care plan.</p> <p>Monitoring to ensure deficiency does not recur</p> <p>The DON/UM will audit 24 hour report for documentation of a worsening or newly developed skin issue, noncompliance, pain or moisture issues that are inhibiting healing of skin. Resident review, careplan updates and additional interventions will be implemented as needed. Audits will be 5 times per week at standup X 2months then 2 times per week times 2 months. Audits started 6/28/13.</p> <p>Nurse Managers will audit the charts of residents with decubitus ulcers for pain, noncompliance or personal preference, moisture or increased incontinence and to ensure repositioning is being documented. Audit includes ensuring the interventions are careplanned and issues addressed. Audits to be done 2 X per week times 8 weeks then one time per week X 4 weeks then monthly X 1 month. Audits started on 6/28/13.</p> <p>DON/Wound/or Restorative nurse will audit 8 random high risk resident's careplans and documentation per month for 2 months to ensure appropriate measures are put in place. Audits started on 6/28/13.</p>		

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

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F 314	<p>Continued From page 28 when the head was elevated.</p> <p>The resident was admitted to the facility on 12/22/11 at 5:00 p.m. The admission Nurses Notes documented the resident, "admitted with wound to sacrum with 3.5 cm x 5.5 cm open area, 1.5 cm deep, undermining of 1 cm at 12 o'clock, 1 cm at 6 o'clock, 1.5 cm at 3 o'clock and 1 cm at 9 o'clock with large area of deep tissue injury surrounding, deep red and purple in color." The interventions in place at that time were: "alternating pressure air mattress overlay, Prevalons to bilateral lower extremity when in bed, and foot cradle to bed as well as weekly skin checks..."</p> <p>The nursing notes documented the resident had some behaviors that put the resident at increased risk for the sores not healing or new and further skin breakdown. These behaviors were: refusal of repositioning every 2 hours, remaining up in the wheelchair for more than 4 hours, elevating the head of the bed greater than 30 degrees, and not changing clothes. The care plan did not address these behaviors nor was there documentation to the number of times the resident exhibited the behaviors. There was lacking documentation the risk and benefits were discussed with the resident when the resident exhibited the behaviors.</p> <p>Below is sequential documentation including the wound nurse documentation from the time the Stage 4 pressure sore was healed to when it returned. PN: = Progress notes; WMD: = Wound clinic/MD documentation; MFR: Monthly Flow Report; and PMD: = Primary physician documentation.</p>	F 314	<p>skin Preventative measures will be spot checked during management room rounds. 7/13/13 ADDED</p> <p>Unit managers will audit the bath documentation for residents with specific MD orders that refer to the number and or type to ensure that appropriate bathing is taking place and documented 1 x week for 8 weeks and then 2x per month for 1 month. Audits started 6/28/13.</p> <p>DON will bring results of the audits and any root cause analysis that is required to QA/PL. Additional education and audits will be based on trends. Audits will begin 6/28/13.</p> <p>Date of Compliance 07/08/13</p>	<p>POST phone call with Karen Marshall.</p> <p>07/08/13</p>	

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F 314	<p>Continued From page 29</p> <p>WMD: 3/14/13 Wound Care Progress Report: "CHIEF COMPLAINT: [name of Resident #7] is seen for evaluation of a stage - IV sacral pressure ulcer that has been present now for about 15 to 16 months. HISTORY OF PRESENT ILLNESS: She has been showing steady improvement, particularly with initiation of regular debridement and low-air-loss mattress.... She continues to get the area wet from her leaking Foley catheter.... PAST MEDICAL...: Her healing is impaired by cauda equina syndrome with paraplegia, morbid obesity, hypothyroidism, noncompliance with off loading, and a leaky Foley catheter that leaves her ulceration damp with urine quite frequently. SKIN WOUND: Examination of her sacrum demonstrates that the ulceration is now completely epithelialized...IMPRESSION: 1. Stage-IV sacral pressure ulcer; now healed..."</p> <p>PN: 3/14/13 at 12:46 p.m., "Wound care. Res admitted approx[imately] 15 months ago with an extensive stage 4 pressure ulcer to sacrum. Wound has now closed. There is and always will be an indented crevice scar surrounded by pink scar tissue. This area will always be at high risk of reopening d/t decreased tensile strength of scar tissue. Son, [name], notified and was very pleased. Res is aware and was able to take a shower vs.[versus] bed bath today. Request to continue air overlay to bed and apply xenaderm daily to sacrum daily..."</p> <p>PMD: On 3/14/13 NURSING HOME VISIT: "HISTORY OF PRESENT ILLNESS: Since she has been here, she has been followed by the wound team for a stage 4 sacral pressure sore. [wound MD name] basically has indicated that</p>	F 314		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704
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F 314	<p>Continued From page 30 this wound has, for all intents and purposes, healed. She is quite noncompliant as far as offloading pressure. She has also been seen by urology because of problems with her leaking catheter, but that does not seem to be as much of a problem now as prior...."</p> <p>PN: There was frequent documentation that the resident had some problems with a catheter that was leaking. Nursing documentation indicated the resident had redness to the peri area and inner thighs. The facility was using barrier cream when she was changed and turned.</p> <p>PN: 3/25/13 at 2:48 p.m., "Wound care. Res continues with closed stage 4 to sacrum. Scar presents as an indented crevice. Periwound pink scar tissue....Res has some MASD [Moisture Associated Skin Damage] to inner thighs and groin d/t long hx of foley use which now chronically leaks. Res has been see by urologist and has refused any surgery in the past. Continue frequent pericares and barrier creams."</p> <p>PN: 4/1/13 at 1:09 p.m. "Wound Care. Res closed stage 4 to sacrum remains stable. Small indented crevice scar to area with pink scar tissue around it. Res has no sensation here. Res inner thighs with mild redness d/t chronic leaking foley; urine pools between thighs spontaneously. Res does not like pads pulled up closer between legs d/t comfort complaints. There are no open areas, blisters or unblanchable redness ntoed. [sic] Continue freq[uent] pericares and barrier creams."</p> <p>PN: 4/4/13 at 1:45 p.m. "Barrier cream to peri area and inner thighs r/t redness. Redness</p>	F 314		
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F 314	<p>Continued From page 31</p> <p>resolving slowly, no open areas....Repositioned as will tolerate, prefers to lay on back. N.O. [new order] to d/c ensure r/t recent wgt gain. [discontinue ensure related to recent weight gain] Res upset about not getting ensure as she believes it is helping her to heal..."</p> <p>PN: 4/9/13 at 12:42 p.m. "Wound Care. Resident stage 4 to sacrum remains closed. Between thighs sl[ight] pink d/t chronic leaking foley pooling urine here frequently. I spoke to resident about suprapubic catheter placement and/or discontinuing foley all together as is no longer functional. Res is fearful of 'surgery' and is reluctant to give up foley. Res became upset and I explained we could talk about it again another time..."</p> <p>PN: 4/30/13 3:03 p.m. "Wound Care. Res has recently closed stage 4 to sacral area. Indented scar remains stable. no open area or unblanchable redness noted."</p> <p>PN: 5/8/13 at 3:43 p.m. "1200 pm -resident old sacral area with two small pinpoint open area. surrounding areas appeared macerated. xanaderm cream applied and peri care given frequently. will continue to monitor. nursed on air mattress.[sic]"</p> <p>PN: 5/14/13 at 2:25 pm. "Wound Care. I have been monitoring res sacral area since closure of large /complex stage 4 pressure wound lasting 16 months before closing. Wound closed into a white, indented scar. Today, I note that res scar is [slightly] macerated and soft today. No open areas noted at this time. Res has no sensation d/t spina equida. Res scar tissue covering sacrum</p>	F 314			

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F 314	<p>Continued From page 32</p> <p>will only be 30% the tensile strength of original tissue and will always be at high risk for breakdown esp d/t size and depth of original wound. Request resident no longer have baths; change to bed baths. Sitting in [increased] moisture (water) may macerate scar and also bath chair is a firm/plastic surface. Reimplement Ensure Immune 1 can daily. Cover scar with promogran and foam 3 x week. Res also has been enjoying getting up more in w/c; I will not limit at this time but I did ask resident to try and be mindful and not spend more than 3 - 4 hours up daily."</p> <p>The primary physician was contacted on 5/14/13 and ordered, "1) Sacral scar: cleanse, place small piece of promogran over scar and cover with non-adhesive foam 3 x week and prm. 2) no showers, bed bath 3 x week. 3)Ensure Immune 1 can po [orally] daily protein supplement."</p> <p>PN: 5/20/13 at 1:41 p.m. "Wound Care. Resident admitted with a very large stage 4 sacral wound....Res scar tissue here is not stable at this time. Indented scar has one pinpoint area that is too moist and very soft. No open areas at this time, no drainage, no redness, no c/o pain. Res has no sensation to this area and does not like to reposition side/side d/t shoulder pain....Continue air overlay, roho. Soft scar tissue cleansed and covered with promogran and foam 3 x week to protect."</p> <p>PN: 5/25/13 at 12:33 p.m. "MDS ---A & O [with] bouts of confusion....Requires assist x 2 [with] hooyer lift for transfers....Incontinent of bowel; indwelling cath patent & draining clear yellow urine to gravity bag. No c/o of urinary</p>	F 314			

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F 314	<p>Continued From page 33</p> <p>discomfort/pain. Indented linear scar continues to be moist & soft with no drainage noted....Staff attempted numerous times to change resident's clothes to no avail. Resident continues to state that they are clean..."</p> <p>WMD: On 5/29/13 WOUND CARE PROGRESS REPORT: "CHIEF COMPLAINT: [Name of Resident #7] is a prior patient of ours last seen 2-1/2 months ago when she had healed a chronic stage-IV pressure ulceration of the sacrum... HISTORY OF PRESENT ILLNESS: The ulceration had been present for well over a year but healed nicely, particularly with the addition of a low-air-loss mattress. The patient has paraplegia secondary cauda equina syndrome and is noncompliant with offloading. She is also incontinent of urine and stool, making healing of that area difficult.... In the past, she did very well with regular debridement and Promogran. The recurrent ulcer was found simply at a regular check of her sacrum.... PROCEDURE: The procedure performed today included debridement. The patient's ulcer was cleansed, topically anesthetized with 4% lidocaine, and debrided with a #3 curette down to healthy, bleeding granulation tissue. Depth of tissue excised is skin and sudcu, less than 20 cm2... IMPRESSION: 1. Stage III sacral pressure ulceration; recurrent..."</p> <p>The physician ordered a culture of the open wound. The culture returned on 6/2/13 and the results were a group B Beta Streptococcus. The resident was started on Keflex 500 milligrams four times a day for seven days.</p> <p>PRESSURE ULCER STATUS RECORD: for 5/29/13 documented by the wound nurse was:</p>	F 314			

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F 314	<p>Continued From page 34</p> <p>"STAGE: IV; SURFACE AREA: 0.3 x 0.3 cm; DEPTH: less then 0.2 cm; DRAINAGE: scant; COLOR: sanguineous; APPEARANCE OF WOUND: granular; and RESPONSE TO TREATMENT: deteriorated."</p> <p>PN: 5/30/13 at 2:31 p.m. "Wound Care. Resident admitted with a very large, extensive stage 4 p.u.... I asked facility wound MD to assess res this week. Indented scar not stable and macerated, therefor MD debrided unhealthy tissue down to health sub-q. One small crater revealed with measurable depth....Wound cleansed and promogran and foam placed 3x week. Periwound intact. Res continues on air overlay, bed bath only, ensure daily, roho to w/c, res encouraged to allow turning and repositioning."</p> <p>MFR: The May 2013 Daily Care report documented the resident received the following for bathing and cleansing of the skin. Sponge Bath: 5/4/13 on days and evenings; Shower: 5/10/13 on days: and Bed Bath 5/22/13, 5/31/13 on days. The May MAR documented an FYI, the resident was to have, "no showers, bed bath 3 times a week" which the days of the month were blank. The documentation indicated the resident received skin cleansing/bath/shower four times for the month of May. There was no documentation that the resident refused a bath.</p> <p>PN: 6/2/13 at 3:10 p.m. "DRSG CDI [dressing clean dry intact] to denuded linear sacral area. No drainage or odor. However, area is inflamed & open. [Primary physician's name] is aware. C/O pain x 1 (8/10) prn med administered with positive results...."</p>	F 314		

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F 314	Continued From page 35 PN: 6/4/13 at 2:07 p.m. "Wound Care. Res admitted with a very extensive stage 4 pressure wound to entire sacral area. Linear small scar became instable and macerated: debrided by wound MD last week. Small, indented, linear scar is now open and shallow. Pink, moist, shallow wound bed. no drainage noted. periwound pink scar tissue. No odor and no c/o pain d/t cauda equina...." PRESSURE ULCER STATUS RECORD: for 6/4/13 documented by the wound nurse was: "STAGE: IV; SURFACE AREA: 0.3 x 1.3 cm; DEPTH: 0.3 cm; DRAINAGE: none; COLOR: none; APPEARANCE OF WOUND: granular; and RESPONSE TO TREATMENT: deteriorated." WMD: On 06/06/13 WOUND CARE PROGRESS REPORT: "CHIEF COMPLAINT: [Name of Resident #7] is seen for evaluation of a recurrent stage IV pressure ulcer of the sacrum. She had healed several months ago. HISTORY OF PRESENT ILLNESS: Her healing is impaired by paraplegia and pain issues with turning and offloading. She apparently is having some problems with some moisture issues. We were successful in the past with Pomogran and a cover and have been using that again and things have been stable but the periwound has remained macerated....PROCEDURE: Procedure performed today included debridement....IMPRESSION: 1. Ulceration at the site of prior stage 4 pressure ulcer....PLAN: 4. We will continue offloading and we will check [each] shift for moisture and change if there is moisture. We will continue turning [every] 2 hours. If she continues to stay macerated we will have to	F 314			

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F 314	<p>Continued From page 36</p> <p>increase the frequency of moisture checks." The physician wrote an ADDENDUM: "[Resident #7], several weeks ago, was noted to have some hypertrophic scar tissue at the site of a previously healed stage-IV pressure ulcer. The area was debrided to remove the unhealthy hypertrophic scar tissue. It was debrided down to healthy granulation tissue. The granulation tissue is tissue that had filled in from her prior stage-IV pressure ulceration. Based on the fact that it has not been that long since it has healed, I left it as a stage-IV rather than a new pressure ulceration....This is standard practice to remove the unhealthy tissue whether it is closed or not in hopes of creating new healing with a more stable epithelialized surface. There is nothing unusual about this procedure, and I believe that the unhealthy tissue is simply the way it has scarred and healed in place...."</p> <p>The electronic medical record was reviewed and "Daily Care" documentation for May 2013, for repositioned every 2 hours was lacking for: Days: 5/2, 5/3, 5/4, 5/6, 5/9, 5/13, 5/19, 5/20, 5/25 to 5/28, and 5/30; Evenings: 5/1 to 5/4, 5/6, 5/7, 5/8, 5/10, 5/12 to 5/16, 5/19, 5/20, 5/22, 5/24, 5/28, and 5/29; Nights: 5/1 to 5/4, 5/6 to 5/10, 5/12 to 5/21, and 5/23 to 5/31.</p> <p>On 6/4/13 at 12:25 p.m. the resident's sacrum pressure sore was observed. The area had a crater that was about 10 cm across where the original pressure sore was. In the center was a 0.3 x 1.3 x 0.3 cm open sore. The sore was pink and clean with some noted granulation. The wound nurse redressed the area and the resident got up for activities.</p>	F 314			

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F 314	<p>Continued From page 37</p> <p>On 6/4/13 at 12:25 p.m. and 1:40 p.m., Resident #7 was interviewed about the sore. She said the original occurred in the hospital when they were trying to teach her to use a slide board for transfer after she broke her leg. Then they did an epidural and that's what caused her to not have much feeling in her back and lower legs. The sore did not hurt because she could not feel it. The resident during interview indicated that positioning on the left side was painful on her shoulder and hip area.</p> <p>She enjoys activities especially Bingo, she makes her own decisions about what she does during the day but she said has some memory problems sometimes and forgets how long she is up in the wheelchair. She didn't know how the second sore developed only that the nurse and Dr worked on it.</p> <p>On 6/6/13 at 8:40 a.m. the DON and unit manager were interviewed about the resident's recurrent Stage IV pressure sore. The resident's rights were discussed along with the non-compliance. There was no documentation about the resident being informed of risk verses benefits or documentation of frequency for non-compliance.</p> <p>On 6/6/13 at 9:00 a.m. the wound nurse and wound physician were interviewed. The discussion was about the resident's cooperation with staff to ensure the sore healed. The physician indicated that their clinic had an off loading program they could adapt to the resident.</p> <p>The resident was harmed when a healed stage-IV sore deteriorated and reopened to a Stage-IV pressure sore. Some of the possible causative</p>	F 314			

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F 314	<p>Continued From page 38</p> <p>factors were:</p> <ol style="list-style-type: none"> 1) Facility failed to develop a plan for the resident's non-compliance behaviors. 2) Facility failed to give a bed bath to the resident 3 times a week as ordered. 3) Facility failed to address the nursing observation of 5/8/13 related to, "two small pinpoint open areas and surrounding areas that appeared macerated," and aggressively implement interventions to prevent further breakdown. 4) Facility failed to develop a care plan for the information identified on the Braden assessment. 5) Failed to address the MASD from a leaking catheter. 6) Failed to develop a plan for off-loading and frequency for turning and positioning. <p>2. Resident #4 was admitted to the facility on 12/3/12 with diagnoses of dementia, anxiety, depression and congestive heart failure. The nursing notes reflect the resident had "red/boggy heels" when she was admitted.</p> <p>The most recent quarterly MDS assessment, dated 3/23/13, documented the resident:</p> <ul style="list-style-type: none"> - had short and long term memory problems, - had severely impaired decision making skills, - required extensive assistance of one person for transfers, dressing, eating, personal hygiene and bathing. - the resident did not have a pressure sore. <p>Resident #4's care plan for "Risk for Pressure Sores" dated 12/4/12, documented a problem of: Potential for skin breakdown r/t decreased strength & mobility, chronic pain, SOB [shortness of breath], limited ambulation, spends majority of</p>	F 314			

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F 314	<p>Continued From page 39</p> <p>each shift in bed or w/c, unable to make frequent or significant changes independently, max assist with moving. Complete lifting without sliding against sheets is impossible, potential for side affects from psych med use, hx of Left upper extremity edema. An undated, hand written addition of res admitted with soft/red heels and scars to buttocks. A note, dated 5/30/13 documented, "Note: res unknowingly rubs feet vigorously on mattress greatly increasing friction.</p> <p>The approaches the facility put in place were: [Note: most were not dated so unable to determine when they were added to the care plan.]</p> <ul style="list-style-type: none"> "- Special protective devices used: Pressure redistributing Mattress. cushion to wheelchair." "- Observe skin daily and report any broken areas to nurse. Turn and redistribute pressure every 2 hours or more frequently. Requires extensive to dependent assist of 1-2 persons with repositioning." "- LN to evaluate weekly." "- Treatment per current MD order." "- Geri-sleeves to bilateral upper extremity." [dated 1/15/13] "- Minimize exposure to moisture and keep skin clean, especially of fecal contamination." "- Maintain or improve nutrition and hydration status, where feasible." "- Monitor for adverse reactions to medications that may increase risk factors for development of pressure ulcers ie; causing lethargy, anorexia, or creating/increasing confusion." "- Prafo boots on at all times except during shower et tx." [dated 5/24/13] "- Tx to left inner heel per MD order." [dated 5/24/13] 	F 314			

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F 314	<p>Continued From page 40</p> <p>"- Padding to w/c arm rest and rails on both sides." [dated 5/29/13]</p> <p>"- Skin prep to bilateral heels - prevent skin breakdown" [was d/c on 5/24/13]</p> <p>On 3/14/13 and 5/29/13 a BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK was completed. The resident scored a 12 each time which equals high risk. The risk factors that were identified were: "SENSORY PERCEPTION: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned.; MOISTURE: Very moist: skin is often, but not always moist. Linen must be changed at least once a shift.; ACTIVITY: Chair fast: Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.; MOBILITY: Very limited.; NUTRITION: Probably inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered...; FRICTION AND SHEAR: Problem: requires maximum assistance in moving. Complete lifting without sliding against sheets is possible. Frequently slides down in bed of chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction." The Braden information did not appear to be used to develop a care plan.</p> <p>The progress notes [PN] were reviewed along with other documentation and the following notations were found:</p> <p>PN: On 5/23/13 at 3:15 p.m. "Wound Care. Res admitted with bilat(eral) red/soft heels. To resolve this we treated with skin prep to heels BID, span am mattress, prevalons in bed and res wears</p>	F 314		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 41</p> <p>darco shoes when up. Today, I note left inner heel has an area that is sl boggy and has a faint purple ring around circumference. There are no open areas to unblanchable redness, but friction and pressure need to be alleviated to protect. Res noted to be rubbing heels persistently back and forth on bed, which removes prevalons. Res has advanced dementia and is unable to verbally respond and/or retain education. Request to d/c Prevalon and d/c skin prep. Start Prafos to bilateral lower extremity at all times and cover left heel with triact ag/foam/kerlix 2x week...."</p> <p>On 5/29/13 the PRESSURE ULCER STATUS RECORD documented by the wound nurse was: Date first observed: 5/29/13, Location: Left inner heel, "STAGE: II; SURFACE AREA: 0.8 x 0.6 cm; DEPTH: less then 0.2 cm; DRAINAGE: none; COLOR: none; APPEARANCE OF WOUND: epithelial."</p> <p>PN: On 5/30/13 at 3:59 p.m. "Wound Care. Res admitted with bilat red, boggy heels. This was resolved with tx. Over the past 6 months at this facility, staff has continued to protect heels with twice daily skin prep to 'toughen' skin, Prevalons in bed, res had soft Armco shoes when up and span am mattress. Res has recently been quite ill with PENA [pneumonia] and has been noted to vigorously rub heels and feet on bed. For these reasons, despite all interventions in place, a small open area is noted to left inner heel at this time. Small and superficial. Pink epithelium. No drainage, odor or redness. Periwound intact... Prafos bilateral lower extremity at all times."</p> <p>On 6/3/13 the PRESSURE ULCER STATUS RECORD documented by the wound nurse was:</p>	F 314			

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F 314	<p>Continued From page 42</p> <p>"STAGE: II; SURFACE AREA: 0.8 x 0.6 cm; DEPTH: less then 0.2 cm; DRAINAGE: scant; COLOR: seropurulent; APPEARANCE OF WOUND: epithelial and granular."</p> <p>PN: On 6/3/13 at 1:24 p.m. "Wound Care. Res admitted with bilat red, boggy heels.... Res is not ambulatory....noted to rub heels vigorously on bed back and forth. Despite interventions in place res obtained a left inner heel small open area.... Res has dementia and is unable to answer my questions or retain/offer any information at this time. No c/o pain noted. Open area is small and shallow. Wound bed is pink and moist. Periwound is intact; no redness or bogginess. Scant seropurulent drainage without odor noted. Left heel is cleansed and covered with triact ag and foam 2x a week, followed with wound rounds, Prafo boots on at all times...."</p> <p>The electronic medical record documentation showed that repositioning every 2 hours documentation for May 2013 was lacking. The resident record had 93 opportunities for documentation. The documentation only had 11 times the staff documented the resident was repositioned.</p> <p>On 6/3/13 at 3:50 p.m. the sore on the left heel was observed. The area was a stage II, 1 x 0.8 cm. The wound nurse redressed the sore.</p> <p>The DON and Unit manager were interviewed on 6/6/13 at 8:40 a.m., the resident's behavior of rubbing her feet on the bed was discussed and the resident did have a behavior program but that was not part of it. They believed that the resident's increased leg activity correlated to the</p>	F 314			

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F 314	Continued From page 43 pneumonia and illness she had at the time. The resident rubbed her feet against the mattress enough to get the prafo boots off and cause enough friction to create a sore without staff intervention. A Stage II pressure sore developed on the left heel when the facility failed to: 1) Prevent breakdown of the heel when she had a history of getting soft boggy heels prior to admission to the facility. 2) Ensure the Prafo boots stayed in place, the resident was not physically able to remove them. 3) Monitor the resident closely when she was rubbing her heel against the bed.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assess resident incontinence patterns and develop toileting programs for 3 of 15 (#s 11, 14 & 15) sampled residents. This had the potential for harming the residents both psychologically and physically due to wearing	F 315	F315 Corrective action for specific residents Resident # 11 has had a voiding pattern completed and has had the toileting plan updated to reflect any changes noted Residents #14 &15 have had a urinary incontinence assessment completed and their care plans have been updated to reflect any changes identified Other residents affected	

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F 315	<p>Continued From page 44 attends and soiling themselves which can create multiple skin issues. Findings include:</p> <p>1. Resident #11 was admitted to the facility on 5/23/12, with diagnoses of intracranial injury with open intracranial wound, monoplegia of lower limb affecting non-dominate side and major depressive disorder.</p> <p>The most recent annual MDS assessment, dated 5/10/13, documented the resident: - had severe cognitive impairment, BIMS = 6. - required extensive assistance of one staff for transfers, dressing, personal hygiene and bathing. - was continent of bowel and frequently incontinent of bladder.</p> <p>The resident's care plan, dated 5/23/12, documented a problem of, "Episodes of incontinence [due to] decreased self awareness secondary to periods of confusion and cognitive deficits. Res[ident] has advanced age and general debility resulting in functional impairment and may not be able to get to the toilet on time." The approaches for the problem were:</p> <p>"- Assist to toilet before and after meals, at bedtime, q 4 hours at night and prn resident request. Requires extensive assist with toilet transfers, hygiene, and clothing/incontinence product management. - Monitor for abnormalities in urine ie: concentrated appearance, hematuria, c/o dysuria, frequency, urgency. - Provide incontinent care and apply barrier cream PRN incontinent episodes. Monitor for skin redness, rash or breakdown during cares. Report</p>	F 315	<p>Residents who are incontinent have the potential to be affected by this practice</p> <p>What measures will be put into place/systemic changes to prevent recurrence</p> <p>Licensed Staff, Nurse Managers and Restorative Nurse has been in-serviced to accurately assess and develop an individualized toileting program for residents if they score between 0-14 on the Urinary Incontinence Assessment if appropriate and desired by the resident to promote continence. They also received through the in-service that toileting plans must be careplanned.</p> <p>CNAS in-serviced on following individualized toileting programs and documentation.</p> <p>MDS inserviced to communicate per stand up or 24 hour report decline in a residents continence.</p> <p>Monitoring to ensure deficiency does not recur</p> <p>Nurse Managers to audit Urinary Incontinent Assessments for completion and accuracy within 7 days of admission. If indicated by score of 0-14 nurse managers will interview CNAS and residents about continence pattern and view continence / incontinence documentation. From this information an individualized</p>	
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F 315	<p>Continued From page 45</p> <p>all concerns to the LN.</p> <p>- [Resident Name] and family have been educated regarding toileting program and agree with current POC [plan of care]."</p> <p>The facility completed an "Assessment for Bowel and Bladder Training" on 5/8/13. The resident scored a 14 which translated to the resident was a "Candidate for toileting, timed or scheduled voiding" program. The Urinary Incontinence Assessment further documented the resident was "usually continent during the day has occasional incontinence at night."</p> <p>The facility failed to further assess the resident to determine when/what time of day the resident had incontinent episodes.</p> <p>The DON and unit manager were interviewed on 6/6/13 at 9:00 a.m. and indicated the resident should have had a voiding pattern completed and would immediately initiate one. No further information was provided.</p> <p>2. Resident #14 was admitted to the facility on 8/6/12 with diagnoses of muscle weakness, history of falls, pressure sore/heel, and buttock open wound.</p> <p>The most recent quarterly MDS assessment, dated 5/3/13, documented the resident:</p> <ul style="list-style-type: none"> - had severe cognitive impairment, BIMS = 7. - required extensive assistance of one staff for transfers, dressing, personal hygiene. - was frequently incontinent of bowel and bladder. <p>The resident's care plan, dated 8/6/12, documented a problem of: "[Resident name] with</p>	F 315	<p>toileting program will be set up if appropriate and desired by resident. This program will be care planned. Audits will start 6/27/13 and continue for 4 months.</p> <p>Current residents will have their Urinary Incontinent Assessment and toileting plan reviewed and implemented or updated as indicated by Nurse Managers. This review will be per their MDS schedule and if appropriate and desired by the resident. Special attention will be paid to night time incontinence and if resident refuses to toilet at night this will be careplanned.</p> <p>Audits will start 6/27/13 and continue for 4 months per MDS schedule. Audits will be completed by the Nurse Managers. Initially 10 residents Urinary Incontinent assessments, careplans, continence/incontinence, and preferences were reviewed and updated as needed. Individualized programs initiated consisting of prompted, scheduled, retraining, or check and change were implemented and care planned based on assessment. The remaining current residents will be reviewed per MDS schedule.</p> <p>The DON will evaluate the toileting programs and bring results to the QA/PI. Further education and audits will be based on trends identified.</p> <p>Date of Compliance 07/08/13</p>	07/08/13

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F 315	<p>Continued From page 46</p> <p>frequent incontinence related to Poor Balance, Decreased Strength and Endurance, Fatigues Quickly, Weakness to LE [lower extremity] if fatigued, Hx [history] of UTI, is aware of urge to void but may not make it in time, ST [short term] Memory Deficits, Impaired Fine Motor Coordination Left Hand." The Approaches were:</p> <ul style="list-style-type: none"> - Assist [Name] to toilet before/after meals, Q HS, Q 4 hours at night and PRN resident request. Check and change per above schedule if refuses to toilet/bedpan, or is already incontinent. Wears incontinent products. - Provide incontinent care and apply barrier cream PRN incontinent episodes. Monitor for skin redness, rash, or breakdown, during cares. Report all concerns to LN. Uses incontinent products and clothing manage. - Resident and family have been educated regarding toileting program, incontinence and risk associated with incontinence and agree with current plan of care. - Bowel care per current MD order. - Encourage completion of fluids during meals and activities. <p>The facility completed an "Assessment for Bowel and Bladder Training" on 8/6/12, 10/31/12, 4/9/13 and 5/3/13. The resident scored a 13 which translated to the resident was a "Candidate for toileting, timed or scheduled voiding" program. The "Urinary Incontinence Assessment" was completed on 8/6/12 and documented the "Resident incont/continent of B & B [bowel and bladder] has impaired mobility R/T L hip FX [related to left hip fracture]." There was no assessment more current to review.</p>	F 315		
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F 315	<p>Continued From page 47</p> <p>The facility failed to complete a more current "Urinary Incontinence Assessment" and a voiding pattern assessment after the resident completed therapy for the fractured left hip.</p> <p>The DON and unit manager were interviewed on 6/6/13 at 9:00 a.m. and indicated the resident was not a candidate for a program. The resident's score on four separate assessments documented she was a candidate for retraining and the unit manager was questioned about the assessment conclusion. The unit manager indicated he had completed an "Assessment for Bowel and Bladder Training," which was dated 6/5/13. The assessment was provided to surveyors which documented the resident was a poor candidate. The facility had not completed a "Urinary Incontinence Assessment" since 8/6/12 which would identify why the resident was not a candidate for retraining.</p> <p>The facility's Bowel and Bladder Policy and Procedure, revised 03/11, documented the following under Guidelines to Assessment: *During the admission process, the nurse will complete the urinary status interview form with input from the resident and/or family in order to obtain the history and treatment of the resident prior to admission to the facility. *...The Urinary Incontinence Assessment will be completed no later than 7 days after admission in order to obtain a good understanding of the resident's bladder patterns. *The charge nurse will complete the assessment for bladder training if the resident is incontinent to determine if the resident is a candidate for individual training or timed/scheduled toileting. *A quarterly assessment for bladder is completed</p>	F 315			

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F 315	<p>Continued From page 48</p> <p>if the resident is incontinent. If there has been a change from last quarter to this quarter, and the score is 0-14, proceed to completing the Urinary Incontinence Assessment. The risk factors should trigger the referrals that need to be made and should be care planned.</p> <p>*The Interdisciplinary team will identify in the care plan specific interventions that minimize potential adverse effect of urinary incontinence...The resident will be placed in a bladder program appropriate for the resident.</p> <p>*Document in the nurses' notes the program initially chosen to follow in the protocol daily for at least 7 days, evaluating the program and adjusting it every few days until a pattern has been established. The program should then be evaluated weekly for 2 weeks to progress or lack of progress, then monthly on the monthly summary.</p> <p>3. Resident #15 was admitted to the facility on 5/21/11, with multiple diagnoses including: venous insufficiency, hypertension, degenerative disk disease, chronic pain, and edema.</p> <p>Resident #15's Annual MDS, dated 4/25/13, documented:</p> <p>*Ability to express ideas and wants *Ability to understand others *BIMS (Brief Interview for Mental Status) score was 15/15, cognitively intact * Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)</p> <p>Resident #15's Urinary Care Plan dated 03/03/10, under the Approaches section documented, "Offer to assist to toilet before/after meals, Q HS</p>	F 315			

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F 315	<p>Continued From page 49 (every night at bedtime). Toilet PRN (as needed) per resident request..."</p> <p>A facility document, "Urinary Incontinence Assessment" dated 5/25/11, documented the following: **"Present Urinary/Toileting Status," the resident is both continent and incontinent of urine, "Resident states she is continent. Hx (history) states she has chosen incontinence." **"Cognitive/Behavior Patterns Associated with Ability to Retrain," "Yes" the resident can comprehend and follow directions. "Yes" the resident can recognize urinary urge sensation.</p> <p>NOTE: The last section of the Urinary Incontinence Assessment, "Perform a 3-day Bladder Flow Record to Assist With Choice of Program," was incomplete. Based on the information obtained from the 3-day Flow Record the facility was then to determine if the resident was a candidate for one of the facility's bladder programs. This section was incomplete.</p> <p>The Resident's facility document, "Assessment for Bowel and Bladder Training" dated 4/23/13, contained the following documentation: *On page (1), her total assessment score was "4" and the assessment scale key documented 0-6= Good Candidate for individual training. *On page (2), the assessment scale key documented, "If the score is 0-14: on quarterly review, if score is changed from last quarter, complete "Urinary Incontinence Assessment." The facility documented, "proceeding to urinary incontinence assessment." The facility failed to</p>	F 315			

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F 315	Continued From page 50 proceed to Urinary Incontinence Assessment. The resident's score on five separate "Assessment for Bowel and Bladder Training" forms documented she was a good candidate for individual training. Note: Her most recent Quarterly MDS, dated 1/31/13, under the section Urinary Continence documented she was occasionally incontinent of bladder. Her Annual MDS, dated 4/25/13, under the section Urinary Continence documented she had become, "frequently" incontinent of bladder. The facility failed to provide documentation that a recent Bladder assessment had been completed related to the Resident's change in continence. On 6/6/13 at 3:00 pm RNUM #11 and the DNS were interviewed and said based on the assessments the facility had done, the resident's Urinary Care Plan was a "generic bladder" care plan and was not resident centered to address her incontinence issues.	F 315	F 364 Corrective action for specific residents Resident # 5,7, and random residents from group meeting and residents who chose the alternate lunch entrée on 6/5/13 food is being served at a palatable temperature and is flavorful. Other residents affected Other residents that eat at the facility have the potential to be affected. What measures will be put into place/systemic changes to prevent recurrence Newport beef has been removed from the menu. Current recipes reviewed for palatability.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on input from the Resident Group interview, test tray evaluation, and resident and staff interviews, it was determined the facility	F 364	Discuss current recipes at the menu meeting with the residents for input on flavor and temperature. In-service dietary staff on serving food that is flavorful at temperatures that are palatable. Monitoring to ensure deficiency does not recur Dietary Manager or Registered Dietician to audit tray and hall cart 2 x a week for 8 weeks, then 1 x month	

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F 364	<p>Continued From page 51</p> <p>failed to ensure food was served at a palatable temperature and was flavorful. This affected 2 of 11 sampled residents (#s 5 & 7), 6 of 11 residents who attended the Resident Group interview, and had the potential to affect residents who requested the alternate lunch entree on 6/5/13. This practice created the potential to negatively affect the residents' nutrition status and psychosocial well-being related to food. Findings included:</p> <p>On 6/3/13 at 2:19 p.m., Resident #5 stated, "The hot food served is not at the correct temperature. Staff will microwave the food [to reheat it] when I ask them to."</p> <p>On 6/4/13 at 1:00 p.m. 11 residents attended the Resident Group interview. Six of the 11 residents stated the food temperature depended on when you were served. The hot food was not always hot. One resident stated at least once a week food had to be sent back because the "hot food was not hot enough."</p> <p>On 6/4/13 at 1:40 p.m., Resident #7 stated, "The hot food is not served hot and the cold food is not served cold."</p> <p>On 6/5/13 at 11:55 p.m., the survey team and the Food Service Manager (FSM) evaluated the lunch main course (entree) and alternate for temperature and palatability. The menu was Chicken Broccoli Casserole, Carrots, Stewed Tomatoes, Milk and the alternate was Newport Beef Casserole. The following was determined.</p> <p>* Newport Beef Casserole, 134 degrees Fahrenheit (*F), unpalatable and lacking in flavor - Chicken Broccoli Casserole, 148.6°F, palatable</p>	F 364	<p>for 2 month for correct temp and palatability. Start date 6/28/13</p> <p>Dietary manager will bring audits to QA/PI and further education and audits will be based on trends.</p> <p>Date of Compliance 07/08/13</p>	07/08/13	

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F 364	Continued From page 52 and flavorful - Carrots, 131°F, palatable and flavorful - Stewed tomatoes, 135°F, palatable and flavorful - Milk, 46°F, palatable and flavorful The FSM stated, "The Newport Beef Casserole is actually beef goulash." The survey team also asked the FSM about the temperature and flavor of the Newport Beef Casserole. The FSM stated, "The temperature could have been warmer and the dish did not have flavor." Federal guidance at F364 indicated, the facility provides food at the proper temperature as discerned by the resident and palatable. On 6/7/13 at 11:00 a.m., the Administrator and the DON were informed of the temperature and palatability of the Newport Beef Casserole. The facility did not provide any additional information.	F 364			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, meal tray card review, and staff interview, it was determined the facility failed to provide adaptive equipment for a resident in order to maintain or improve the resident's ability to drink independently. This failed practice created the potential for decreased fluid intake and risk of dehydration for 1 of 6 (#35) random residents observed during dining. Findings include:	F 369			

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704	
(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 369	Continued From page 53 On 6/3/13 at 5:45 pm, and on 6/4/13 at 6:00 pm, during a meal observation in the day room on the 300 hall, Resident #35 had regular drinking glasses in front of her on the table. When she would attempt to pick up a glass, her hand would tremor and she would set the glass back down before taking a drink. Resident #35's meal tray card dated 06/3/13 and 6/14/13, documented under tray aids, "drinks in mugs with lids." On 6/4/13 at 6:10 pm, the Dietary Manager was interviewed about the resident not having lids on her mugs. She said the 300 hall staff keeps a supply of mugs in their dining room and when staff delivered the food trays, lids were "probably" not included because the dietary staff "thought" the lids were already available. She said she would speak to staff about this and make sure from now on lids were on resident's tray. On 6/4/13 at 6:15 pm, RNUM #4, was interviewed and asked to look at Resident #35's meal tray card. RNUM #4 identified that documented under "tray aids" was, "drinks in mugs with lids." RNUM #4 said she would be re-educating staff about the importance of assistive equipment. She went to the kitchen and returned with lids for the resident's mugs.	F 369	F369 Corrective action for specific residents Resident # 35 has assistive devices at the dining room table. Other residents affected Other residents have the potential to be affected that need assistive devices. What measures will be put into place/systemic changes to prevent recurrence Meal tickets now have more detailed info as it relates to resident assistive devices. Kitchen staff has been educated on their responsibility to provide assistive devices as listed on meal ticket. Monitoring to ensure deficiency does not recur The Dietary Manager will audit 2 x per week for 8 weeks and then 1 x month for 2 months for meal tickets to reflect assistive devices needed and that they are available for the resident. Start date 6/28/13 Dietary Manager will bring audit results to QA/PI, education and further auditing will be based on trends.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	Date of Compliance 07/08/13	07/08/13

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

PRINTED: 06/18/2013
FORM APPROVED
OMB NO. 0938-0391

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F 371	Continued From page 54 (2) Store, prepare, distribute and serve food under sanitary conditions RECEIVED JUL 05 2013 DIV OF LIC & CERT This REQUIREMENT is not met as evidenced by: Based on observation, review of a capital expenditure request (CER), and staff interviews, it was determined the facility failed to prepare and serve food under sanitary conditions. This affected 15 of 15 (#s 1-15) sampled residents, 22 of 22 (#s 19-40) random residents and had the potential to affect all residents who dined in the facility. This practice created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included: 1. On 6/3/13 at 9:20 a.m., the steamer in the kitchen was observed with rust on the inside bottom surface and on the inside bottom surface of the steamer door. The Food Service Manager (FSM) stated, "I think the facility will be purchasing a new one soon." 2. On 6/3/13 at 9:35 a.m., 3 of 11 ceiling vents were observed with a brownish-grayish substance on the surface of the vents. The surface of the vents was tacky to the touch. One vent was at the entrance to the kitchen from the Syringa dining room. Another vent was above a food preparation area. The third vent was above a centrally located, food preparation and equipment storage, area of the kitchen. The ceiling was a suspended ceiling with large rectangular tiles. The tiles	F 371	F371 Corrective action for specific residents Resident # 19-22, 26, 28-30, 33, and 34 have discharged. Resident #1-15 and 23-25,27,31,32,35-40 food is being prepared under sanitary conditions with vents being cleaned and the steamer placed out of order until the new one arrives. Vents in the kitchen were cleaned and logged on TRIS 6/9/2013. The ceiling tiles surrounding the vents have been replaced. The steamer has been placed out of order until the new one arrives. 7/3/13 New steamer has been installed. Other residents affected All residents have the potential to be affected. What measures will be put into place/systemic changes to prevent recurrence Maintenance has been in-serviced on need to keep the kitchen vents clean and follow the preventative maintenance calendar for vent cleaning and replace the tiles as needed.	

ADDED ON 7/3/13
POST Phone CALL with Karen Marshall

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F 371	Continued From page 55 appeared to have been a white color when originally suspended from the ceiling. The tiles surrounding the three vents were brownish-greyish in color and had the same type of tacky substance on the surfaces. Several other suspended ceiling tiles were a dingy yellow color. The FSM stated, "The vents need to be cleaned." On 6/3/13 at 4:40 p.m., the surveyor and the Regional Director of Clinical Services (RDCS) observed the ceiling vents and surrounding tiles. The RDCS stated, "They [the vents and surrounding tiles] are brownish-grey." The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." On 6/4/13 at 4:57 p.m., the surveyor informed the Administrator of the condition of the electric steamer in the kitchen. The Administrator stated, "We are getting bids on the steamer. We have only one bid completed so far. We need 2 bids to replace the steamer." On 6/6/13 at 10:10 a.m., the Administrator provided the surveyor with a CER for a steamer. The Administrator stated, "Corporate is allowing us to replace the steamer with only one bid."	F 371	Dietary staff in-serviced to notify maintenance of the need to clean the vents, prior to the monthly scheduled cleaning. Dietary staff has been in-serviced to check the steamer for rust areas and notify the ED. Cleaning of the vent in the kitchen will be completed and logged on TELS computer maintenance system for completion and tracking once a month by director of maintenance. Monitoring to ensure deficiency does not recur Dietary Manager will audit ceiling vents and for rust on the steamer weekly times 2 months. CDM or RD will audit steamer monthly in the sanitation audit. Maintenance will audit and clean ceiling vents monthly times 3 months then follow with TELS audit. Start date 6/28/13 The executive director will review the audits monthly for compliance and bring to QA/PI. Ongoing education or audits to be scheduled based on trends. Date of Compliance 07/08/13	07/08/13	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	F 431 Corrective action for specific residents Resident #33 has discharged.		

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F 431	<p>Continued From page 56</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to properly label a medication, properly secure a medication during medication pass, and failed to</p>	F 431	<p>Resident #41 medications have been reviewed and no expired medications are present.</p> <p>Other residents affected</p> <p>All other residents have the potential to be affected by this practice</p> <p>What measures will be put into place/systemic changes to prevent recurrence</p> <p>When medications are brought to the facility from hospice/home health agencies, the nursing staff will ensure that the labels on the medication match the physician orders . If not, the facility will obtain medication from the pharmacy with the appropriate labels. Education letter sent to hospice agency on facility policy that medication card label must match the MD orders and the MAR. Unit Managers and LN's have been in-serviced to compare labels on all medication to physician orders and what to do if a discrepancy is found.</p> <p>Unit Managers, LN's and Central Supply have been in-serviced to check every medication expiration date prior to placing into medication carts and to do audits of the medication carts monthly to dispose of any medication that is expired.</p> <p>LN's have been in-serviced to keep medication secured when not attended</p>		

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F 431	<p>Continued From page 57</p> <p>ensure expired medications were not available to the residents. This was true of 1 of 10 (Resident #33) residents observed during medication pass, and 2 of 5 licensed nurses observed during medication pass, and 2 of 5 medication carts reviewed. Findings included:</p> <p>1. On 6/5/13 at 1:20 pm, LN # 2 was observed dispensing medication for Random Resident #33, from a bubble pack card. The bubble pack card read, "Lorazepam 1 mg" and was hand written in black marker. Resident #33's name was hand written in blue ink on the same side of the card. The other side of the bubble pack card read, "Q AM, lorazepam, 1 mg 2 tabs". It documented the date filled, expiration date, lot number and manufacturer and was all hand written in black ink.</p> <p>Note: There were 2 pills in each bubble to be dispensed and the label did not indicate what dose and what route to give the resident. The card read Q AM, but the medication was administered at 2:00 PM.</p> <p>Random Resident #33's 6/2/13 Physician Admission Orders read in part: Lorazepam 2 mg, PO, Q AM; Lorazepam 2 mg PO Q 14:00 (2:00 pm), and Lorazepam 1 mg PO at bedtime.</p> <p>On 6/6/13 at 8:20 am, RNUM #11 said Resident #33 was there for a short stay. He said the medications were supplied by a Home Health and Hospice agency and "I'm going to have to be more diligent and check the medications closer when they come from the Home Health or Hospice agency."</p> <p>On 6/6/13 at 4:15 pm, the Administrator was</p>	F 431	<p>Monitoring to ensure deficiency does not recur</p> <p>The unit managers will audit hospice resident's medications to ensure that labels match physician orders 2 times a week for 8 weeks then 1 times a week for 4 weeks then once a month for 2 months. Audits began on 6/26/13.</p> <p>SDC or designee is auditing medication carts for expired medications and unsecured medications 2 x/week for 8 weeks, then 1x/week for 4 weeks then monthly for 2 months. Audits began 6/24/13.</p> <p>The DON will take the results of the audits to the monthly QA/PI meeting to review. Education and further audits will be based on trends identified.</p> <p>Date of Compliance 07/08/13</p>	07/08/13
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F 431	<p>Continued From page 58</p> <p>informed of the labeling issue on Random Resident #33's bubble pack card. No other information or documentation was provided.</p> <p>2. On 6/6/13 at 9:05 am, during Medication Pass, LN #2 was observed dispensing Aspirin 81 mg into a medication cup which sat on top of the medication cart. LN#2 stated "I need to get something out of the Med (Medication) Room." LN #1 left the medication, unsecured, in the cup, on top of the medication cart and went into the Medication Storage Room. Soon after, LN #2 returned to the medication cart with another medication. The surveyor informed LN#2 the Aspirin she had left on the medication cart was unsecured, LN #2 stated, "Oh, I'm sorry, I'm not suppose to leave it out."</p> <p>On 6/6/13 at 4:15 pm, the Administrator was informed of the observation of the unsecured medication during Medication Pass. No other information or documentation was provided which resolved the issue.</p> <p>3. On 6/6/13 at 11:15 am, during 300 Hall Medication Cart Review, a small bottle of "Nitrostat tablets 4 mg (1/150 gr)" with a expiration date of 5/13/13, was observed in the top drawer. The surveyor asked RNUM #14 what she would do with the expired Nitrostat medication. She said, "Destroy it."</p> <p>On 6/6/13 at 2:00 pm, during Medication Cart Review of the A Wing Cart 1, a tube of "Ciclopirox .77% cream" was found with Random Resident #41's name on it, and with an expiration date of 12/15/12. Also found with Random Resident's #41's name on it, was a bottle of "Promethazine,</p>	F 431			

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F 431	Continued From page 59 HCL 25 mg tabs, take 1 tab by mouth q 6 hours as needed" with an expiration date of 4/11/12. The RNUM #14 stated, "I don't know why that is still in there, it's with the PRNs." Note: Both of these expired medications were in a drawer for PRN medications for Random Resident #41 and could have been administered to Random Resident #41. On 6/6/13 at 4:15 pm, the Administrator was informed of the observation of the expired medications in the medication carts. No other information or documentation was provided which resolved the issue.	F 431		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the gas fired dryers were clean and maintained in safe operating condition. This had the potential to affect most residents in the facility including 15 of 15 (#s 1 - 15) sampled residents. There was a potential for harm because flammable material was near the fire box of the gas dryers. Findings include: During the environmental tour on 6/5/12 at 10:10 a.m. inspection of the laundry was completed. There were two gas fired dryers in the laundry.	F 456	F456 Corrective action for specific residents There were no residents directly affected but had the potential to effect 1-15 sampled residents. The dryers fire box area, areas surrounding the dryers, floors, walls and ceilings were cleaned.	

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F 456	Continued From page 60 The dryers were installed in the walls. To inspect the back where the fire box and electrical equipment were, staff and surveyor had to leave the building and enter from a door along the outside wall. Upon entry, the observation was lint balls were located all over the dryers, floor, walls and outside vent piping. These lint balls were 1/2 to 1 inch in size and too numerous to count. Also in the area were numerous spider webs hanging from the ceiling and walls. The floor had a buildup of dust and dirt. One of the dryers was running and lint balls were observed on top and next to the fire box of the dryer. The maintenance supervisor was interviewed on 6/5/13 at 10:10 a.m. and he stated the room was to be vacuumed on the last day of each month but it was apparent the helper did not complete the task. The administrator was informed on 6/5/13 at 3:30 p.m. She indicated the maintenance person had cleaned the room.	F 456	Other residents affected All residents have the potential to be affected. What measures will be put into place/systemic changes to prevent recurrence Dryer and vent cleaning to be done by specialized contractor semi-annually. Facility maintenance inserviced on cleaning the dryer room and back of dryer one time per week. This will be logged into the TELS system for ongoing audits. Monitoring to ensure deficiency done not recur Dryer vent/room has been cleaned and will be cleaned on a weekly basis by maintenance. Dryer vent will be cleaned semi annually by specialized contractor. The executive director will audit every 2 weeks times 8 weeks and one time a month times 2 months to ensure clean and free of lint, dust and cobwebs. Start date 6/28/13 Maintenance to report monthly on TELS compliance to QA/PI. Ongoing education or audits to be scheduled based on trends.		
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514	Date of Compliance 07/08/13	07/08/13	

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F 514	<p>Continued From page 61 and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the residents' medical records were complete and contained accurate documentation. This was found to be true for 4 of 15 (#s 4, 7, 11, & 14) sampled residents and one (#33) random resident. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 12/3/12, with diagnoses of dementia, anxiety, depression and congestive heart failure.</p> <p>The resident's May 2013 electronic documentation for: ADL care, check and change, diets and snack intake, oral care and repositioning every 2 hours were reviewed. The documentation had many days which were lacking documentation. Some examples were:</p> <p>ADL documentation for May 2013 was lacking for, "Bed Mobility, Transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, dressing, eating, toileting, personal hygiene and bathing." Some dates were: Days: 5/3, 5/13; Evening: 5/6, 5/8, 5/16, 5/25, and 5/27; Nights: 5/2.</p> <p>Diet documentation for May 2013 was lacking for: Breakfast: 5/7, 5/20, 5/26, and 5/30; Lunch: 5/20 and 5/26; Dinner: 5/4, 5/12, 5/23, and 5/24.</p> <p>Snack documentation for May 2013 was lacking for: AM snack: 5/1, 5/2, 5/3, 5/4, 5/5, 5/6, 5/7, 5/8, 5/13, 5/14, 5/15, 5/20, 5/21, 5/25, 5/27, 5/28, and</p>	F 514	<p>F514</p> <p>Corrective action for specific residents Resident # 33 has discharged. Resident #4 ADL care, check and change, meal and snack intake, oral care and repositioning are being documented. Resident #7 meal and snack intake and repositioning are being documented. Resident #11 meal and snack intakes are being documented. Resident #14 ADL care, meal and snacks are being documented.</p> <p>Other residents affected Other resident have a potential to be affected and will have meals, snacks, ADL care, oral care, repositioning and check and change if appropriate documented.</p> <p>What measures will be put into place/systemic changes to prevent recurrence</p> <p>CNAS in-serviced that documentation must be completed prior to leaving shift.</p> <p>Licensed staff inserviced to ensure that CNAS complete their charting before leaving shift. L.S. checking documentation to verify completion prior to cna leaving shift to ensure documentation is complete.</p>	

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F 514	<p>Continued From page 62</p> <p>5/29; PM snack: 5/4, 5/6, 5/8, 5/9, 5/10, 5/11, 5/16, 5/25, and 5/27; HS snack: 5/4, 5/6, 5/8, 5/10, 5/11, 5/16, 5/22, 5/25, and 5/27.</p> <p>Repositioning every 2 hours documentation for May 2013 was lacking. The resident record had 93 opportunities for documentation. The documentation only had 11 times the staff documented the resident was repositioned.</p> <p>The administrator and DON were informed of the lack of documentation on 6/5/13 at 3:30 p.m. No further information was provided.</p> <p>2. Resident #7 was admitted to the facility, on 12/22/11, with diagnoses of decubitus ulcer, paraplegia and depressive disorder.</p> <p>The resident's May 2013 electronic documentation for diets and snack intake and repositioning every 2 hours were reviewed. The documentation had many days which were lacking documentation. Some examples were:</p> <p>Diet documentation for May 2013 was lacking for: Breakfast: 5/8, 5/14, 5/17, 5/22, 5/24, 5/24 and 5/30; Lunch: 5/3, 5/8, 5/14, 5/22, 5/24, 5/25 and 5/30; Dinner: 5/2, 5/3, 5/7, 5/8, 5/12, 5/14, 5/15, 5/20, and 5/28.</p> <p>Snack documentation for May 2013 was lacking for: AM snack: 5/1, 5/3, 5/4, 5/5, 5/7, 5/8, 5/10, 5/11, 5/13 to 18, 5/21 to 24, 5/27, 5/28, 5/29 and 5/31; PM snack: 5/3, 5/8, and 5/19; HS snack: 5/3 and 5/19.</p> <p>Daily care documentation for May 2013, for repositioned every 2 hours was lacking for: Days:</p>	F 514	<p>Licensed staff inserviced to ensure that the residents name is on each MAR.</p> <p>Monitoring to ensure deficiency does not recur</p> <p>Nurse Managers to audit that documentation is complete for meals, snacks, oral and ADL care. Repositioning and check and change documentation complete if applicable to the resident. Audits 3 X per week times 12 weeks. Starting 6/28/13</p> <p>Health Information to audit 10% of the Medication Administration Records 1 time per week times 8 weeks to ensure resident names are on the record. Audits will start 6/28/13.</p> <p>UM auditing for resident names on mars weekly x 4weeks then monthly x 2 months. Audits will start 6/26/13.</p> <p>Don/ED to bring results of audits to QA/PI Ongoing education or audits to be scheduled based on trends.</p> <p>Date of Compliance 07/08/13</p>	07/08/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 63</p> <p>5/2, 5/3, 5/4, 5/6, 5/9, 5/13, 5/19, 5/20, 5/25 to 5/28, and 5/30; Evenings: 5/1 to 5/4, 5/6, 5/7, 5/8, 5/10, 5/12 to 5/16, 5/19, 5/20, 5/22, 5/24, 5/28, and 5/29; Nights: 5/1 to 5/4, 5/6 to 5/10, 5/12 to 5/21, and 5/23 to 5/31.</p> <p>3. Resident #11 was admitted to the facility on 5/23/12, with diagnoses of intracranial injury with open intracranial wound, monoplegia of lower limb affecting non dominate side and major depressive disorder.</p> <p>The resident's May 2013 electronic documentation for diet intake was reviewed. The documentation had multiple days which were lacking documentation. The examples were:</p> <p>Diet documentation for May 2013 was lacking for: Breakfast: 5/14, 5/30, and 5/31; Lunch: 5/12, 5/14, 5/30, and 5/31; Dinner: 5/14, 5/26, 5/27, and 5/31.</p> <p>Snack documentation for May 2013 was lacking for: AM snack: 5/3, 5/14, and 5/22; PM snack: 5/3, 5/7, 5/12 to 5/16, 5/20 to 5/23, 5/25, and 5/28 to 5/31; HS snack: 5/1, 5/4, 5/6, 5/9, 5/16, 5/21, 5/22, 5/23, 5/25, and 5/28 to 5/31.</p> <p>4. Resident #14 was admitted to the facility on 8/6/12 with diagnoses of muscle weakness, history of a fall, pressure sore on the heel and buttock open wound.</p> <p>The resident's May 2013 electronic documentation for: ADL care, diet and snacks were reviewed. The documentation had multiple days without documentation.</p>	F 514			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2013
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F 514	<p>Continued From page 64</p> <p>ADL documentation for May 2013 was lacking for, "Bed Mobility, Transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, dressing, eating, toileting, personal hygiene and bathing." Some dates were: Evenings: 5/2, 5/8, 5/10, 5/16, 5/22, 5/25, and 5/27.</p> <p>Diet documentation for May 2013 was lacking for: Breakfast: 5/3, 5/11, 5/12, 5/14, and 5/22; Lunch: 5/5, 5/14, 5/24, 5/29, and 5/31; Dinner: 5/14, 5/26, 5/27, and 5/31,</p> <p>Snack documentation for May 2013 was lacking for: AM snack: 5/1 to 5/8, 5/13, 5/14, 5/15, 5/20, 5/21, 5/25, 5/27, 5/28, and 5/29; PM snack: 5/2, 5/4, 5/6, 5/8, 5/9, 5/10, 5/16, 5/22, 5/25, and 5/27; HS snack: 5/2, 5/4, 5/6, 5/8, 5/10, 5/16, 5/22, and 5/25.</p> <p>The administrator and DON were informed of the lack of documentation on 6/5/13 at 3:30 p.m. No further information was provided.</p> <p>5. On 6/5/13 at 1:20 pm while observing Medication Pass, LN #2 was observed providing Lorazepam medication from a bubble pack for Random Resident #33. The bubble pack medication did not document an accurate dosage or time as to when the medication was to be given (Refer to F431). The LN said she referred to the MAR for the correct dosage and time. Upon review of the hand written MAR which included the Lorazepam order, it was determined the page did not include Resident #33's name.</p> <p>On 6/6/13 at 8:20 am, the RNUM #11 was shown Resident #33's MAR and asked if he could tell who it belonged to. RNUM #11 said, "No, but I could guess. I will get his name label and put it on</p>	F 514		

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F 514	Continued From page 65 his MAR." On 6/6/13 at 2:00 pm the DON was informed of the issue with Resident #33's name not being on the MAR. No other documentation or information was provided which resolved the issue.	F 514		

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Arnold Rosling, RN, BSN, QMRP Amy Jensen, RN Karla Gerleve, RN	C 000		
C 118	02.100,03,c,ii Available Services and Charges ii. Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate; This Rule is not met as evidenced by: Refer to F156 as it related to residents being informed.	C 118	C118 Refer to F156 C125 Refer to F241	
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 it related to providing dignity during	C 125		

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Bureau of Facility Standards

Amy Jensen

TITLE *PT*

(X6) DATE *6/28/13*

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

Bureau of Facility Standards

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C 125	Continued From page 1 dining and staff shouting above others regarding a resident's language.	C 125		
C 311	02.107,07 FOOD PREPARATION AND SERVICE 07. Food Preparation and Service. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance, and shall be attractively served at proper temperatures. This Rule is not met as evidenced by: Please refer to F364 as it related to the palatability and flavor of food.	C 311	C311 Refer to F364	
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F371 as it related to the steamer and the ceiling vents and tiles in the facility's kitchen.	C 325	C325 Refer to F371	
C 351	02.108,06,a,iii Laundry Environmental Requirements iii. The laundry shall be well lighted and ventilated, adequate in size for the needs of the facility, maintained in a sanitary manner, and kept in good repair. This Rule is not met as evidenced by:	C 351	C351 Refer to F456	

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C 351	Continued From page 2 Please refer to F456 as it related to the dryers.	C 351		
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: Please refer to F246 as it related to call lights being readily accessible at all times.	C 393	C393 Refer to F246 C782 Refer to F280 C784 Refer to F312	
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 refer to F280 as it related to periodically reviewing and revising care plans.	C 782		
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	C 784		

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C 784	Continued From page 3 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 refer to F312 as it related to residents needs being identified and services being provided to meet those needs.	C 784			
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to F369 as it related to providing special eating equipment and utensils.	C 787	C787 Refer to F369		
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it related to residents getting pressure sores.	C 789	C789 Refer to F314 C795 Refer to F315		
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Please refer to F315 as it related to assessment	C 795			

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C 795	Continued From page 4 and implementation of individualized bladder training program.	C 795			
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Please refer to F431 as it related to medication labels.	C 832	C832 Refer to F431		
C 835	02.201,02,i Meds in Possession of Resident Limitations i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record. This Rule is not met as evidenced by: Refer to F176 in related to self administration of	C 835	C835 Refer to F176		

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C 835	Continued From page 5 medications.	C 835		
C 879	02.203 PATIENT/RESIDENT RECORDS 203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F514 as it related to medical records accuracy.	C 879	C879 Refer to F514	
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it related to incomplete medical records.	C 881	C881 Refer to 514	