



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
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CERTIFIED MAIL: 7012 1010 0002 0836 1574

June 24, 2014

Cole Clarke, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Clarke:

On **June 13, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Coeur d'Alene Health Care & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

After each deficiency has been answered and dated, the administrator should sign both the Form

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 7, 2014**. Failure to submit an acceptable PoC by **July 7, 2014**, may result in the imposition of civil monetary penalties by **July 28, 2014**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **July 18, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 18, 2014**. A change in the seriousness of the deficiencies on **July 18, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 18, 2014** includes the following:

Denial of payment for new admissions effective **September 13, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 13, 2014**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional

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Office or the State Medicaid Agency beginning on **June 13, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **July 7, 2014**. If your request for informal dispute resolution is received after **July 7, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LT/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2014
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during your annual Federal recertification and complaint survey. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Nina Sanderson, LSW The survey team entered the facility on 6/9/14, and exited the facility on 6/13/14. Survey definitions: BID = two times a day BMP = Basic Metabolic Panel CBC = Complete Blood Count COPD = Chronic Obstructive Pulmonary Disease DNS = Director of Nursing Services GI = Gastrointestinal Upset MAR = Medication Administration Record MDS = Minimum Data Set TSH = Thyroid Stimulating Hormone	F 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law. This Plan of Correction will serve as the Facility's allegation of substantial compliance	
F 241 SS=D	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: Based on observation and resident and staff interview, it was determined the facility failed to ensure residents were treated with dignity and respect. This was true for 2 of 8 residents (Resident #'s 7 and 11) sampled for dignity. The	F 241	RECEIVED JUL 30 2014 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Ad. Cloche TITLE Administrator (X6) DATE 7/28/14

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

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

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OMB NO. 0938-0391

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F 241	Continued From page 1 deficient practice had the potential to cause more than minimal psychosocial harm if residents became embarrassed after being reprimanded by staff. Findings included: On 6/9/14 between 12:35 PM and 1:05 PM, the surveyor observed the noon meal in the Main Dining Room, as follows: *12:35 PM. Resident #s 7 and 11 sitting alone at a table together. The closest staff were at a neighboring table approximately 4 feet away. Resident # 7 was sitting with his head down, chin touching his chest, and eyes closed. Resident #11 was looking at Resident #7 with a concerned expression on his face. Both residents had their lunch meals on the table, but neither was eating. Resident # 7 moaned and moved his feet, which caused his wheelchair to move several inches away from the table. *12:37 PM. Resident #11 stated Resident #7's name twice, then said, "Eat a little. Please. Just take a few bites." The surveyor approached Resident #11 and asked how the meal was. Resident #11 stated, "Not too good. I'm more worried about him (pointing to Resident #7) right now." *12:45 PM. OT #1 approached the table and cued Resident #11 to eat his meal. The OT did not look at Resident #7, nor cue or assist him to eat. *12:46 PM. OT #1 left the table. Resident #7 picked up an unpeeled banana and put it in his mouth. Resident #11 abandoned his own meal, and moved his wheelchair towards Resident #7. LN #3 was sitting at a table assisting other residents approximately 4 feet away. Without moving, LN #3 stated, loud enough to be heard where the surveyor stood approximately 10 feet from Resident #11, "[Resident #11], you gonna eat your own lunch?" Resident #11 stated,	F 241	F 241 1.) Resident # 11 was reassured that he did not do anything wrong and we appreciated his efforts to help us. Education and corrective action was completed with LN #3. 2.) DON completed an audit of the main dining room to ensure each resident is treated with respect. 3.) DON in-serviced staff on speaking to and treating residents with dignity and respect. A dining room monitor will be designated to ensure residents are treated with dignity and respect. 4.) DON/designee will conduct weekly audits x one month, then monthly x2 to ensure residents are treated with respect and dignity. The results of these audits will be reported to QAPI monthly x3 to ensure substantial compliance. 5.) The facility will be in substantial compliance on August 20, 2014.	

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F 241	Continued From page 2 "Yeah," and returned to his place at the table. The resident continued to watch Resident #7 attempt to eat the unpeeled banana, and did not eat his own meal. *12:48 PM. Resident #7 was still attempting to feed himself the unpeeled banana. Resident #11 asked Resident #7, "Do you need a hand?" LN #3 remained at the neighboring table assisting other residents, but stated Resident #11's name three times, in a scolding tone of voice, with each repetition slightly louder and sharper in tone than the last. [NOTE: LN #3 did not ask Resident # 11 why he was attempting to assist Resident #7.] *1:00 PM. OT #1 was asked about the surveyor's observation of Resident #11 being reprimanded for attempting to assist Resident #7. OT #1 stated Resident # 11 was, "Confused. He has a problem of being too concerned about the other residents." *1:10 PM. Resident #11 exited the dining room and stated to the surveyor, "I know I broke the rules. I was just trying to help." On 6/11/14 at 9:40 AM, the Administrator, DNS, and Corporate Nurse were informed of the surveyor's observations. The DNS stated Resident #7 had been more independent feeding himself until recently, when he became ill and needed more help. However, the DNS stated LN #3 and OT #1 should have been more respectful when addressing Resident #11, and addressed his concerns that Resident #7 needed help for that meal. The facility offered no further information.	F 241			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246			

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F 246	<p>Continued From page 3</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident had access to his/her call light. This was true for 2 of 6 residents (Resident #'s 2 and 1) sampled for call light accessibility. The deficient practice had the potential to cause more than minimal harm when residents were unable to alert staff to their needs. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 4/22/14 with multiple diagnoses which included left medial iliopsoas abscess, history of CVA with left sided weakness, and recent right wrist fracture.</p> <p>Resident #2's admission MDS assessment, dated 4/29/14, coded: *Moderately impaired cognition; and *Extensive assistance of 2 persons for bed mobility and transfers.</p> <p>Resident #2's care plan for the problem area of, "At risk for Falls...", dated 5/1/14, documented an intervention of, "Call bell within reach."</p> <p>On 6/9/14 at 1:45 PM, Resident #2 was observed laying in her bed. The panel on the wall for the call light cord was split, so that two cords were attached, One of the call light activation buttons</p>	F 246	<p>F 246</p> <ol style="list-style-type: none"> 1.) Resident # 2's call light was immediately secured to her bed for accessibility. Resident # 2 no longer resides at the facility. Resident # 1 was given a touch call light for easy use. 2.) DON completed a comprehensive audit of current residents to ensure call lights are accessible and easy to use. 3.) DON in-serviced facility staff to check call light placement each time they enter a resident's room to ensure access and easy use. The mock survey team will check call light placement daily during rounds to ensure accessibility and easy use. 4.) DON/designee will conduct weekly audits x4 weeks, then monthly x2 months to ensure resident's call lights are accessible and easy to use. The results of these audits will be reported to QAPI monthly x3 months to ensure substantial compliance. 5.) The facility will be in substantial compliance on August 20, 2014. 	

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F 246	<p>Continued From page 4</p> <p>was on the floor underneath the panel. The other call light cord was clipped to the upper right hand corner of the mattress, approximately 1 foot above and 1 foot to the right of the resident's head. The cord was then draped over the head of the bed, so that the activation mechanism fell between the headboard and the wall, away from the resident. The call button itself was suspended approximately 1 foot above the floor next to the wall. The resident remained in bed, and the call light was observed in this position, until 2:30 PM, with observations every 5 minutes during that timeframe.</p> <p>On 6/10/14, at 9:55 AM, the resident was again observed laying in her bed, propped onto her left side. The two call light cords were again observed attached to the panel on the wall. During this observation, one of the cords was clipped back onto itself against the wall, so the activation mechanism was only a few inches below the wall panel, and not within the resident's reach as she lay in bed. The other call light activation button was resting on top of the overbed light, which was on the wall approximately 3 feet above the resident's head, both out of sight and out of reach for her. Observations were made of the resident every 5-10 minutes for the next 2 hours, with no change in the position of her call light buttons during that time.</p> <p>On 6/12/14 at 2:30 PM, the DNS and facility Medical Director were asked about the call light for Resident #2. The DNS stated, "Yes, she's supposed to have it. But she removes it sometimes." When the surveyor informed the DNS about the specific locations of the resident's call light during the observations on 6/9/14 and</p>	F 246			

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F 246	<p>Continued From page 5</p> <p>6/10/14, the DNS stated, "Oh, no. She couldn't have done that by herself. We must have forgotten to give it (the call light) to her." The facility offered no further information.</p> <p>2. Resident #1 was admitted to the facility with multiple diagnoses to include diabetes mellitus type II, bipolar disorder, Parkinson's disease, Stage II pressure ulcer, Methicillin Resistant Staphylococcus Aureus and encephalopathy.</p> <p>The resident's most recent Significant Change MDS dated 5/10/14, coded the following:</p> <ul style="list-style-type: none"> * Problems with short term and long term memory. * Daily decision making skills - severely impaired. * Total dependence of two people for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. * Functional limitation in range of motion - Impairment to both upper extremities. <p>The resident's Restorative Program care plan dated 5/14/14, documented PROM (Passive Range Of Motion) to fingers (R/L hands) 15 minutes per day, 6-7 days per week.</p> <p>On 6/9/14 the following was observed:</p> <ul style="list-style-type: none"> - 1:40 PM, Resident #1 was sitting up in her wheel chair beside her bed. The resident's right and left hand were visibly contracted. Between the palm of each hand and the fingers there was a rolled wash cloth. The resident's fingers were wrapped around the wash cloths. The resident's push button call light was fastened to her clothing. - 2:35 PM, the resident was laying in her bed on her right side with with rolled washcloths between her fingers and the palms of her hands. The call light was attached to a blanket on top of the 	F 246		
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F 246	<p>Continued From page 6 resident.</p> <p>On 6/10/14 the following was observed:</p> <ul style="list-style-type: none"> - 11:50 AM, The resident was sitting up in her tilt in space wheel chair beside her bed. The resident's right and left hand were visibly contracted. Between the palm of each hand and the fingers there was a rolled wash cloth. The resident's fingers were wrapped around the wash cloths. The resident's push button call light was fastened to her clothing. - 11:55 AM, the resident was groaning, loudly and had a scowl on her face. The resident had slid down one and one half feet in her chair, her head was positioned below the head rest, her bottom has slid forward on the wheel chair cushion approximately 6-8 inches, and the resident's feet which were placed in a foot cradle had slipped off of the foot pedals and were on the floor. - 11:56 AM, LN #4 was standing in the TV room on the 300 hall and heard the groaning. LN #4 quickly identified the resident's room the groaning was coming from. LN #4 walked into Resident #1's room and stated, "I think I know what's wrong, she needs to be repositioned." LN #4 left the resident's room to find a CNA to assist her with the resident. <p>NOTE: It could not be determined whether or not the resident had the cognitive ability or the fine motor skills to push the button on the call light when assistance was needed.</p> <p>On 6/13/14 at 10:30 AM, LN #4 was interviewed. The surveyor asked LN #4 if the resident was able to use the call light with contracted fingers and rolled washcloths. The LN stated the resident had not been able to use her call light for approximately one month. The LN stated the</p>	F 246			

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F 246	Continued From page 7 resident is very vocal and staff know the resident needs assistance when the resident starts to groan. On 6/13/14 at 10:40 AM, CNA #2 was interviewed. CNA #2 stated, "On a good day she (the resident) can use her call light." The CNA stated, "The resident groans loudly when she needs assistance."	F 246			
F 248 SS=E	On 6/13/14 at 10:50 AM the DNS was informed about the above observations. The DNS stated the resident's call light was being changed from a push button call light to a pressure pad call light. 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure an activities program to meet the individualized needs of all residents. This was true for 3 of 6 sampled residents (#s 2, 4, and 5) reviewed for individualized activities programs, and had the potential to impact any resident wanting to participate in scheduled activities on 6/10/14. The deficient practice had the potential to cause more than minimal psychosocial harm if residents suffered from boredom or became socially isolated. Findings included:	F 248	F 248 1.) Residents # 2 ,4 and 5's activity care plans were reviewed by the clinical team in collaboration with therapy. Activities appropriate for these residents were put into place. Resident #2 no longer resides at the facility. 2.) The IDT will complete an audit of resident's activity care plans to ensure each resident has an individualized activity plan appropriate for their cognitive status. 3.) The IDT in collaboration with therapy will research programs appropriate for cognitively impaired residents. The activity director will be in-serviced on appropriate programs for resident's cognitive level and following the activity calendar as written. Residents will be notified in advance of changes made to the activity calendar. 4.) The ED/designee will conduct weekly audits x4 weeks, then monthly x2		

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F 248	Continued From page 8 The facility activities calendar for June 2014 documented: Monday, June 9: *10:00 AM, Price is Right in the Activity Room (television program); *11:30 AM, Sit 'n Fit in the Main Dining Room (exercises) [NOTE: Lunch was scheduled to be served in that area of the facility beginning at 12:15 PM]; *3:00 PM, Movie in the Common area; *7:30 PM, Movie in the Activity Room Tuesday, June 10: *10:30 - 11:30 AM, Shopping for Residents. [NOTE: The activity calendar posted on the wall outside the Main Dining Room for this date listed, "The Price is Right" television program at 10:00 as the activity.] *1:15 PM, Volunteer pet visit; *1:30 PM, Patio social [NOTE: This allowed only 15 minutes for the pet visits before the next scheduled activity.] *7:30 PM, Movie in the Activity Room. Wednesday, June 11: *10:00 AM, Price is Right in the Activity Room; *11:00 AM, Resident Council; *1:15 PM, Bingo in the Activities Room; and *7:30 PM, Movie in the Activity Room. Thursday, June 12: *10:00 AM, The Price is Right; *11:30 AM, Sit n Fit in the Main Dining Room; *1:00 PM, Volunteer pet visits; *1:15 PM, Manicures; *3:00 - 4:00 PM, Bible study; and *7:00 PM, Movie. 1. Resident #5 was admitted to the facility on 1/4/05 with multiple diagnoses which included schizophrenia, macular degeneration, and	F 248	months to ensure residents are encouraged to participate in scheduled and individualized activities appropriate for their cognitive status. The results of these audits will be reported to QAPI monthly x 3 months to ensure substantial compliance. ED will monitor and follow-up. 5.) The facility will be in substantial compliance on August 20, 2014.		

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F 248	<p>Continued From page 9 dementia.</p> <p>Resident #5's most recent annual MDS, dated 1/16/14, coded: *Long term and short term memory deficits, with severely impaired decision making skills; *Mood severity score of 12, indicating probable depression; and *Very important to be with groups of people, to be outside, to participate in religious services, and to participate in activities of preference.</p> <p>Resident #5's care plan documented: *Problem area of, "Resident has Altered Psychosocial Well-Being r/t Depression." Initiated 9/21/13. *Interventions included, "Encourage resident to attend activities of choice..." and, "Assure that Resident continues to take an active role in facility with activities and peer settings." *Problem area of, "Activities." Initiated 10/11/13. *Interventions included, "Resident enjoys playing ball toss in close range," "Encourage Resident to attend live entertainment," "Resident enjoys ice cream Friday," and, "Resident needs assistance getting to activities." [NOTE: None of the care plan interventions addressed the resident's preferences to be outside, or to participate in religious activities.]</p> <p>*On 6/10/14 at 9:40 AM, Resident #5 was observed sitting in her wheelchair in the TV lounge across from the nurse's station. Between 8 and 10 residents were in the space as well. One by one, other residents were removed from the space by staff. "HGTV" was playing on the television. Resident #5's eyes were open, but not focused on anything in the room. The resident was sitting directly behind another resident, with</p>	F 248		

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F 248	Continued From page 10 her view to the television blocked. The resident stated, "I have no money. If you don't have any money, you can't help me." *At 9:50 AM, LN #4 moved Resident #5's wheelchair, without explanation, to allow one of the residents sitting in front of this resident to be removed from the area. Resident #5 was left in a position so that she would have had to look around another resident to view the television. *At 10:00 AM, Resident #5 was the only remaining resident in TV lounge area, although her wheelchair was placed at such an angle that viewing the television would have been difficult. At 10:05 AM, the surveyor observed the activity calendar in the hallway outside the Main Dining Room. "The Price is Right" television program was listed as an activity being currently conducted in the activity room, followed by "Sit n Fit" exercise program at 11:00 AM. The surveyor went to the activity room to observe the scheduled activity; no residents were present and the television was not on. At 10:10 AM, the surveyor observed Resident #5 to still be the only resident in the TV lounge area. She was asleep in her wheelchair, with the television still tuned to "HGTV." The AD was walking up and down the hallway past the nurse's station. At 10:20 AM, the DNS noticed Resident #5 sleeping in the TV lounge area. The DNS stated to CNA #2, "Do you have any activities going on?" CNA #2 responded, "There will be Sit and Fit at 11:00." *At 11:10 AM, Resident #5 was moved in her wheelchair to be directly in front of the television, still tuned to "HGTV." Over the next 10 minutes, 6 more residents were brought into the room. Not all were facing the television. Not all were awake. The surveyor went to observe the Sit and Fit exercise program in the Main Dining Room, as scheduled. There was only one resident in the	F 248			

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F 248	<p>Continued From page 11</p> <p>dining room, sitting at a table with his head down on the tabletop, sleeping. No staff were present. At 11:20 AM, the AD was observed outside the Activity room, on the facility's patio, with one resident. The resident was tending to multiple potted plants.</p> <p>On 6/12/14 at 7:10 AM, the AD was asked about Resident #5. The AD stated the resident was a, "very low participant due to her medical condition. She gets primarily sensory stimulation." When asked to describe that activity, the AD stated, "Three times a week for 15 minutes she gets 1 on 1 attention from me in her room. I hold her hand and let her know we care." Otherwise, the AD stated, "In the mornings, she likes to watch TV, like old westerns. She's usually in bed sleeping, she's rarely awake. She likes ball toss, which we usually do around 4 times a week." The surveyor asked if ball toss was something that would typically happen as part of the Sit and Fit activity, the AD stated it would. The AD stated the Sit and Fit activity had been canceled on 6/10/14 so other residents could go shopping. The AD was asked if Resident #5 could have been taken out to the patio when the other resident was tending the potted plants. The AD stated, "She usually likes to sleep."</p> <p>2. Resident #2 was admitted to the facility on 4/22/14 with multiple diagnoses which included left medial iliopsoas abscess, history of CVA with left sided weakness, and recent right wrist fracture.</p> <p>Resident #2's admission MDS assessment, dated 4/29/14, coded: *Moderately impaired cognition; *Mood severity score of 10, indicating probable</p>	F 248			

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F 248	<p>Continued From page 12 depression; *Very important for the resident to have music, pets, news, and outdoor activities.</p> <p>Resident #2's care plan, dated 5/1/14, documented: *Problem of, "...Altered Psychosocial Well-Being r/t Mood Disorder, Depression, New Admit." *Goals included, "Resident will be at ease interacting with staff and other residents..." *Interventions of, "Encourage Resident to attend activity of choice;" and, "Assure that Resident continues to take an active role in facility with activities and peer settings."</p> <p>On 6/9/14, the resident was observed in bed, in her room, between 1:45 and 2:30 PM. The room was dark and the blinds were drawn. The resident had only a few personal belongings in the room. There was a hutch next to the left hand side of her bed, with a photo of a dog. The resident identified the photo of her dog, stating, "It's my baby." When asked if she would like the photo placed where she could see it, the resident stated, "That's OK. I have her in my memory." The room was quiet, with no music or news playing. There were no leisure items visible aside from the items on the hutch.</p> <p>On 6/10/14, the resident was observed laying in bed in her room, with the room dark and quiet, between 9:55 and 12:25 PM (including the lunch meal time), and between 2:10 and 4:30 PM.</p> <p>On 6/12/14 at 7:10 AM, the Activities Director (AD) and the Administrator were asked about the Resident #2's leisure time. The AD stated, "She does not want to do anything right now. I go in and acknowledge her. She speaks German, so I</p>	F 248		
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F 248	<p>Continued From page 13</p> <p>try to say a couple of German words to her." The AD was unable to describe how the items Resident #2 identified as "very important" on her MDS assessment had been incorporated into her care plan for leisure time.</p> <p>3. Resident #4 was admitted to the facility on 2/13/13 with multiple diagnoses including history of CVA and worsening dementia.</p> <p>Resident #4's most recent annual MDS, dated 2/8/14, coded: *Moderately impaired cognition; *Minimal depression; and *Very important to keep current with the news, have books and magazines, be outside weather permitting, to be around animals, and to participate in religious services.</p> <p>Resident #4's care plan documented: *Problem of, "Activities." Initiated on 10/11/13. [NOTE: There was no further detail listed in the problem area.] *Interventions documented, "Resident enjoys doing her large print crossword puzzles in her room," "Resident likes to talk about her life story," and, "Resident enjoys children and pet visits."</p> <p>On 6/9/14 at 1:35 PM, Resident #4 was observed sitting in her room in her wheelchair. The resident was sitting at her overbed table, which was placed against the wall. The room was dark and the blinds were closed. There was a lamp along the wall just behind the right-hand corner of the overbed table, but the lamp was not turned on. There was a large-print crossword puzzle book laying on the far left-hand corner of the table, closed. The resident had a tissue in her hand. She was alternately wiping her nose, then rubbing</p>	F 248		

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F 248	<p>Continued From page 14</p> <p>the tissue on the table, which would cause gummy streaks to appear. The resident repeated this action for approximately 15 minutes, stating, "I've got to get this gunk cleaned up off of this table." After about 15 minutes, she wheeled herself to the sink in her room, got the tissue wet, and washed the table down with a wet tissue. She then positioned herself at an angle, facing the table but about 2 feet away. She fell asleep. The surveyor made observations every 5 minutes until the final observation at 2:30 that afternoon, with no change in the resident's location.</p> <p>On 6/10/14 at 10:05 AM, Resident #4 was observed sitting in her wheelchair in her room, with her head down and her eyes closed, in front of the overbed table. The puzzle book was in the same position as the day before, and closed. The room was dark, the blinds drawn, and the lamp not on. Making observations every 5 minutes, there was no change in the resident's position or activity level until she was awakened for lunch at 12:20 PM. In the dining room, the resident was placed at a table by herself, where she remained alone throughout the meal.</p> <p>On 6/10/14 at 2:10 PM, the resident was again sitting in her room in front of the overbed table. The puzzle book was open and the lamp was on. The resident was awake and looking in the direction of the book, but was not otherwise engaged with the book (i.e., not touching it, working on a puzzle, turning pages, etc.) She remained in this position until the Resident Group meeting was scheduled to start at 2:30 PM. The resident did not attend the group meeting.</p> <p>On 6/10/14 at 3:30 PM, the surveyor again observed the resident. She was in the same</p>	F 248			

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F 248	<p>Continued From page 15</p> <p>location in her room, with her table and puzzle book located in the same position. On this observation, however, the resident's head was down, with her chin touching her chest, and her eyes were closed. The surveyor made observations every 5-10 minutes, with the resident in that same position until 5:55 PM.</p> <p>On 6/12/14 at 7:10 AM, the AD and Administrator were asked about the activities routine for Resident #4. The AD stated, "She engages in socials every day in the dining room before lunch. And she likes to do self-directed activities, such as puzzle books. She also likes to wash my bingo cards and fold towels." When asked how the resident was assisted, cued, or encouraged to initiate using her puzzle book, the AD stated, "Well, I help her on Thursdays. Thursday is the day I spend with my non-cognitive residents."</p> <p>4. On 6/10/14 at 2:40 PM, during the resident group meeting, the residents were asked about the activities program. Six residents were in attendance. The residents stated the activities department could use some help, as there were not always enough activities. One resident stated, "Those of us in here are lucky. We are able to get around and do things on our own. We have a garden outside, and we can play games even if there is no one to help us. Some of the people here, though, can't do that without help. They get to lay in bed and sleep, or they can watch TV."</p> <p>On 6/12/14 at 7:10 AM, the AD and the Administrator were asked about the statements from the resident group. The AD stated, "They don't know everything I do and they don't know everyone I talk to. I have been trying to get volunteers to grow the program, which is getting</p>	F 248		

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F 248	Continued From page 16 better. But I still need to learn." The surveyor asked the AD to point out, on the calendar, which structured activities were designed to meet the needs of residents with cognitive impairment. The AD pointed to the "Sit n Fit" activity. When told the surveyor had been unable to locate that activity on 6/10/14, the AD stated, "Oh it was canceled that day, so we could take the other residents shopping." The AD was asked what the remaining residents did during the shopping activity. The AD stated, "I don't know. I'm only one person, and I work as hard as I can." The facility did not ensure: *Individualized, person-appropriate activities designed to enhance specific resident interests and abilities; *Scheduled activities were conducted as planned; *The development and implementation of an activities program designed to support the needs of the residents, either individually or as a resident body. On 6/12/14 at 6:30 PM, the DNS and Administrator were informed of the surveyor's findings. The facility offered no further information.	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged 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	F 280		

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F 280	<p>Continued From page 17</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and ombudsman interview, and record review, it was determined the facility failed to update resident care plans to reflect their current status. This was true for 2 of 9 (Resident #s 8 and 9) residents sampled for care plan revisions. The deficient practice had the potential to cause more than minimal harm if staff did not know how to anticipate and prevent unpleasant interactions between two residents who did not like each other. Findings included:</p> <p>a. Resident #8 was admitted to the facility on 6/4/13 with multiple diagnoses which included developmental delay.</p> <p>Resident #8's most recent annual MDS assessment, dated 5/29/14, coded unclear speech, long and short term memory deficits with modified independent decision making skills, and verbal behaviors directed towards others 4-6 days out of the past 7 days.</p>	F 280	<p>F 280</p> <ol style="list-style-type: none"> 1.) Resident #8 and #9 care plans were reviewed and updated by the MDS coordinator to reflect specific interventions for managing conflict between these two residents. 2.) An audit of current residents with behaviors was conducted to ensure specific interventions for managing conflict are noted on the plan of care. 3.) MDS coordinator was in-serviced by DON to include specific interventions on the resident's plan of care related to managing conflict. 4.) DON/designee will conduct weekly audits x4 weeks, then monthly x2 months to ensure care plans reflect specific interventions for managing behaviors/conflict between residents. The results of the audit will be reported to QA/PI monthly x3 months to ensure ongoing substantial compliance. 5.) The facility will be in substantial compliance on August 20, 2014. 	

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F 280	<p>Continued From page 18</p> <p>b. Resident #9 was admitted to the facility on 1/4/14 with multiple diagnoses which included bipolar disorder, and edema and open areas to his lower extremities.</p> <p>Resident #9's most recent quarterly MDS assessment, dated 4/8/14, coded that he was cognitively intact, and had no behavioral concerns.</p> <p>Neither Resident #8's care plan, nor Resident #9's care plan, contained information regarding conflict with another specific resident.</p> <p>On 6/10/14 at 3:30 PM, during a resident interview, Resident #9 stated his biggest concern in the facility was that he had to, "adapt where I go and what I do because of [Resident #8]. He's [slang term for Developmental Delay], and I don't know why, but he yells whenever he sees me. You can't understand much of what he says, but the curse words you can pick out. I have to come into the dining room by a different door, because he sits at a table by the main door. He yells at them if they try to get him to sit somewhere different. He spit on me once. I know they have issued a discharge to him, but until he leaves I have to do things differently. They even got [Ombudsman's Name] to come out, but he still does it."</p> <p>On 6/11/14 at 10:46 AM, the Ombudsman was interviewed regarding Resident #9's concerns. The Ombudsman stated the facility had involved her in the situation, "from the onset." The Ombudsman stated for some reason, Resident #8 reacted whenever he saw Resident #9, began yelling, and at times made rude gestures. The Ombudsman stated Resident #8 was unable to</p>	F 280		

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F 280	<p>Continued From page 19</p> <p>articulate why he got upset with Resident #9, and most of the time when Resident #8 was upset, his statements were unintelligible. The Ombudsman stated she had observed the behavior on several occasions, and did not feel the behavior was abusive in nature, and, "the facility is very careful to keep the two of them apart. The staff know it, and [Resident #9] knows it." The Ombudsman stated she was helping the facility obtain alternative placement for Resident #8.</p> <p>On 6/11/14 at 2:30 PM, the Administrator was asked about the ongoing conflict between the two residents. The Administrator stated Resident #8 tended not to like men in general, but seemed to especially dislike Resident #9. The Administrator stated Resident #8 had a fairly predictable daily routine, and was usually in his room with the door closed or sitting at a table in the corner of the dining room. The Administrator stated the facility tracked Resident #8's whereabouts every 15 minutes, and had instructed staff to ensure he was not encountering Resident #9. The Administrator produced behavior monitoring sheets for Resident #8, which documented behaviors of verbal and physical aggression towards others. These behaviors were documented to occur infrequently (1-2 times per week for May and June of 2014). The Administrator stated Resident #9 had reported an incident wherein Resident #8 spat on him, but it was years ago, and Resident #9 had discharged from the facility since that event had occurred. The Administrator stated the time of day most concerning was at 11:00 each morning, when Resident #8 walked to the ice machine, which was on the hallway towards Resident #9's room, to get ice. The Administrator stated the staff were aware of this, and would watch Resident #8 until</p>	F 280			

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F 280	<p>Continued From page 20</p> <p>he had obtained his ice and returned to the dining room. The Administrator stated the facility had decided to issue a letter of discharge to Resident #8, as they were concerned that resident would continue to target Resident #9, as well as other male residents. The Administrator stated the facility was working with Legal Aid regarding guardianship for Resident #8, and then he would be sent to a specialized unit. The Administrator was asked to produce the care plans for Resident #8 and Resident #9, which instructed the staff how to help prevent any conflict while Resident #8 was still in the facility, or what to do if such conflict occurred. The Administrator stated if that information was not on the resident care plans already obtained by the surveyor, it probably didn't exist.</p> <p>On 6/12/14, between 10:30 AM and 2:30 PM, five staff (3 CNAs and 2 LNs) were interviewed regarding Resident #s 8 and 9. All five were aware of the ongoing conflict. They all stated they kept track of where Resident #8 was, and made sure he was not getting near Resident #9. They all stated if those residents began to approach one another, they were usually able to re-direct them away from one another. They were all aware the time of most concern was when Resident # 8 went to get ice in the mornings. Otherwise, they all stated Resident #8 was usually either in his room, or sat in the corner of the dining room near the south door. As such, they all stated Resident #9 was encouraged to use the west door to enter the dining room.</p> <p>On 6/12/14 at 6:30 PM, the Administrator and DNS were informed of the surveyor's concern with a lack of care plan including the specifics of what staff were to do if conflict occurred between</p>	F 280		

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F 280	Continued From page 21 the two residents. The facility offered no further information.	F 280	F 281	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</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 there was a dosage on a medication and the manufacturer's specifications for the medication were followed. This was true for 1 of 5 (#13) sampled residents observed during the Medication Administration observation. This failed practice had the potential for more than minimal harm if the resident developed thrush (a fungal infection) in her mouth or throat. Findings include:</p> <p>Resident #13 was admitted to the facility with multiple diagnoses to include COPD, chronic pain, and depression.</p> <p>The resident's Admission Medication orders dated 6/6/14, documented the following medication, "Fluticasone (Flovent) [two] puffs BID (twice daily)."</p> <p>On 6/11/14 at 8:15 AM, the resident was sitting in her room waiting for her morning medications. RN #4 was observed as she dispensed Resident #13's oral medication and the Flovent HFA 220 mcg, inhaler. RN #4 handed the resident her oral medication first with a cup of water. The resident took her oral medications and then used the</p>	F 281	<ol style="list-style-type: none"> 1.) Resident # 13's medication order was clarified for current dosage. Medication record was updated to reflect current dosage of medication and instructions to rinse mouth with water without swallowing to prevent thrush. 2.) An audit of current residents was completed by the DON to ensure medication orders contain correct dosage and instructions. 3.) LNs were in-serviced by the DON on writing medication orders to include the correct form, route and dosage as well as following manufacturer instructions. 4.) DON / designee will conduct audits weekly x4 weeks, then monthly x 2 months to ensure medications are written correctly. The results of these audits will be reported to QA/PI monthly x3 months to ensure substantial compliance. 5.) The facility will be in substantial compliance on August 20, 2014. 	

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F 281	Continued From page 22 Flovent inhaler. The RN did not direct the resident to rinse her mouth out without swallowing after the use of the Flovent. On 6/12/14 at 9:00 AM, reconciliation of the above medication with the resident's Admission Medication orders dated 6/6/14, revealed the Admission Medication order did not document a dose for the Flovent HFA inhaler. The facility had been administering Flovent 220 mcg dose for the past 7 days. Additionally, the manufacturer's specifications for the Flovent included, "After use, rinse your mouth with water without swallowing to help prevent thrush in your mouth and throat." On 6/12/14 at 9:30 AM, RN #4 was interviewed about the above observation. The RN stated the resident should have rinsed her mouth after using the Flovent and the admitting nurse should have clarified the dose on the inhaler when the resident was admitted. On 6/12/14 at 9:45 AM, the DNS was informed about the above observation. The DNS stated the admitting nurse should have clarified the does on the inhaler when the resident was admitted. The DNS stated the facility would call and clarify the order with the physician. Additionally, she stated the MAR would be rewritten to include the information for the resident to rinse her mouth after using the inhaler. On 6/12/14 in the afternoon the DNS provided the surveyor with a copy of the clarification order for the Flovent and the updated MAR to include the information about rinsing the mouth after use of the Flovent.	F 281			
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312			

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F 312 SS=D	<p>Continued From page 23 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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to offer assistance to a resident unable to feed himself. This was true for 1 of 9 residents (Resident #7) sampled for ADL assistance. The deficient practice had the potential to cause more than minimal harm if the resident became nutritionally compromised due to lack of assistance at meals. Findings included:</p> <p>Resident #7 was admitted to the facility on 11/23/11. He had multiple diagnoses which included dementia secondary to CVA versus alcohol abuse.</p> <p>Resident #7's most recent quarterly MDS assessment, dated 5/7/14, coded: *Long term and short term memory deficits with severely impaired decision making skills; and *Required supervision after set-up with meals.</p> <p>Resident #7's care plan documented: *Problem area of, "Self-care deficit related to: impaired mobility, impaired cognition." Date initiated 10/1/13. *Goals included, "Res[ident] will feed self with [set-up] through next review." *Interventions included, "Eating: [set-up], eats in</p>	F 312	<p>F 312</p> <ol style="list-style-type: none"> 1.) Resident #7 was immediately assisted with his meal. Resident #7 no longer resides at the facility. 2.) DON completed an observation audit of the main dining room to identify residents who need assistance with meals. These residents will be monitored by designated staff to ensure assistance is provided per plan of care. 3.) DON in-serviced nursing staff on assisting residents with meals as indicated. 4.) DON/ designee will conduct audits weekly x4 weeks, then monthly x2 months to ensure residents who are unable to feed themselves are assisted with their meals. The results of the audit will be reported to the monthly QA/PI x3 months to ensure substantial compliance. 5.) The facility will be in substantial compliance on August 20, 2014. 	

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F 312	<p>Continued From page 24 [main dining room]," and, "Monitor and report decline in abilities."</p> <p>On 6/9/14, Resident #7 was observed at the noon meal: *12:35 PM, Resident #7 was observed sitting in his wheelchair at a table in the dining room. His lunch meal was in front of him, which consisted of an unpeeled banana, cooked vegetables, one-half of a sandwich, noodles, and juice. The sandwich was sitting in the liquid from the vegetables, so that the bottom bread had become soggy. The resident was hunched over in his wheelchair, with his chin on his chest and his eyes closed. The DNS entered the dining room from the kitchen, holding a meal tray for another resident. She stated, as she passed another table, "[Resident #7] needs some help. We need help for [Resident #7]." After delivering the tray, the DNS passed by Resident #7 and stated, "I'll be right there to help you, [Resident #7]." The DNS was then paged to take a telephone call, and left the dining room at 12:37 PM without assisting Resident #7. Resident #7's tablemate began imploring the resident to eat, but no staff approached Resident #7's table for 8 more minutes. *12:45 PM, OT #1 stopped by Resident #7's table, to cue and assist Resident #7's tablemate with his meal. However, the OT did not interact with, cue, or assist Resident #7. She did not inquire as to whether or not he liked the taste of his food, if his food had grown cold, or if he would like his soggy sandwich replaced. At 12:46, the OT left the table. Resident #7 then picked up his unpeeled banana, and placed it in his mouth. The resident quickly removed the banana from his mouth, set it back on the table, and covered his plate with his napkin. [NOTE: 11 minutes had</p>	F 312		
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F 312	Continued From page 25 passed since the DNS first identified Resident #7 needed assistance with his meal. No assistance had yet been offered.] Resident #7's tablemate attempted to approach the resident to assist him, but was reprimanded by LN #3, who was sitting at a neighboring table. (Refer to F241 for full details.) No staff approached Resident #7's table for 5 more minutes. *At 12:50 PM, OT #1 was asked about Resident #7. The OT acknowledged she had been to the table to attend to Resident #7's tablemate, but stated, "I didn't even look at [Resident #7]. He's not my patient." The OT stated as far as she knew, Resident #7 was at times fairly independent with feeding himself, but at times needed, "lots of encouragement and lots of help." When asked what she thought of the resident's abilities for the meal being observed, the OT stated, "He needs lots of encouragement." At that time, approximately 12:55 PM, CNA #2 approached Resident #7 and removed his napkin from his plate. CNA #2 did not speak to the resident or attempt to assist him while at the table, and immediately left. The OT continued conversing with the surveyor, explaining that Resident #7 was not always receptive to cues and assistance, and his tablemate had a problem of, "being too concerned about the other residents. We've talked to him about it before." *At 1:00 PM, with prompting from the surveyor, OT #1 approached Resident #7 to offer assistance. [NOTE: 25 minutes had elapsed since the surveyor first began observing Resident #7 at the meal. No assistance, cues, or encouragement had been offered.] OT #1 attempted to engage Resident #7 in the food which had been sitting on his plate for 25 minutes, without offering a fresh plate or warm food, or replacing the soggy sandwich. Resident	F 312			

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F 312	<p>Continued From page 26</p> <p>#7 waved the OT away, and did not eat his lunch.</p> <p>On 6/10/14, Resident #7 was again observed at the noon meal:</p> <p>*12:13 PM. Resident #7 was sitting in his wheelchair by a table in the dining room. His head was down, with his chin on his chest. His eyes were closed.</p> <p>*12:25 PM. Resident #7's meal tray was delivered to his table. CNA #5 sat with Resident #7 at the table. The surveyor was approximately 10 feet away. For the next 20 minutes, CNA #5 was observed, for the most part, to be sitting back in the chair, her arms resting on the armrest, without interacting with Resident #7. On 3 occasions, CNA #5 leaned forward, spoke quietly to the resident, and offered bites of food. The resident remained still; his head, body, and extremities did not move.</p> <p>*12:45 PM. Resident #7 and CNA #5 were observed at the table. The resident no longer had a plate in front of him, but rather the plate was located to CNA #5's left hand side, on the opposite side of the resident. CNA #5 stated she had taken Resident #7's plate away from him, as he had been spitting and throwing food. CNA #5 pointed to the floor as evidence the resident had spit and thrown his food. The floor was clean except for one small (1/4 inch to 1/2 inch) broccoli floret. The CNA stated, "When he's ready to eat rather than throw and spit his food, I'll give it back." [NOTE: When informed of this observation, the facility did initiate an investigation to rule out abuse or neglect in this circumstance.]</p> <p>On 6/10/14, Resident #7 was observed at the dinner meal:</p> <p>*6:10 PM. The resident was sitting in his wheelchair, alone and unattended at the table.</p>	F 312		

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F 312	<p>Continued From page 27</p> <p>His evening meal tray was in front of him, which included baked beans, a green salad, a turkey burger in a hamburger bun, and applesauce. The resident was sitting with his head down and his eyes closed. He was not approached by staff for 20 minutes.</p> <p>*6:20 PM. LN #6 approached Resident #7 and offered him a drink. The resident declined. The LN informed the resident she would be back shortly to check on him, and left the table. The resident continued to sit with his eyes closed, and did not touch his meal.</p> <p>*6:35 PM. The DNS, standing approximately 10 feet away from Resident #7's table, told CNA #2, "[Resident #7] does not want to eat right now, so you'll have to get something for him later."</p> <p>[NOTE: It was unclear how this assessment had been made, as no staff had approached the resident for 15 minutes.]</p> <p>*6:40 PM. The food on Resident #7's plate remained untouched. The plate had been on the table for at least 30 minutes. The surveyor requested the temperature of the food be taken. The CDM and RD approached the table, and reported Resident #7's turkey burger was 87.6 degrees F, and his baked beans were 100 degrees F. Neither the RD nor the CDM offered to reheat or replace Resident #7's food.</p> <p>*6:42 PM. CNA #7 sat with Resident #7 to cue him to eat. [NOTE: At this time, the resident had his food for at least 32 minutes. The RD and CDM had established the temperature of the food to be cold.]</p> <p>On 6/11/14 at 9:40 AM, the Administrator, DNS, and Regional Nurse were interviewed about the meal observations for Resident #7. The DNS stated: *She had recognized Resident #7 was not</p>	F 312		
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F 312	Continued From page 28 feeding himself during the noon meal on 6/9/14, and had instructed staff to assist him. She had assumed those instructions were going to be carried out as she left the dining room, and had even sent a staff member into the dining room in her place. The DNS stated Resident #7 should have had cues and/or assistance during that time. *She had not been aware CNA #5 had removed Resident #7's plate during the noon meal on 6/10/14, and such an approach was not appropriate. *She stated during the dinner meal on 6/10/14, after LN #6 offered Resident #7 something to drink, the LN reported to the DNS the resident did not want to eat. Therefore, the DNS told CNA #2 to offer the resident something later. The DNS stated she was not aware the resident's food had grown cold when CNA #7 sat with the resident. However, the DNS indicated the resident's food would have been reheated or replaced had he shown an interest in eating at that time. On 6/12/14 at 6:30 PM, the Administrator, DNS, and Regional Nurse were informed of the surveyor's findings. The facility offered no further information.	F 312		
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	F 315		

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F 315	Continued From page 29 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to offer a resident the opportunity to use the toilet before becoming incontinent. This was true for 1 of 6 residents (Resident # 4) sampled for toileting assistance. The deficient practice had the potential to cause more than minimal harm if the resident developed complications, such as skin breakdown or infections, from becoming incontinent of urine. Findings included: Resident #4 was admitted to the facility on 2/13/13 with multiple diagnoses which included CVA and Alzheimer's Dementia with behaviors. Resident #4's most recent annual MDS assessment, dated 2/8/14, coded: *BIMS of 8, indicating moderately impaired cognition, **"Trouble falling or staying asleep, or sleeping too much," was marked, "Yes." The corresponding column for frequency was left blank. [NOTE: The MDS did not document which of those items was problematic for the resident - trouble sleeping or sleeping too much.] *Extensive assistance of 1 person for transfers and toilet use; and *Occasionally incontinent of bladder. Resident #4's most recent quarterly MDS assessment, dated 5/5/14, coded: *BIMS of 9, indicating moderately impaired cognition;	F 315	F 315 1.) Resident # 4 was immediately toileted and cares provided. A 3-day bowel bladder tracker was completed to identify the resident's pattern of elimination. A restorative toileting program has been implemented for this resident. 2.) DON and MDS coordinator assessed current incontinent residents to identify their potential for retraining and pattern of elimination. Residents that score 0-6 are not candidates for retraining. These residents will utilize incontinent products unless the physician orders not to use, and/or the family or resident choose not to use an incontinent product. Restorative toileting programs will be implemented as indicated. 3.) DON in-serviced nursing staff on toileting residents per plan of care, including checking incontinent residents every two hours. 4.) DON/designee will conduct audits weekly x 4 weeks then monthly x2 months to ensure residents are offered the opportunity to use the toilet before becoming incontinent. The results of the audit will be reported to monthly QA/PI x3 months to ensure substantial compliance. 5.) The facility will be in substantial compliance on August 20, 2014.	
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F 315	<p>Continued From page 30</p> <p>*"Trouble falling or staying asleep, or sleeping too much," was marked, "Yes." The corresponding column for frequency was blank.</p> <p>*Extensive assistance of 1 person for transfers and toilet use; and</p> <p>*Frequently incontinent of bladder.</p> <p>Resident #4's care plan documented:</p> <p>*For the problem area pertaining to self-care deficit, initiated 10/1/13, there was an intervention for toilet use. The intervention had a statement, "Continent of [bowel and bladder] during waking hours," which was crossed out, indicating it had been discontinued. However, there was no date documented as to when this change had been made. The intervention further documented, "Offer toileting [every 2 hours when awake] as she attempts toileting..."</p> <p>*For the problem area of, "Incontinence and Falls," initiated 5/9/14, the intervention, "Take to [bathroom every 2 hours] while awake and per her request. [Nights]: toilet at [5:00 AM]."</p> <p>[NOTE: The resident's care plan did not document a problem area or interventions for sleep.]</p> <p>On 6/10/14 at 10:05 AM, Resident #4 was observed sitting in her wheelchair in her room in front of her overbed table. Her head was down and her eyes were closed. The surveyor observed the resident every 5-10 minutes between 10:05 AM and 12:20 PM (2 hours and 15 minutes.) The resident remained in the same position and location in her room throughout the observation period. At 12:20 PM, CNA #2 entered Resident #4's room, roused her, and pushed her to the dining room in her wheelchair. CNA #2 did not offer Resident #4 the opportunity to use the toilet prior to taking her to the dining room.</p>	F 315		
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F 315	<p>Continued From page 31</p> <p>On 6/10/14, between 2:10 and 2:30 PM, and again between 3:30 and 5:55 PM, observations were made of Resident #4 every 5 to 10 minutes. For each of these observations, the resident was sitting in her wheelchair in her room, in front of her overbed table. Between 2:10 PM and 2:30 PM, she was awake as she sat in her wheelchair. Beginning with the 3:30 PM observation, the resident had her head down, chin on her chest, and eyes closed. No staff were observed to approach the resident during any of these observations.</p> <p>On 6/10/14 at 5:55 PM, Resident #4 exited her room in her wheelchair and entered the hallway. The resident was visibly distressed, and stated, "Please. please, please help me. My bottom is soaking wet. You don't even have to touch it." The resident's pants, bottom of her shirt, and portions of her incontinence brief were visibly wet with urine. The resident began attempting to stand. As she lifted her body from the wheelchair, the seat cushion was also visibly wet. The resident stated, "Hurry up. I just need to be changed, It stinks." The resident began pulling her pants off both of her legs. CNA #7 approached Resident #4 and assisted her to her room and into the bathroom at that time, where the resident was assisted to sit on the toilet. The surveyor asked CNA #7 when the resident had last been toileted. CNA #7 stated, "Honestly, she has not been toileted since day shift. She's been asleep in her wheelchair all afternoon." [NOTE: The facility's "day shift" ended at 2:00 PM, which means the resident had not been toileted in at least 3 hours, 55 minutes, by the time she was noted to be incontinent of urine.]</p> <p>On 6/12/14 at 10:10 AM, RN #8, the facility's</p>	F 315		

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F 315	Continued From page 32 Restorative and MDS nurse, was interviewed regarding Resident #4. *RN #8 stated, "They are supposed to take her to the bathroom every two hours when she is awake. Under no circumstances do I want them waking her. She has no skin breakdown, and good quality rest is important for her." *RN #8 stated that though she had identified the need for, "good quality rest" as more important for this resident than using the toilet, there had been no evaluation of either her sleep patterns or voiding patterns, and there was no ongoing monitoring of the resident's sleep patterns. *RN #8 was unable to explain how the facility had determined that the resident sleeping while sitting in her wheelchair, with her head down and her chin on her chest, was, "good quality rest." *When asked to provide a care plan for Resident #4's sleep patterns, RN #8 stated, "If you didn't find one, then there isn't one. But why would we need one?" *RN #8 stated the facility had not consulted the resident about her preferences for daytime sleep versus the opportunity to use the toilet. *RN #8 was unable to explain why Resident #4 would have been awakened to go to the dining room for lunch, but not offered the toilet at that time. On 6/12/14 at 6:30 PM, the Administrator, DNS, and Regional Nurse were informed of the surveyor's findings. The facility offered no further information.	F 315			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration	F 327			

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F 327	<p>Continued From page 33 and health.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents had ready access to drinking water. This was true for 1 of 6 (Resident #2) residents sampled for hydration needs. The deficient practice had the potential to cause more than minimal harm if residents experienced thirst, dehydration, urinary tract infections, or constipation when unable to reach their drinking water. Findings included:</p> <p>Resident #2 was admitted to the facility on 4/22/14 with multiple diagnoses which included left medial iliopsoas abscess, history of CVA with left sided weakness, and recent right wrist fracture.</p> <p>Resident #2's admission MDS, dated 4/29/14, coded: *BIMS of 9, indicating moderately impaired cognitive skills; *Extensive assistance of 2 for bed mobility; and *Needs set-up for eating.</p> <p>Resident #2's care plan documented: *Problem area of nutritional risk, with interventions which included, "Encourage fluids with meals and throughout the day," and, "...loves cranberry juice."</p> <p>On 6/10/14 at 9:55 Am, Resident #2 was observed in her room, laying in her bed. She was propped slightly onto her left side with pillows. Her over bed table was to the right side of her</p>	F 327	<p>F 327</p> <ol style="list-style-type: none"> 1.) Water pitcher was immediately made readily accessible to resident # 2. Resident #2 no longer resides at the facility. 2.) An audit of current residents was completed by the DON to ensure water is accessible. 3.) DON in-serviced staff to make drinking water readily accessible to residents. Mock surveyors will check resident rooms on daily rounds to ensure water pitchers are accessible as indicated 4.) DON/designee will conduct audits weekly x4 weeks, then monthly x2 months to ensure residents have water pitchers within reach. The results of the audit will be reported to the monthly QA/PI x3 months to ensure substantial compliance. 5.) The facility will be in substantial compliance on August 20, 2014. 	

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F 327	Continued From page 34 bed, approximately 4 feet away from the resident. Her water pitcher and a glass of red juice were atop the over bed table. There were no other fluids visible in the resident's room. Observations were made every 5-10 minutes between 9:55 AM and 11:35 AM, with no change in the resident's position, or the position of her fluids in the room. At 11:55 AM, the resident was observed laying on her right side, and the over bed table with her water and juice were immediately to the right side of the bed, within the resident's reach.	F 327			
F 329 SS=D	On 6/12/14 at 2:30 PM, the DNS, MD, and Regional Nurse were informed of the surveyor's observations. The DNS stated, "No, that's not OK. Her fluids should always be within reach." The facility offered no further information. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	F 329 1.) The scheduled times for resident # 1's Metoprolol were changed to reflect 12 hours between doses; blood pressure and pulse are taken prior to administration of the medication and recorded on the MAR. Resident # 3's care plan has been updated to reflect monitoring side effects of Lithium. 2.) DON/MDS coordinator completed an audit of current residents on medications with parameters to ensure vital signs are documented. DON/MDS coordinator completed an audit of current residents on antipsychotics to ensure the care plan is updated to include monitoring for specific side effects.		

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F 329	<p>Continued From page 35</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility did not ensure a resident was free from an unnecessary medication. This was true for 2 of 10 (#1 and #3) reviewed for medication use, and had the potential to cause harm if the resident had received a medication for hypertension when her blood pressure or pulse were not within the defined parameters; and a resident who received Lithium without proper monitoring could become toxic, dehydrated, and/or develop additional complications with her diabetes.</p> <p>1. Resident #1 was admitted to the facility with multiple diagnoses to include hypertension, Parkinson's, and bipolar disorder.</p> <p>Resident #1's all active Physician's Orders dated 6/1/14, documented the following medication was started on 6/26/13, with the following parameters; Metoprolol Tartrate 25mg tablet: Give 1 tablet orally every 12 hours. (Hold for Systolic Blood Pressure (SBP) under 100 or pulse under 55).</p> <p>Resident #1's May 2014 MAR documented an order for Metoprolol Tartrate 25 mg tablet; Give 1 tablet orally every 12 hours (hold for SBP under 100 or pulse under 55). The MAR documented the medication should be given at 10:00 AM and</p>	F 329	<p>3.) DON in-serviced LNs to document vital signs on the MAR for medications with vital sign parameters. DON in-serviced MDS coordinator to include monitoring side effects for residents receiving antipsychotic medications.</p> <p>4.) DON / designee will conduct MARs audits weekly x4 weeks then monthly x2 months to ensure vital signs are documented for medications with vital sign parameters. DON / designee will conduct care plans audits weekly x4 weeks, then monthly x2 months to ensure they include monitoring side effects of antipsychotic medications. The results these audits will be reported to QA/PI monthly x3 months to ensure substantial compliance.</p> <p>5.) The facility will be in substantial compliance on August 20, 2014.</p>	

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F 329	<p>Continued From page 36</p> <p>8:00 PM. The resident's heart rate was documented; however the resident's blood pressure had not been taken prior to administration of the medication for 57 doses.</p> <p>NOTE: The order was for the medication to be given every 12 hours, however the medication was being administered after only 10 hours which could potentially increase the resident's risk to experience hypotension.</p> <p>On 6/13/14 at 10:50 AM the DNS and Regional Nurse Consultant were informed and interviewed related to the above issue. The DNS reviewed the MAR and confirmed the blood pressures were not documented. She stated the heart rate and blood pressure should have been taken prior to the medication being administered.</p> <p>2. Resident #3 was admitted to the facility on 10/8/13 and readmitted on 5/23/14 with multiple diagnoses to include severe dehydration and hypernatremia secondary to decreased intake, insulin dependent diabetes mellitus, hypothyroidism, bipolar disorder, and depression.</p> <p>The resident's Psychosocial Well Being care plan dated 10/11/13 was reviewed on 6/9/14 and did not document the resident had been started on Lithium.</p> <p>NOTE: The above care plan documented on 6/10/14 Lithium was added to the problem area, however the care plan did not address complications, adverse consequences, or a system for monitoring the Lithium.</p> <p>A Physician's Order dated 6/5/14 documented the following:</p>	F 329		
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F 329	<p>Continued From page 37</p> <ul style="list-style-type: none"> - Lithium 300 MG by mouth twice daily. - Labs in 2 weeks: Lithium level and CBC. - Six month labs to be drawn: Lithium Level, TSH, and BMP. <p>Hallowell, L. 2015 The Nursing (2015) Drug Handbook. J. Abramovitz (35th Ed.). Philadelphia, PA: Wolters Kluwer, documented the following information related to Lithium use:</p> <ul style="list-style-type: none"> * Administration: Give drug after meals with plenty of water to minimize GI upset. * Contraindications and Cautions: Use with caution in elderly patients, patients with thyroid disease, severe debilitation or dehydration or sodium depletion. * Overdose signs and symptoms: Diarrhea, vomiting, muscle weakness, lack of coordination, ataxia, blurred vision, large output of dilute urine, and agitation. * Nursing Considerations: Black Box Warning, "Lithium toxicity is closely related to serum lithium levels and can occur at doses close to therapeutic levels..." - Monitor baseline ECG, thyroid studies, renal studies, and electrolyte levels. - Check fluid intake and output. - Weigh patient daily; check for edema and sudden weight gain. - Adjust fluid and salt ingestion... Under normal conditions, patient fluid intake should be 2 1/2 to 3 L(iters) daily and followed by a balanced diet with adequate salt intake. - Check urine specific gravity and report level below 1.005, which may indicate diabetes insipidus. - Lithium alters glucose tolerance in diabetic patients. Monitor glucose level closely. <p>NOTE: There was nothing documented in the</p>	F 329		
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F 329	<p>Continued From page 38</p> <p>resident's medical record which identified the Lithium to be the most appropriate choice for this resident given her multiple co-morbidities to include dehydration and difficulty with managing her insulin dependent diabetes.</p> <p>On 6/12/14 at 2:30 PM, the Medical Director, DNS, and RN consultant were interviewed related to the above concern. The surveyor asked if the resident and/or POA was aware of the risk vs benefits of the Lithium including the black box warning. The RN consultant stated the resident's medical record documented consent was obtained from POA for the Lithium, but the consent did not document specific risks associated with the Lithium to include the black box warning. The surveyor asked why monitoring for overdose signs/symptoms, and nursing considerations were not care planned to provide direction to staff. The DNS confirmed there was not a care plan for the Lithium, however the resident and the lithium were discussed on 6/11/14 during the facility's Psychotropic meeting with the pharmacist and physician. The Regional Nurse stated she would check the MAR for the above information. The surveyor asked the Medical Director how it was determined the Lithium was the most appropriate choice of medication for the resident, who had just recently been admitted to the hospital for dehydration, hypernatremia, and catatonia. The Medical director stated the resident had been on multiple medications in the past for bipolar and the resident's husband told the hospital psychiatrist Lithium had worked for the resident in the past. The Medical Director stated the Lithium would not have been his first choice for the resident, however after consulting with the hospital psychiatrist and at the husbands insistence the</p>	F 329		
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F 329	Continued From page 39 resident was started on the Lithium. The Regional Nurse stated the facility needed to have collaboration between the facility, pharmacy, and physician to ensure the medication is monitored appropriately. No further information was provided to resolve this concern.	F 329			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on a resident group interview, review of a 3-week nursing schedule, record review, observations, and resident and staff interviews, it was determined the facility failed to ensure there	F 353	F 353 1.) The DON and staffing coordinator immediately reviewed the nursing schedule to ensure staffing hours met the needs of the residents. The ED was notified of the results. 2.) DON met with the staffing coordinator to review appropriate staffing levels that will meet the needs of the residents. The facility is actively recruiting to fill open positions. A full time restorative aid has been hired. 3.) DON/designee in-serviced the staffing coordinator and charge nurses to ensure there is adequate staff to meet the needs of the residents. The DON/ ED will be notified when staffing levels fall below state minimum prior to the start of each shift. ED will meet with residents monthly and as needed to ensure concerns are addressed. 4.) The DON / designee will conduct weekly audits x4 weeks then monthly x2 months to ensure adequate staffing for the care of the residents. The results of the audit will be reported to monthly QA/PI x3 months to ensure substantial compliance 5.) The facility will be in substantial compliance on August 20, 2014.		

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NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814
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F 353	Continued From page 40 was adequate staffing to provide for the needs and well-being of each resident. This affected 4 of 9 sample residents (#s 4, 7, 10, and 12) and 2 of 6 residents who attended the group interview. And, it had the potential to affect all other residents who lived in the facility. This failure created the potential for psychosocial and physical harm for all residents in the facility. Findings include: 1. On 6/10/14 at 2:40 PM, during the resident group interview, the residents stated there was frequently not enough staff in the facility to meet their needs, and as such it was customary for their daily routine to be structured around staff availability. All residents in attendance were in agreement on this point, but also stated residents who were independent with transfers and toileting were less likely to be impacted. Specifically, the resident group reported: *It was not uncommon for residents who needed assistance with toileting to be taken to the dining room without being offered the toilet first. Further, if a resident asked for assistance to use the toilet after being taken to the dining room, they were frequently told no one would be available to assist them until after the meal, because all staff needed to be in the dining room. This was particularly noticeable to the residents during the lunch and dinner meals. *Residents requiring two-person assist for transfers or cares would frequently have to wait for assistance, as it was difficult for two staff members to make themselves available at one time. *One resident reported s/he would be placed on the bedpan between 1:00 Pm and 1:30 PM, but not taken off until after the evening shift came on at 2:00 PM, because limited staff was available,	F 353		
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F 353	<p>Continued From page 41</p> <p>and many residents needed help at that time.</p> <p>*One resident reported s/he preferred to dine in his/her room for the evening meal, but did like to sit in the wheelchair while s/he ate. However, the resident stated s/he frequently had to dine in his/her bed because the meal would be ready before two staff were available to help him/her out of bed.</p> <p>*One resident stated s/he was not offered the opportunity to get up and get dressed until mid-morning, because s/he required 2 person assist, and there were not two staff members available to assist before that time.</p> <p>2. During individual resident interviews, one resident stated there were times s/he and other residents would like to socialize with one another in the facility's common areas. However, there were numerous occasions when this could not take place because there were not enough staff to get some of the residents out of bed.</p> <p>3. When reviewing the 3-week nursing schedule, the following nursing hours per resident per day were calculated: *5/18/14 - 2.58 hours (Saturday) *5/25/14 - 2.35 (Saturday) *6/7/14 - 2.43 (Saturday) [NOTE: The state minimum for nursing staffing hours is 2.4 hours per resident per day. The facility did not meet that requirement on 5/25/14, and barely exceeded it on 5/18/14 and 6/7/14.]</p> <p>4. Please see F241 as it pertains to resident dignity, F312 as it pertains to ADL assistance, and F315 as it pertains to toileting assistance.</p> <p>5. On 6/12/14 at 5:05 PM, the DNS was asked about the resident group concerns related to</p>	F 353			

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F 353	Continued From page 42 staffing levels in the facility. The DNS stated, "I'm not surprised. I'd love to have more staff. I just don't get enough applications. Or I hire them and they quit. We all help, but sometimes it's just not enough." On 6/12/14, the Administrator was asked about staffing levels. The Administrator stated, "I think we stay just above the [state] minimum. It would be nice to have more help." [NOTE: The facility did not meet this minimum requirement on 5/25/14.] On 6/12/14 at 6:30 PM, the Administrator and DNS were informed of the surveyor's concerns. The facility offered no further information.	F 353		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure hot water available for the designated handwashing sink in the kitchen. This was true for 9 of 10 sampled residents (Resident #'s 1 - 9) and any resident eating food prepared in the facility's kitchen. The	F 371	F 371 1.) The hot water available for the designated hand washing sink in the kitchen was repaired on 6/16/2014. 2.) Maintenance director completed an audit of the water temperatures in the kitchen to ensure they are within adequate range. 3.) ED in-serviced dietary staff and maintenance director to ensure the water temperatures are within the required range. 4.) ED/designee will conduct audits weekly x4 weeks and monthly x2 months to ensure water temperature at the hand washing sink is within the required range. The results of the audit will be reported to the monthly QA/PI x3 months to ensure substantial compliance. 5.) The facility will be in substantial compliance on August 20, 2014.	

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F 371	<p>Continued From page 43</p> <p>deficient practice had the potential to cause more than minimal harm if a resident developed a food-bourne illness from improper handwashing in the kitchen. Findings included:</p> <p>The State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, under F 371 documented, "...staff involved in food preparation ...should have access to proper hand washing facilities with...hot water..."</p> <p>On 6/9/14 at 8:45 AM, during the initial tour of the kitchen, the surveyor asked to access the handwashing sink. The water in the sink was cool to the touch. The surveyor alerted the CDM, who attempted to adjust the temperature of the water in that sink without success. When tested, the water was only 56 degrees Fahrenheit (F). The CDM stated that was the only handwashing sink available in the kitchen, and she would have it checked that day.</p> <p>On 6/12/14 at 7:30 AM, the surveyor again entered the kitchen and used the handwashing sink. The water was still cool. The CDM stated the facility had called a plumber, and the plumber would be out later that day. The CDM stated the sink had not been fixed since first identified by the surveyor three days earlier, and the kitchen staff continued to utilize the sink during that time.</p> <p>On 6/12/14 at 9:24 AM, the CDM, Maintenance Director, and Plumber met with the surveyor. The plumber stated the problem was specific to that sink, due to a valve being turned the wrong way on the pipe from the ware washing sink to the handwashing sink.</p>	F 371			

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F 371	Continued From page 44 On 6/12/14 at 1:30 PM, the surveyor was again unable to access hot water at the handwashing sink in the kitchen. The CDM stated it had been working a few minutes prior, but could not get hot water at that time. On 6/12/14 at 1:35 PM, the CDM asked the surveyor to again check the water in the handwashing sink. On this occasion, the water was warm to the touch. A digital thermometer showed the temperature as 107 degrees F. On 6/12/14 at 6:30 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	F 441 1.) DON educated CNAs # 2 and #9 on hand hygiene practices. 2.) DON completed an observation audit to ensure the nursing staff are performing appropriate hand hygiene practices during resident cares. 3.) DON/designee in-serviced nursing staff related to following infection control requirements related to hand washing before and after resident cares. 4.) DON/designee will conduct observation audits weekly x4 weeks, then monthly x2 months to ensure nursing staff are practicing hand hygiene in accordance with CDC guidelines during resident cares. The results of these audits will be reported to the monthly QA/PI x3 months to ensure substantial compliance 5.) Facility will be in substantial compliance on August 20, 2014.		

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F 441	<p>Continued From page 45</p> <p>isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility's policy and procedure on handwashing it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 10 (#1) sampled residents. Failure to follow hand hygiene procedures placed residents at risk for infections. Findings included:</p> <p>The current CDC (Centers for Disease Control and Prevention) website (<Http://www.cdc.gov>), an accepted professional standard, listed indications for handwashing that included but were not limited to:</p> <ul style="list-style-type: none"> * Before having direct contact with residents. * After contact with a resident's intact skin (when taking blood pressure or lifting a resident). * After contact with body fluids. * If moving from a contaminated-body site to a clean-body site during patient care. 	F 441		
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F 441	<p>Continued From page 46</p> <ul style="list-style-type: none"> * After contact with inanimate objects including medical equipment in the immediate vicinity of the resident. * After removing gloves. * After any direct contact with the resident. <p>Resident #1 was admitted to the facility with multiple diagnoses to include diabetes mellitus type II, bipolar disorder, Parkinson's disease, Stage II pressure ulcer, Methicillin Resistant Staphylococcus Aureus and encephalopathy.</p> <p>On 6/10/14 the following was observed while CNA #2 and CNA #9 provided cares for Resident #1.</p> <ul style="list-style-type: none"> * 11:30 AM, CNA #2 and #9 entered the resident's room and applied gloves. Neither CNA washed their hands before the gloves were applied. CNA #2 explained the procedure to the resident and then the CNAs rolled the resident to her left side and right side and CNA #2 checked the resident's attend for wetness. After CNA #2 checked the resident's attend she took her potentially contaminated gloves off and threw them away. CNA #2 did not wash her hands and returned to the resident's bed to transfer the resident. CNA #9 did not remove her gloves or wash her hands. CNA #2 and CNA #9 sat the resident up on the side of her bed. The resident was then transferred to her wheelchair. CNA #9 then picked up a washcloth and washed the resident's face. CNA #9 then removed her potentially soiled gloves, did not wash her hands and proceeded to make the resident's bed. * 11:35 AM, CNA #2 and CNA #9 washed their hands, collected the garbage and linen and left the resident's room. * 11:40 AM, the surveyor asked the CNA's when should they have washed their hands. CNA #2 stated, "I should have washed my hands when I 	F 441		
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F 441	Continued From page 47 entered the resident's room before providing cares, but it is hard to put gloves on wet hands." NOTE: CNA #9 was a new CNA to the facility and was being trained by CNA #2. On 6/10/14 at 7:00 PM, the Administrator, DNS, and Regional Nurse consultant were informed related to the observation. The DNS shook her head and stated they (the cna's) know better than that. No further information was provided to resolve the concern.	F 441		
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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 annual licensure survey of your facility. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Nina Sanderson, LSW The survey team entered the facility on 6/9/14, and exited the facility on 6/13/14.	C 000	<p>RECEIVED JUL 30 2014 FACILITY STANDARDS</p>	08/20/2014
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please see F 241 as it pertains to resident dignity.	C 125	See POC for F241	08/20/2014
C 327	02.107,08,b Separate Handwashing Sink b. A separate sink, granular or liquid soap, and paper towels shall be provided in the food preparation area for handwashing. Kitchen sinks shall not be used for handwashing. This Rule is not met as evidenced by: Please see F 371 as it pertains to the kitchen handwashing sink.	C 327	See POC for F371	08/20/2014
C 393	02.120,04,b Staff Calling System at Each Bed/Room	C 393	See POC for F246	08/20/2014

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

Col Clarke

TITLE

Administrator

(X6) DATE

7/28/14

Bureau of Facility Standards

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C 393	Continued From page 1 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 relates to call light accessibility.	C 393		
C 672	02.150,03,c Staff Knowledge of Infection Control c. Exhibited knowledge by staff in controlling transmission of disease. This Rule is not met as evidenced by: Please refer to F441 as it relates to infection control.	C 672	See POC for F441	08/20/2014
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are	C 674	See POC for F248	08/20/2014

Bureau of Facility Standards

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C 674	Continued From page 2 designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Please see F 248 as it pertains to the facility activities program.	C 674		
C 767	02.200,02,d & d,i Nursing Services 59 or less Residents 2.4 Hrs d. Nursing hours per patient/resident per day shall be provided to meet the total needs of the patients/ residents. The minimum staffing shall be as follows: i. Skilled Nursing Facilities with a census of fifty-nine (59) or less patients/residents shall provide 2.4 hours per patient/resident per day. Hours shall not include the Director of Nursing Services but the supervising nurse on each shift may be counted in the calculations of the 2.4 hours per patient/resident per day. This Rule is not met as evidenced by: Based on the facility's staffing documentation and staff interviews, it was determined that the facility did not maintain a minimum staffing level of 2.4 nursing hours per resident on 5/25/14. The lack of sufficient coverage was true for 9 of 10 sampled residents (#'s 1-9) and had the potential to affect all residents residing in the facility on that	C 767	<ol style="list-style-type: none"> 1.) The DON and staffing coordinator immediately reviewed the nursing schedule to ensure staffing hours met the needs of the residents. The ED was notified of the results. 2.) DON met with the staffing coordinator to review appropriate staffing levels that will meet the needs of the residents. The facility is actively recruiting to fill open positions. A full time restorative aid has been hired. 3.) DON/designee in-serviced the staffing coordinator and charge nurses to ensure there is adequate staff to meet the needs of the residents. The DON/ ED will be notified when staffing levels fall below state minimum prior to the start of each shift. ED will meet with residents monthly and as needed to ensure concerns are addressed. 	08/20/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001600	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2014
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NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH CARE & REHABILIT	STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 767	Continued From page 3 date. The findings include: A three week staffing schedule was reviewed for the weeks of 5/17/14, 5/24/14, and 5/31/14. The number of nursing staff hours worked per resident per day were calculated to be below 2.4 on 5/25/14, at 2.35 hours per resident. On 6/12/14, the Administrator was asked about staffing levels. The Administrator stated, "I think we stay just above the [state] minimum. It would be nice to have more help." The surveyor informed the Administrator of the staffing level for 5/25/14. The Administrator offered no further information.	C 767	4.) The DON / designee will conduct weekly audits x4 weeks then monthly x2 months to ensure adequate staffing for the care of the residents. The results of the audit will be reported to monthly QA/PI x3 months to ensure substantial compliance 5.) The facility will be in substantial compliance on August 20, 2014.	08/20/2014
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please see F 280 as it pertains to care plan revisions.	C 782	See POC for F280	08/20/2014
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F 327 as it pertains to availability of fluids.	C 784	See POC for F327	08/20/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001600	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/13/2014
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C 787	Continued From page 4	C 787		
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please see F 312 as it pertains to assistance at meals.	C 787	See POC for F312	08/20/2014
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F281 as it relates to professional standards of care.	C 788	See POC for F281	08/20/2014
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 see F 315 as it pertains to resident toileting.	C 795	See POC for F315	08/20/2014



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0009
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August 7, 2014

Cole Clarke, Administrator
Coeur d'Alene Health Care & Rehabilitation Center
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

RE: Corrected copy of the June 13, 2014, Complaint Investigation findings for
Complaint #6095

Dear Mr. Clarke:

On June 13, 2014, a Complaint Investigation was conducted in conjunction with the Recertification & State Licensure survey. On **July 22, 2014**, your facility was sent a letter from our office notifying you of the results of that survey.

The **July 22, 2014**, findings letter is revised as follows as the previous sent findings letter contained erroneous conclusions for allegation #1 & allegation #2.

ALLEGATION #1:

The complainant stated an identified resident choked and aspirated while sitting at the nurses' station, and the suction machine at the nurses' station did not work. A suction machine was retrieved from another nurses' station, and it did not work either. A suction machine retrieved from another resident's room that had MRSA (Methicillin-Resistant Staphylococcus Aureus) was wiped down and used on the identified resident.

FINDINGS #1:

Grievances reviewed for January through June of 2014 did not include any documented concerns related to improperly working suction machines.

Cole Clarke, Administrator
August 7, 2014
Page 2 of 3

A resident with a suction machine in her room was interviewed and stated she never had to use it and staff checked it periodically to ensure it was working.

The facility had two suction machines, one located at the nurses' station and the other located directly across from the dining room. Each suction machine had a checklist that was to be completed by staff on a regular basis to ensure the machines were working properly.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated management instructed staff to limit the use of incontinent briefs on night shift, so no briefs were used. Residents are put to bed with padding.

FINDINGS #2:

This allegation was substantiated previously during a follow-up visit conducted on September 11, 2013, and the facility was cited at F241 related to failure to ensure residents are treated with dignity. Please refer to the September 11, 2013, survey report for additional information.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated medical records were missing. Staff distributed a list of names of whose medical records were missing, and the missing medical records belonged to residents that had been discharged.

FINDINGS #3:

The survey team requested six closed medical records to review. All six closed records were provided to the survey team within fifteen minutes of being requested.

Ten of ten sampled residents' medical records were immediately available and complete when requested by the survey team.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Cole Clarke, Administrator
August 7, 2014
Page 3 of 3

As only one of the complaint's allegations was substantiated, but not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

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

LKK/dmj