



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 1536

July 17, 2014

Joe F. Rudd, Jr., Administrator
Marquis Care at Shaw Mountain
909 Reserve Street
Boise, ID 83712-6508

Provider #: 135090

Dear Mr. Rudd:

On **June 27, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Marquis Care at Shaw Mountain 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

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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 30, 2014**. Failure to submit an acceptable PoC by **July 30, 2014**, may result in the imposition of civil monetary penalties by **August 19, 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 **August 1, 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 **August 1, 2014**. A change in the seriousness of the deficiencies on **August 1, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 1, 2014** includes the following:

Denial of payment for new admissions effective **September 27, 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 27, 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, they will provide you with a separate formal notification of that determination.

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 27, 2014** and continue until substantial

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

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **July 30, 2014**. If your request for informal dispute resolution is received after **July 30, 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,



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

LKK/dmj
Enclosures

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

RECEIVED

JUL 29 2014

PRINTED: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DIV. OF MEDICAID (X3) DATE SURVEY COMPLETED C 06/27/2014
NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW MT			STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Becky Thomas, RN, Team Coordinator Brad Perry, BSW, LSW Linda Kelly, RN Judy Atkinson, RN Linda Hukill-Neil, RN</p> <p>The survey team entered the facility on June 23, 2014 and exited on June 27, 2014</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DNS/DON = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment ml = Milliliters PRN = As Needed UM = Unit Manager</p>	F 000	<p>This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies.</p> <p>Survey Definitions: "Daily" as used in Monitors = Monday - Friday FH = Friendship House IDT = Interdisciplinary Team LN = Licensed Nurse DM = Dietary Manager LSW = Licensed Social Worker RCM = Resident Care Manager. Also referred to as UCM in 2567. DNS = Director of Nursing Services ESS = Environmental Services Supervisor FHCC Friendship House Care Coordinator AD = Activity Director AC = Admissions Coordinator HR = Human Resources MR = Medical Records RCP = Receptionist CS = Central Supply TC = Transportation Coordinator</p>	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 241	<p>Corrective Action:</p> <ol style="list-style-type: none"> Catheter bag for Resident #16 has been strapped to her leg as per Care Plan. The resident identified as Resident #16 frequently raises her pant leg or moves the leg bag down so she can see it as that is her preference. Care Plan Resident #16 has been updated to reflects need to keep leg bag attached to resident's leg and covered as much as possible, and to resident's preference to view leg bag. <p>Continued on p. 2</p>	

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JUL 29 2014
FACILITY STANDARDS

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

TITLE

Administrator

(X6) DATE

7/29/2014

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

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F 241	<p>Continued From page 1</p> <p>Based on observation, it was determined the facility failed to maintain a resident's dignity in the Friendship House Dining Room when a resident was observed to have a foley catheter leg bag around her right ankle. This was true for 1 of 18 (#16) sampled residents. This failed practice created the potential for a negative effect on the resident's self-esteem. Findings included:</p> <p>On 6/25/14 at 5:15 PM, during the dinner meal observation in the Friendship House Dining Room 16 residents and 4 staff members were present. Resident #16 was observed sitting sideways at the table eating her dinner. The resident's foley catheter leg bag, which was no longer attached to the resident's leg, had fallen below her pant leg around her right ankle and exposed 300cc of dark amber urine. The catheter bag had a plastic outside cover which was touching the floor.</p> <p>On 6/25/14 at 5:40 PM, RN #13 was interviewed regarding the exposed foley catheter bag and asked if it could be a dignity issue for the resident. RN #13 nodded his head "yes" in agreement, and stated he thought it was a dignity issue. He stated, "It's not supposed to be at her right ankle, I should have spotted that before she started eating."</p> <p>On 6/25/14 at 5:50 PM, UM #14 was interviewed and stated, "The cover should not be touching the floor and the bag should be under the pants."</p> <p>On 6/26/14 at 5:50 PM, the Administrator and DNS were informed of the dignity issue with the exposed foley catheter leg bag. No other information was provided by the facility.</p>	F 241	<p>Identification: All residents that have catheter bags are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> Care Plan updated with additional language to check leg bag strap and covering of leg bag each shift to ensure bag attached to resident's leg and not touching the floor. Nursing staff received in-service regarding resident dignity, specifically with regard to ensuring that catheter leg bags are attached to resident's leg, covered appropriately, and documenting the resident's refusals to keep catheter bags from view of others. <p>Monitor:</p> <ol style="list-style-type: none"> RCM to conduct audit of residents with catheter leg bags for appropriate placement and exposure to others. Audits to begin on 7/28/2014 and will continue at the following frequencies: <ul style="list-style-type: none"> Weekly x four (4) weeks Q two (2) weeks x four (4) weeks. Monthly x three (3) months DNS to review audits and report findings to QA Committee. 	8/1/2014	
F 246	483.15(e)(1) REASONABLE ACCOMMODATION	F 246	Please see p. 3		

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F 246 SS=D	<p>Continued From page 2 OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents call lights were within reach for 2 random residents (#'s 17 & 18). The deficient practice had the potential to cause harm if the resident's needs were not met. Findings included:</p> <p>1. On 6/23/14 at 9:45 AM Resident #18 was observed in her bed asleep. The call light was attached to an intravenous (IV) pole, which was 3 feet from the resident's bedside. The call light was out of reach of the resident.</p> <p>On 6/23/14 at 9:55 AM CNA #1 was interviewed and was shown the call light placement. He stated, "Oh wow!" CNA #1 then took the call light from the IV pole, gave it to the resident (who was now awake) and told the resident to use the call light if she needed anything.</p> <p>2. On 6/23/14 at 9:21 am, during the initial tour, Resident #17 was found to be lying in his bed sleeping. The call light was coiled up on the resident's nightstand to his left and was approximately three feet away from the resident's left shoulder.</p>	F 246	<p>Corrective Action: Call lights placed within reach for the residents identified in 2567.</p> <p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: Staff inserviced regarding standards of care and resident's rights to have call lights placed within their reach.</p> <p>Monitor:</p> <ol style="list-style-type: none"> IDT (specific title of staff person noted in parentheses next to frequencies listed below) to conduct audit of random resident's to ensure call lights are placed within resident's reach. Audits to begin on 7/28/2014 and to continue at the following frequencies: <ul style="list-style-type: none"> Weekly x four (4) weeks (FHCC) Q two (2) weeks x four (4) weeks (HR) Monthly x three (3) months (RCM) DNS to review audits and report findings to the QA Committee. 	8/1/2014

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F 252	<p>Continued From page 4</p> <p>shaped crack on the ceiling above bed #2, over 25 quarter inch gouges in the wall below the window, a 10 inch exposed section of metal flashing on the wall near the sink, and the bottom quarter of an inner bathroom door was marred and scratched;</p> <p>*Room 202- the bottom quarter of an inner bathroom door was marred and scratched and had a 2 inch by 2 inch hole in it;</p> <p>*Room 204/206- the bottom quarter of an inner bathroom door was marred and scratched;</p> <p>*Room 205/207- the bottom quarter of an inner bathroom door was marred and scratched;</p> <p>*Room 209/211- the bottom quarter of an inner bathroom door was marred and scratched;</p> <p>*Room 305- the bottom quarter of the room door was marred and scratched;</p> <p>*Room 309- the bottom quarter of the room door was marred and scratched;</p> <p>*Room 312- had 5 unidentified dark brown spots which were approximately 1/4 to 1/2 in diameter, above bed #2; and,</p> <p>*Shower Room in the 200 hallway- had a 1/2 inch wide by 6 inch long section of veneer missing from the inside of the door near the bottom.</p> <p>B. On 6/24/14 from 12:45 PM to approximately 1:00 PM, the chairs in the Friendship House unit common room and the Table Rock Dining room were observed.</p> <p>Four maroon and gold stripped chairs in the Friendship house had visibly worn fabric on the seats and arm rests.</p> <p>Ten chairs in the Table Rock Dining room were observed to have 1 to 4 inches of varnish missing from all four legs of the chairs, which exposed the bare wood. Five of the 10 chairs also had varnish missing from the armrests, which exposed the bare wood.</p>	F 252	<p>Monitor:</p> <ol style="list-style-type: none"> 1. IDT (specific title of staff person noted in parentheses next to frequencies listed below) to conduct audit of random resident rooms and common areas to identify doors, walls, ceilings, chairs, or other areas that may need repair. Audits to begin on 7/28/2014 and to continue at the following frequencies: <ul style="list-style-type: none"> • Weekly x one (4) weeks (MR) • Q two (2) weeks x four (4) weeks (TC) • Monthly x three (3) months (CS) 2. Administrator to review audits and report findings to the QA Committee. 	8/1/2014

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F 252	Continued From page 5 On 6/25/14 from 3:00 to 4:05 PM, during the environmental tour, the Maintenance Director was informed of the wall gouges in Room 200 and he stated, "[I] haven't completed painting and remodeling." When asked about the various marred doors he stated, "It's probably time to go through the whole building and work on them." When asked about the ceiling spots in Room 312 he said rooms are deep cleaned between residents, however, things are sometimes missed. When asked about the chairs in the Table Rock Dining room he stated, "They could use a little stain...or could be thrown away." When asked about the worn fabric on the Friendship House sitting chairs he stated, "I know what you're talking about."	F 252		
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 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	F 280	<p>Corrective Action: Care Plan for Resident #5 updated to reflect intervention for weight loss and current level of ADL care.</p> <p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>All resident Care Plans have been reviewed by DNS and RCMs to ensure they correctly reflect ADL and Nutritional care needs. Updates completed as identified.</p> <p>Systemic Changes: IDT staff inserviced with regard to coordination of care with respect to the Significant Change Assessment and updating of Resident Care Plans to reflect the resident's current level of care.</p> <p>Continued on p. 7</p>	

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F 280	<p>Continued From page 6</p> <p>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 record review and staff interview, it was determined the facility failed to ensure care plans were revised when residents experienced a significant change. This affected one of nine (#5) sampled residents. This practice created the potential for harm due to lack of direction in the care plan. Findings included:</p> <p>Resident #5 was admitted to the hospital on 2/8/11 with multiple diagnoses which included senile dementia, anxiety, acute bronchitis, and iron deficiency anemia.</p> <p>The resident's most recent quarterly MDS assessment, dated 2/17/14, documented the resident was totally dependent and needed the assistance of one person for bathing.</p> <p>The resident's most recent MDS significant change assessment, dated 4/7/14, documented the resident experienced a decline and needed limited to extensive assistance of 1-2 persons in the following areas: *Bed mobility; *Transfer; *Locomotion On Unit; *Locomotion Off Unit; *Eating; *Toilet Use; and,</p>	F 280	<p>Monitor:</p> <ol style="list-style-type: none"> DNS to conduct audit of all Significant Change Assessments with regard to accuracy and Care Plan revision to ensure adequate and correct directives to staff. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months Administrator to review audits and report findings to the QA Committee. 	8/1/2014

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F 280	<p>Continued From page 7</p> <p>*Personal Hygiene.</p> <p>On 6/26/14 at 11:50 AM, UM #14 was interviewed regarding the ADL care plan which did not address the resident's current level of care. The current care plan documented interventions for staff to provide supervision and verbal cueing for hygiene, grooming, bathing, dressing, and mobility. Additionally, the care plan documented the resident was independent with bed mobility. UM #14 stated, "The resident is not independent, yes, it should be updated."</p> <p>On 6/26/14 at 5:50 PM, the Administrator and DNS were made aware of the concern regarding care plan revisions. The facility did not provide any additional information related to the finding.</p>	F 280		
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 and policy review, it was determined the facility failed to ensure staff utilized proper technique when eye drops were administered and blood glucose (BG) tests were obtained. This affected 1 of 2 residents (#5) who received eye drops during medication pass observations and 1 of 2 residents (#7) during BG glucose testing observations. These failures created the potential for less than optimal benefit for the eye drops and erroneous BG results. Findings included:</p>	F 281	<p>Corrective Action: LN staff members identified in 2567 received inservice from DNS regarding proper techniques with regard to administration of eye drops and blood glucose testing during the week of the Survey.</p> <p>Identification:</p> <ol style="list-style-type: none"> All residents with Physician Orders for eye drops are identified as possibly being affected by this deficiency. All diabetic residents are identified as possibly being affected by this deficiency. <p>Systemic Changes:</p> <ol style="list-style-type: none"> LN staff inserviced with regard to proper eye drop administration procedure and technique. LN staff inserviced with regard to blood glucose testing procedure and technique. <p>Continued on p. 9</p>	

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F 281	<p>Continued From page 8</p> <p>1. Note: Clinical Nursing Skills, 7th edition, 2010, by Perry and Potter, stated for the administration of ophthalmic medications, "Ask a patient to look at ceiling...hold cotton ball or clean tissue in non-dominant hand on patient's cheekbone just below lower eyelid...with dominant hand resting on patient's forehead, hold filled medication eyedropper approximately 1 to 2 cm above conjunctival sac. Drop prescribed number of medication drops into conjunctival sac."</p> <p>On 6/25/14 at 11:20, LN #3 was observed as she administered Artificial Tears (ophthalmic drops) to Resident #5. The LN instructed the resident to sit on her bed, lean her head back and stated, "Look straight at me." The LN pulled up the resident's left upper eyelid and dropped 2 drops into the left eye and then pulled up the right upper eyelid and dropped 1 drop in the right eye.</p> <p>On 6/26/14 at 5:50 PM, the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility which resolved the issue.</p> <p>2. Note: Clinical Nursing Skills, 7th edition, 2010, by Perry and Potter stated regarding blood glucose testing, "...Clean site with antiseptic swab, and allow it to dry completely...Alcohol can cause blood to hemolyze...Wipe away first droplet of blood with cotton ball...First drop of blood may contain more serous fluid than blood cells...Obtain test results..."</p> <p>On 6/24/14 at 8:40 AM, LN #2 was observed performing a blood glucose test on Resident #7. The LN wiped the finger tip with an alcohol swab, let it dry, pricked the finger with the lancet and placed the glucometer test strip at the tip of the</p>	F 281	<p>Monitor:</p> <ol style="list-style-type: none"> RCM to conduct audit of random eye drop administrations and blood glucose testing by LN staff. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months DNS to review audits and report findings to the QA Committee. 	8/1/2014	

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F 281	Continued From page 9 blood drop to obtain the glucose reading. The LN failed to wipe the 1st blood drop away and use the 2nd drop of blood per the facility's policy for blood glucose testing as noted below. The DNS provided a copy of the facility's policy and procedure on "Obtaining a Fingerstick Glucose Level" on 6/26/14 at 11:40 AM. This policy states, "Discard the first drop of blood if alcohol is used to clean the fingertips because alcohol may alter the results." On 6/26/14 at 5:50 PM, the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility which resolved the issue.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure physicians' orders were followed for an abductor pillow; interventions were implemented for low blood glucose (BG) levels; bowel care medications were administered as ordered; and, 2 Cal (nutritional supplement) was given as ordered. This was true for 5 of 8 sample	F 309	Corrective Action: 1. Nursing Staff inserviced regarding following Resident Care Plans, and specifically the Care Plan of the resident identified in 2567 as Resident #3 with respect to use of Hip Abductor. 2. LN Staff inserviced by DNS regarding facility Hypoglycemic policy and procedures. 3. LN Staff inserviced by DNS with regard to Dietician fax to Physician protocols. 4. LN Staff inserviced by DNS with regard to PRN Bowel Care Physician Orders. Identification: All residents are identified as possibly being affected by this deficiency. Continued on p. 11	

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F 309	<p>Continued From page 10 residents (#s 3, 5, 7, 8, and 11). These failures created the potential residents to experience complications, discomfort and/or compromised medical status. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 9/22/10, and readmitted on 5/2/14, with multiple diagnoses which included dislocation of the hip.</p> <p>The resident's admission MDS assessment, dated 5/9/14, coding included: * Moderately impaired cognition; * Extensive assistance by 2 or more people bed mobility, transfers and toilet use; and, * Wheelchair (w/c) use.</p> <p>The resident's Order Summary Report included the order, "Strict hip precautions. Keep knees apart..." This order was dated 5/2/14.</p> <p>The resident's mobility care plan included the intervention "Posterior Hip Precautions: Right hip...Abductor bolster covered with pillowcase between knees while in bed and sitting..." This intervention was initiated 5/2/14 and revised 5/14/14.</p> <p>On 6/26/14 at 5:00 p.m., the resident was observed seated on a bedside commode next to her bed. An abductor pad was on the resident's bed and nothing was between the resident's knees.</p> <p>On 6/27/14 from 8:25 a.m. to 8:40 a.m., the resident was observed seated in her wheelchair in her room. During this time, an abductor pad was on the bed and nothing was between the resident's knees. CNA #8 was in the resident's room the entire time and he never placed the</p>	F 309	<p>Systemic Changes:</p> <ol style="list-style-type: none"> 1. BG parameters set up in EMAR, as per facility policy and procedure. 2. RCM Staff to audit EMAR, specifically for hypoglycemia and needed BG re-checks, on a daily basis. <p>Monitor:</p> <ol style="list-style-type: none"> 1. RCM to audit use and proper of placement abductor pillow for Resident #3. 2. RCM to audit BGs and following Hypoglycemic policy as noted above. 3. DNS to monitor Dietician faxes to Physician for completed follow-up. 4. RCM to monitor EMAR for random residents receiving PRN bowel care medication to ensure compliance with Physician's Order. 5. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> • Weekly x four (4) weeks • Q two (2) weeks x four (4) weeks • Monthly x three (3) months 6. Administrator to review audits and report findings to the QA Committee. 	8/1/2014	

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F 309	<p>Continued From page 11 abductor pad between the resident's knees.</p> <p>On 6/27/14 at 8:40 a.m., CNA #8 was asked if the something should be in place between the resident's knees. The CNA acknowledged the abductor pad on the bed then said, "I'm not sure." The CNA said he would need to check.</p> <p>On 6/27/14 at 10:30 a.m., the Administrator and DNS were informed of the issue. No other information was received from the facility which resolved the issue.</p> <p>2. Resident #7 was admitted to the facility on 5/6/14 with multiple diagnoses including Type II diabetes.</p> <p>The resident's Order Summary Report included the following: * "BG checks AC, HS and 0200...[Blood glucose checks before meals, at bedtime and 2:00 a.m....]" It was ordered 5/23/14 and started 5/24/14. * Humulin R insulin per sliding scale. It was ordered 5/19/14 and started 5/20/14. * "Give 15gm [grams] of carbs [carbohydrates] if BG is 70. Wait 15 min[utes] and recheck BG, if BG remains 70 notify MD [physician]. [E]very shift related to diab[etes]..." It was ordered and started 6/20/14. * Novolin N insulin 20 units subcutaneously (SQ) in the morning and evening. It was ordered 6/6/14 and started 6/7/14.</p> <p>On 6/24/14 at 8:30 a.m., LN #2 was observed as she poured the resident's morning medications, which included the aforementioned scheduled dose of Novolin N insulin. The LN informed 2 surveyors the resident's BG was 56 at 7:15 that</p>	F 309		

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F 309	<p>Continued From page 12</p> <p>morning for which she had given the resident a glass of milk then resident went to breakfast.</p> <p>When asked what the recheck BG was, LN #2 stated, "I didn't recheck her. She said she didn't feel bad. She needed to eat." The LN said she would recheck the resident's BG. The LN unlocked the medication cart, removed the glucometer, and took it into the resident's room.</p> <p>At 8:40 a.m., LN #2 rechecked the resident's BG. It was 149. The LN stated, "I should have rechecked it sooner than I did." (Note: The LN rechecked the resident's BG only after surveyors asked about it, which was 1 hour and 20 minutes after the LN provided an intervention for the low BG.)</p> <p>Review of the June 2014 MAR and Progress Notes (PN), dated 5/6/14 at 9:52 p.m. through 6/24/14 at 8:42 a.m., revealed there was documented evidence that an intervention was implemented on 6/5 when the resident's BG was 58 at 11:30 a.m.</p> <p>The June 2014 MAR and aforementioned PN included additional documentation that the BG was not rechecked in 15 minutes, or not at all, after interventions were implemented when the resident's BG was below 70, as follows:</p> <ul style="list-style-type: none"> * 6/1 - BG at 11:30 a.m. = 33, recheck at 12:06 p.m. (36 minutes later) = 145; * 6/6 - BG at 1:45 a.m. = 53, recheck at 2:00 a.m. = 57, recheck at 2:30 a.m. (1/2 hour later) = 84; * 6/7 - BG at 2:00 a.m. = 57, recheck at 3:00 a.m. (1 hour later) = 90; * 6/9 - BG at 2:00 a.m. = 68, recheck not documented; * 6/11 - BG at 2:15 a.m. = 37, recheck at 2:45 	F 309		

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F 309	<p>Continued From page 13</p> <p>a.m. = 78; * 6/16 - BG at 2:30 a.m. = 47, recheck at 3:30 a.m. (1 hour later) = 111; * 6/17 - BG at 2:10 a.m. = 46, recheck at 2:45 a.m. = 43, recheck at 3:30 a.m. = 146; and, * 6/24 - BG at 7:00 a.m. = 56, recheck as noted above.</p> <p>On 6/26/14 in the morning, the DNS was asked to provide the facility's policy regarding hypoglycemia.</p> <p>Later that morning, the DNS provided a Nursing Care of the Resident with Diabetes Mellitus policy which included a section titled Management of Hypoglycemia.</p> <p>The Management of Hypoglycemia section included, "2. ...For asymptomatic [absence of symptoms] and responsive residents with hypoglycemia (< [less than]70...or less than the physician-ordered parameter): a. give the resident an oral form of rapidly absorbed glucose...; b. recheck blood glucose in 15 minutes; c. if blood sugar is > [greater than]130... (rebound hyperglycemia) administer diabetic medications; d. if blood sugar is <70...repeat oral glucose and recheck blood glucose in 15 minutes;...; 3. For symptomatic (lethargic, drowsy but responsive (conscious) residents with hypoglycemia (<70...or less than the physician-ordered parameter): a. if he/she is able to swallow: (1) immediately give the resident an oral form of rapidly absorbed glucose...(2) recheck blood glucose in 15 minutes; (3) repeat juice if indicated, recheck blood glucose in 15 minutes. b. if he/she is unable to swallow: (1) immediately administer oral glucose paste to the buccal mucosa, intramuscular glucagon, or IV</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>[intravenous] 50% dextrose...(2) recheck blood glucose in 15 minutes; (3) repeat protocol if indicated, recheck blood glucose in 15 minutes...g. if no improvement, notify the physician...; 4. For symptomatic and unresponsive residents with hypoglycemia (<70...or less than the physician-ordered parameter): a. immediately administer oral glucose paste to the buccal mucosa, intramuscular glucagon, or IV 50% dextrose, per facility protocol and notify the physician..."</p> <p>On 6/26/14 at 1:00 p.m., the DNS was asked about the lack of an intervention when the resident's BG was 58 on 6/5 and the lack of or delays to recheck the resident's BGs after interventions were implemented when the resident's BG was low. The DNS reviewed the resident's medical record then acknowledged there were delays and there was no evidence an intervention was implemented on 6/5. The DNS stated, "There has been some confusion with our system regarding low BGs."</p> <p>The facility did not provide any other information regarding the issue.</p> <p>3. Resident #11 was admitted to the facility on 2/16/14 with multiple diagnoses which included diabetes without complication type II, polyneuropathy in diabetes, and lower limb amputation, above knee.</p> <p>The resident's Medication Review Report for June 2014 documented the following order: "For BG 60 administer one time dose of Glucagon as per order and notify MD. For BG over 200 administer, Humalog as per order, notify MD for BG >300 every shift."</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>NOTE: The order should have read, "For BG <60 administer..."</p> <p>The resident's MAR for the month of June 2014, documented a BG of 55 on 6/4/14 at 4:30 PM. However, the MAR did not contain documentation the BG was rechecked as per the facility's policy.</p> <p>On 6/4/14 at 11:50 PM, a progress note documented, "No ASE [associated side effects] from Glucagon inj, MD notified of low BG & Glucagon inj & ordered slight adjustment in SS [sliding scale]..." However, a progress note was not found to indicate the BG had been rechecked as per the facility's policy.</p> <p>On 6/26/14 at 5:40 PM, RN #10 was interviewed regarding their hypoglycemia policy to recheck the BG 15 minutes after giving glucose and asked if the nurse should have rechecked the BG. RN #10 stated, "yes."</p> <p>On 6/26/14 at 5:50 PM, the Administrator and DNS were made aware of the concerns with low BG's. The facility did not provide any further information regarding the concern.</p> <p>4. Resident #5 was admitted to the hospital on 2/8/11 with multiple diagnoses which included senile dementia, anxiety, acute bronchitis, and iron deficiency anemia.</p> <p>Medical record review documented a Dietitian Assessment, dated 6/12/14 (Thursday) at 10:45 AM, with a recommendation to, "Increase 2.0 kcal supplement to 60 ml BID [two times per day] r/t [related to] weight loss and acceptance has improved."</p>	F 309		
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F 309	<p>Continued From page 16</p> <p>The resident's medical record contained a fax, dated 6/12/14, written to the resident's physician by UM #14 which documented, "Per dietitian recommendations may we have an order to increase 2.0 kcal to 60 ml BID r/t to weight loss." The physician returned the fax the same day and circled "YES," and wrote, "Will see patient Monday and evaluate further."</p> <p>An Order Summary Report, dated 6/26/14, documented an order for 2.0 kcal was received on 6/25/14 with a start date of 6/26/14.</p> <p>On 6/26/14 at 10:55 AM, the RD (Registered Dietician) was interviewed in regard to the resident's weight loss. The RD stated the resident had a long history of fluctuation with regard to weight loss and thought the resident's recent weight loss was environmental with increased confusion related to the resident being moved to the Friendship House, a locked dementia unit. The RD stated the resident experienced a decline in her dementia and was having increased wandering and exiting behaviors. The RD stated, "The 2.0 kcal supplement had been discontinued and was restarted on 2/18/14 to one time daily and she had recommended an increase of the 2.0 kcal to BID on 6/12/14." When asked why it took so long to get an order for the 2.0 kcal supplement, the RD stated, "That is a good question."</p> <p>On 6/26/14 at 11:50 AM, UM #14 was interviewed about why it took so long to get an order to increase the 2.0 kcal supplement to BID per the RD's recommendation. She stated, "The 2.0 kcal was ordered on 6/13/14 but the order was found</p>	F 309			

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F 309	<p>Continued From page 17 on the 25th." When asked why there an approximate two week delay, UM #14 shrugged her shoulders up and down and stated, "I can't answer."</p> <p>On 6/27/14 at 5:50 PM, the Administrator and DNS were informed of the delay in treatment for weight loss. The facility did not provide any further information.</p> <p>5. Resident #8 was readmitted on 7/10/12 with multiple diagnoses including constipation, dysphasia due to cerebrovascular disease, flacid hemiplegia affecting dominant side and muscular wasting and disuse atrophy.</p> <p>The resident's May and June 2014 MAR's documented orders dated 7/11/13 as, "Milk of Magnesia...by mouth as needed for Bowel Care if no BM [Bowel Movement] in 72 hours" and "Bisacodyl Suppository...as needed for Bowel Care if no BM 8 hours post MOM [Milk of Magnesia]." Note: This equals at least an 80 hour lapse of time between the last BM and the administration of a suppository.</p> <p>The resident's May and June 2014 Follow Up Question Report (Bowel and Bladder record) and May and June 2014 MAR's documented the following: * 5/1/14 at 11:58 AM the resident had a BM. A suppository was given on 5/5/14 at 5:57 AM and the resident had a BM on 5/5/14 at 8:20 PM. Note: No MOM was given prior to the suppository. * 5/5/14 at 11:58 AM the resident had a BM. A suppository was given on 5/9/14 at 5:51 AM and the resident had a BM on 5/9/14 at 7:04 PM. Note: No MOM was given prior to the suppository. * 5/9/14 at 7:04 PM the resident had a BM. A</p>	F 309			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 18 suppository was given on 5/12/14 at 6:31 AM and the resident had a BM on 5/12/14 at 3:14 PM. Note: this was less than 80 hours between BM's; and, * Similar findings for 5/20-5/23/14, 5/28-5/31/14, 6/1-6/3/14, 6/6-6/9/14, 6/15-6/17/14, and 6/17-6/21/14. On 6/26/14 at 11:00 AM Resident Care Manager #10 was interviewed regarding the issue. She reviewed the MAR's and stated it, "looks like we are jumping right to suppository versus MOM...Looks like I need to look at his bowel care protocol."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure residents received adequate assistance for during dining for 2 of 13 sampled residents (#'s 3 & 8). The deficient practice had the potential to result in residents nutritional needs not being met. Findings included:	F 312	Corrective Action: 1. Nutritional Care Plan for resident identified in 2567 as Resident #8 has been updated to direct staff with regard to placing only adaptive utensils in front of the resident at meals to reduce any potential confusion, increased assistance with feeding, and Physician Order for Occupational Therapy Evaluation has been requested. 2. CNA Staff inserviced by DNS with regard to following Resident Nutritional Care Plans, specifically to providing feeding assistance for sight impaired residents. Identification: All residents are identified as possibly being affected by this deficiency. Systemic Changes: Nursing staff inserviced as noted above in Corrective Action. Continued on p. 20	

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F 312	Continued From page 19 1. Resident #8 was readmitted on 7/10/12 with multiple diagnoses including dysphasia due to cerebrovascular disease, flacid hemiplegia affecting dominant side and muscular wasting and disuse atrophy. The resident's nutritional care plan documented interventions with revision dates of 1/31/13: **"Dining Assistive Devices: Sippy cup, lipped plate, and right curved weighted utensils" and **"Provide extensive assistance with constant encouragement remaining with resident during meals." During the dinner meal from 5:38 PM to 6:13 PM on 6/25/14 the following observations were made for Resident #8: * 5:38-5:43 PM- The resident received his meal which consist of a piece of quiche, diced potatoes, a whole tomato, and a piece of bread. He immediately ate the bread with his left hand. He was also given two sets of eating utensils; a weighted curved fork and spoon and a regular fork, spoon, and knife. The resident appeared to be confused and picked up each of the utensils repeatedly with his left hand and placed them back on the table; * 5:46 PM- CNA #11 sat down at the table between Resident #8 and another resident. CNA #11 immediately focused on the other resident and assisted that resident with his meal and began talking only to that resident. Resident #8 stopped picking up the utensils and used his left hand to pick up the quiche. The CNA did not cue or assist the resident to use the weighted utensils which were provided; * 5:50 PM- The CNA turned to Resident #8 and said, "What do you think [Resident #8 Name]?"	F 312	Monitor: 1. IDT (specific title of staff person noted in parentheses next to frequencies listed below) to conduct audit of random residents, with adaptive utensils and need for assistance, to ensure resident's Nutritional Care Plan is being followed. 2. IDT to monitor any sight impaired residents to ensure resident's Nutritional Care Plan is being followed. 3. Audits to begin on 7/28/2014 and continue at the following frequencies: • Weekly x four (4) weeks (HR) • Q two (2) weeks x four (4) weeks (RCP) • Monthly x three (3) months (RCM) 4. DNS to review audits and report findings to the QA Committee.	8/1/2014	

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F 312	<p>Continued From page 20</p> <p>The CNA then turned back to the other resident and began talking to him. Resident #8 still used his hand to eat and finish the quiche;</p> <p>* 5:58 PM- The CNA looked at Resident #8, made no comment and then turned her attention back to the other resident;</p> <p>*6:01 PM- The CNA looked at Resident #8 (who was not eating) for a few seconds and then moved to a different table to assist another resident for approximately 10 seconds and then moved back to the original table;</p> <p>*6:03 PM- The CNA turned to Resident #8 and asked if the resident wanted assistance with his ice cream, gave him the weighted curved spoon, moved the dinner plate away, and moved the ice cream in front of the resident;</p> <p>*6:06 PM- The CNA noticed the ice cream bowl had moved away from the resident, so she adjusted the ice cream where the resident could reach it. The CNA then walked away from the table and a nurse sat down at the table in her place; and,</p> <p>*6:13 PM- Resident #8 pushed himself away from the table.</p> <p>The potatoes and tomato remained uneaten.</p> <p>On 6/25/14 at 6:25 PM CNA #11 was interviewed regarding the meal observation. The CNA was asked about the extra set of regular utensils provided to the resident and she stated, "It's what the kitchen gives him." When asked why she did not cue the resident or give him the weighted utensils she said, "I usually give him adaptive silverware."</p> <p>On 6/26/14 at 11:00 AM Resident Care Manager #10 was interviewed regarding the observation and care plan. She said she would educate staff on residents who need more assistance with</p>	F 312			

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F 312	<p>Continued From page 21</p> <p>dining and stated, "It sounds like we need to do an occupational therapy assessment...or [the resident] needs a higher assist [level]."</p> <p>2. Resident #3 was readmitted on 5/2/14 with multiple diagnoses including closed dislocation of hip, glaucoma, macular degeneration of retina, pain, dehydration, protein-calorie malnutrition, anemia and failure to thrive (FTT).</p> <p>The resident's admission MDS assessment, dated 5/9/14, coding included:</p> <ul style="list-style-type: none"> * Moderately impaired vision, no corrective lenses; * Moderately impaired cognition; and, * Supervision and 1 person assistance for eating. <p>The CAA worksheet dated 5/15/14 documented:</p> <ul style="list-style-type: none"> * Visual Function: Cataracts, glaucoma, or macular degeneration, decreased visual acuity. "...decreased abilities related to above... Functional limitations related to vision problems. "...difficulty with...eating related to decreased vision." * ADL Functional/Rehabilitation...Eating- "...Physical limitations: weakness, limited range of motion, poor coordination, poor balance, visual impairment, pain, etc. Resident continues to be able to feed herself after tray set up." <p>The resident's care plan included the following focus areas and interventions:</p> <ul style="list-style-type: none"> * Risk for dehydration/fluid imbalance - "Encourage/offer fluids." * Potential/Impaired nutrition - "I prefers to use a clothing protector. Resident has very poor vision; Identify location of food on plate using clock face." * Vision deficit..."Adapt environment to resident's 	F 312			

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F 312	<p>Continued From page 22</p> <p>individual needs to ensure resident is able to recognize objects/own environment. Keep environment free of small objects and clutter. Position window blinds to decrease glare."</p> <p>On 6/25/14 at 6:25 PM, CNA #12 was observed as she delivered Resident #3's dinner tray and placed it on the overbed table. The CNA left the room to go get the resident's coffee. Moments later, the CNA returned with the coffee and asked if she wanted creamer in her coffee and the resident told her yes. The CNA unwrapped the resident's silverware, placed it on the left hand side of the tray (resident was right handed) and stated, "I set your silverware right here (without identifying where here was). Is there anything else I can do?" The resident stated, "No." The CNA left the room without any further cueing or offer to cut food up and unwrap covered items. As soon as the CNA left, the resident stated, "Shoot, forgot to ask for towel. They are probably busy and it is no big deal." Resident tucked her napkin into her shirt to use as a clothing protector. A few minutes later, CNA #12 returned to the resident's room and the resident asked the CNA if she would place a towel on her. CNA placed the towel over the clothing and she left the room again. The resident felt around on the meal tray with her hands to locate items. When asked if she could see items in front of her, the resident stated, "It's hard and only dark shapes." The resident fumbled with her silverware and her knife dropped onto the bed. The resident held her fork up to the light with her right hand and said she could see the tines and knew it was a fork. The resident tried to use the fork to get a bite of quiche and could not break a piece off. She tried to use her spoon to cut the quiche without success. The resident then stabbed at the</p>	F 312			

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F 312	<p>Continued From page 23</p> <p>quiche with the fork and pieces of it flung onto the tray. She was successful breaking free some of the quiche and potatoes. A glass of clear red liquid and a dessert dish were snugly covered with plastic wrap.</p> <p>On 6/26/14 at 3:10 PM, CNA #12 was interviewed about the meal setup for resident #3 and using the care plan. CNA stated, "I have her prop up in bed, pull up the bedside table, will tell and show her where everything is, offer a clothing protector, ask if there is anything else I can do." When asked about resident's preference on clothing protector, using the clock face to identify the location of food on her plate, CNA #12 stated, "Resident prefers a towel, the kitchen cuts up the food and she does okay with soft food. I am new and been here just a few weeks and have only worked with resident maybe twice. I don't usually do the hall meal carts and it was wacky with call lights last night."</p> <p>On 6/27/14 at 8:20 AM, Resident #3 was observed sitting in her wheelchair in her room. CNA #8 brought in the resident's breakfast tray and set it on the overbed table in front of the resident. The CNA uncovered the plate and told the resident there was french toast. The CNA immediately proceeded cutting up the toast without asking and poured syrup on it per resident's request. CNA stated, "Your coffee and juice are right here. The CNA did not identify where "right here" was.</p> <p>The CNA was interviewed immediately afterwards. He was asked if he followed resident's care plan by using the clock face to identify the location of food. CNA stated, "I don't use the clock system and I take [resident's name]</p>	F 312			

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F 312	Continued From page 24 hand and show her where things are. I've been off for awhile."	F 312			
F 322 SS=D	The Administrator and DNS were informed of the issue on 6/27/14 at 10:30 AM. The facility did not provide any additional information on this issue. 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation and policy review, it was determined the facility failed to ensure staff elevated the head of a resident's bed while medications were administered through a PEG (percutaneous endoscopic gastrostomy) tube.	F 322	Corrective Action: LN identified in 2567 has been inserviced regarding policy and procedure related to administering medications by PEG tube. Identification: All residents with PEG tubes are identified as possibly being affected by this deficiency. Systemic Changes: LN staff inserviced with regard to policy and procedure related to administering medications by PEG tube. Monitor: 1. RCM to conduct audit of random medication administrations by PEG tube. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> • Weekly x four (4) weeks • Q two (2) weeks x four (4) weeks • Monthly x three (3) months 2. DNS to review audits and report findings to the QA Committee.	8/1/2014	

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F 322	<p>Continued From page 25</p> <p>These affected 1 of 2 residents (#18) during PEG tube medication pass observations. This failure created the potential for the resident to experience gastrointestinal distress and/or aspiration. Findings included:</p> <p>Note: Clinical Nursing Skills, 7th edition, 2010, by Perry and Potter, stated for administering medications by enteral tube, "Prepare patient by placing in a high-Fowler's (semi-sitting) position (if not contraindicated by patient's medical condition)."</p> <p>On 6/26/14 at 10:20 PM, LN #4 was observed administering 12 medications to Resident #18 through a PEG tube. The resident was lying flat in bed with only 2 pillows underneath her head. The resident stated, "It makes me want to throw up. I'm sick to my stomach." (Note: Refer to F332, medication errors, for details)</p> <p>The DNS provided the facility's policy and procedure on "Administering Medications through an Enteral Tube" on 6/26/14 at 11:40 AM. This policy states, "Assist the resident to semi or high-Fowler's position (30 [degree] to 45 [degree])...Have the resident maintain the semi or high-Fowler's position for at least 30 minutes, if tolerated by the resident's physical or medical condition."</p> <p>The Order Summary Report and MAR dated 6/1/14 to 6/30/14, documented to elevate HOB (head of bed) 30 degrees during enteral administration and for 30 minutes post feeding. The resident had no contraindication of having the HOB elevated.</p>	F 322		

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F 322	Continued From page 26 On 6/26/14 at 5:50 PM, the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility which resolved the issue.	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, it was determined the facility failed to ensure residents were as free from accidents and hazards as possible related to: -This was true for 13 of 13 (#'s 1-13) sample residents, 2 random residents (#s 19 & 20) and had the potential to affect all residents who frequented the Sun Lounge, Main Dining Room, Rehabilitation Room, and Resident Room 211 due to hazardous transition thresholds on the floor. This practice placed the residents at risk for more than minimal harm for falls; -This was true for 1 of 9 shower rooms, when one bottle of chemicals was found in an unlocked shower room. This failure created the potential for harm for any independently mobile, cognitively impaired resident who could access the unsecured chemicals; and, -This was true for 1 of 13 sampled residents (#7) when side rails were implemented without being	F 323	Corrective Action: 1. Floor transitions in rooms identified in 2567 have been replaced or adjusted. 2. Chemicals removed from Shower Room identified in 2567 and a lock installed on the door the same day the issue was identified during the Survey. 3. Assistive Device Assessment completed for Resident #7 to address her safety to use bed cane. Identification: All residents are identified as possibly being affected by this deficiency. Systemic Changes: 1. ESS to continue monthly audits of floors for transitions issues, as per policy and procedure, and to ensure chemicals are stored and locked as per policy and procedure. 2. RCMs inserviced with regard to Assistive Device Assessments, including the resident's safety to use the assistive device. Continued on p. 28	

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F 323	Continued From page 27 evaluated for safety. This had the potential to harm the resident due to the risk of limb entrapment in the side rail. Findings included: 1. Observations: a. On 6/24/14 between breakfast and lunch Resident #20 was observed in the main dining room in her wheelchair (WC). She attempted to leave the dining room 4 times, by placing her left hand in the door jam and her right hand on the tire of her WC in order to make the transition over the rubberized threshold on the floor between the vinyl dining room surface and hallway carpeting. The resident stated, "It's hard to get through these and hard on the other side, since it's uphill also." b. On 6/24/14 at 2:25 PM and 2:40 PM, Resident #1 and #20 were observed in the Sun Lounge in their WC's. They attempted to leave the room at least 3 times before successfully transitioning over the rubberized threshold on the floor between the vinyl dining room surface and hallway carpeting. c. On 6/25/14 from 10:15-10:30 AM, the 2 inch wide thresholds of several rooms in the facility were measured by the surveyor and found the following: * The Main Dining room was approximately 1/4 to 1/2 inch high; * The Sun Lounge room had two entrances which were each approximately 1/2 inch high; * The Rehabilitation room had two entrances which were each approximately 1/2 inch high; and, * Resident room #211 was approximately 1/2 inch	F 323	Monitor: 1. IDT (specific title of staff person noted in parentheses next to frequencies listed below) to conduct audit of random floor transitions in the facility and chemical storage to ensure compliance. Audits to begin on July 28, 2014 and to continue at the following frequencies: <ul style="list-style-type: none"> • Weekly x four (4) weeks (LSW) • Q two (2) weeks x four (4) weeks (AD) • Monthly x three (3) months (MR) 2. DNS to conduct audit of random Assistive Device Assessments. Audits to begin on 7/28/2014. 3. Administrator to review audits and report findings to the QA Committee.	8/1/2014	

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F 323	<p>Continued From page 28 high.</p> <p>d. On 6/25/14 at 6:10 PM, Resident #19 was observed in the Sun Lounge in her WC. She attempted to leave the dining room 6 times, by placing her left hand in the door jam and her right hand on the opposite door jam in order to make the transition over the rubberized threshold on the floor between the vinyl dining room surface and hallway carpeting. The resident stated, "It's a struggle," to leave the room.</p> <p>Interviews:</p> <p>a. On 6/25/14 at 10:12 AM, Occupational Therapist #9 said of the thresholds, "if you stop before going out, you really notice it."</p> <p>b. On 6/25/14 at 10:45 AM, Resident #20 was interviewed regarding the thresholds. She said both the Main Dining and Sun Lounge rooms were problems and stated they were, "Pretty good bumps...If you get a running start you can make it over." She also said she had to pull on the door frames in order to get out of both rooms.</p> <p>c. On 6/25/14 from 2:00-3:05 PM, during the environmental tour, the Maintenance Director measured the rooms in question and stated the following: * The Main Dining room- "Right at a quarter to five sixteenths [inch]."; * The Sun Lounge room- "There you're right at a half [inch]."; * The Rehabilitation room- "Half inch."; and, * Resident room 211- "Five eights."</p> <p>2. On 6/24/14 at 3:22 PM, "Shower Room #8" was observed to be unlocked. On the shower wall</p>	F 323		

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F 323	<p>Continued From page 29</p> <p>in the middle of the room and approximately 3 feet high was a full one quart bottle of Bio-Enzymatic Urine Digester with odor counteractant. The bottle had a warning label which documented: "Caution: Keep out of the reach of children...Not for internal consumption. If product is ingested induce vomiting and consult physician. If contact occurs with skin, wash with soap and water. If contact with eyes, flush with copious amount of water."</p> <p>On 6/24/14 at 3:30 PM, Resident Care Manager #10 and the DNS were shown the chemical. The DNS stated about the door handle, "That's odd it doesn't have a key...we will make sure it is actually locked when we leave."</p> <p>On 6/25/14 at 6:55 PM, the Administrator and DNS were informed of the issue. No further information was provided by the facility.</p> <p>3. Resident #7 was admitted to the facility on 5/6/14 with multiple diagnoses which included compression fractures at thoracic 7 through 12 levels without specific spinal cord injury.</p> <p>The resident's admission MDS assessment, dated 5/13/14, coding included: * Moderately impaired cognition, with a BIMS score of 12; * Extensive assistance with bed mobility and transfers; and, * Not steady moving from a seated to standing position or surface-to-surface transfers, such as bed to chair or wheelchair.</p> <p>The resident's mobility care plan, dated 5/6/14, included the intervention, "[B]edcane to right side</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER MARQUIS CARE AT SHAW MT	STREET ADDRESS, CITY, STATE, ZIP CODE 909 RESERVE STREET BOISE, ID 83712
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F 323	<p>Continued From page 30 of bed" which was initiated 5/21/14.</p> <p>The resident's Physical Restraint/Assistive Device Assessment, dated 5/27/14, documentation included:</p> <ul style="list-style-type: none"> * "What restraint or assistive device is utilized" - "[B]edcane to right side of bed;" * "[B]edcane allows for increase in resident participation in bed mobility. * Cognitive - "Alert" and "Poor safety insight;" * "Does the device restrict resident mobility" - "Yes;" * "How does device assist...(reasons & benefits of use) - "[B]edcane allows for increase in resident participation in bed mobility;" * "What risks have been discussed with the resident... - "Potential for device to become loose or dislodged;" * "Is the resident utilizing a side rail" - "No." <p>This assessment was done 6 days after the bedcane was initiated on 5/21/14.</p> <p>A small siderail (approximately 1/8) was observed in the raised position on the right side of the resident's bed on:</p> <ul style="list-style-type: none"> * 6/23/14 at 2:30 p.m.; * 6/24/14 at 9:45 a.m. and 10:30 a.m.; and, * 6/25/14 at 10:15 a.m. and 2:30 p.m. <p>On 6/26/14 at 1:00 p.m., the DNS was asked if the resident had been assessed to determine if she was safe with the use of the siderail. The DNS said a "bedcane," not a side rail, was on the resident's bed. He indicated that bedcanes did not require a safety assessment. The DNS reviewed the resident's aforementioned 5/27/14 Physical Restraint/Assistive Device Assessment, however, and acknowledged that it did not document the resident was safe with the use of</p>	F 323		
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F 323	Continued From page 31 the "bedcane." He stated, "We should be doing them [safety assessments] and based on most residents, we are."	F 323			
F 332 SS=D	The facility did not provide any other information which resolved this issue. 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview, it was determined the facility failed to maintain a medication error rate less than 5 percent. This was true for 2 of 29 medications (6.8%) which affected 2 of 4 residents (#s 7 and 18) during medication pass observations. Failure to recheck a blood glucose (BG) level prior to preparation of administering insulin and failure to administer medications as ordered through a PEG (percutaneous endoscopic gastrostomy) tube placed the residents at risk for adverse reactions. Findings include: 1. On 6/24/14 at 7:45 AM, Resident #7 was observed in the main dining room. The resident said, "Breakfast was good. Lots of protein." On 6/24/14 at 8:30 AM, LN #2 was observed as she poured Resident's #7 morning medications, which included 20 units of Novolin N insulin. The LN informed the 2 surveyors the resident's BG	F 332	Corrective Action: 1. LN identified in 2567 received inservice from the DNS as noted in F 309. 2. LN identified in 2567 received inservice from the DNS as noted in F 322. Identification: All residents are identified as possibly being affected by this deficiency. Systemic Changes: Please refer to Systemic Changes as noted in F 309 and F 322. Monitor: Please refer to audits as noted in F 309, and F 322	8/1/2014	

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F 332	<p>Continued From page 32</p> <p>was 56 at 7:15 AM and she had given the resident a glass of milk and the resident went to breakfast shortly thereafter.</p> <p>When LN #2 was about to take the medications, including the syringe with Novolin insulin, into the resident's room she was asked if she intended to give the medications. The LN stated, "Yes." The LN was then asked if the resident's BG had been rechecked. The LN stated, "I didn't recheck her. She said she didn't feel bad. She needed to eat." At that point, LN #2 rechecked the resident's BG and it was 149. The LN then administered the Novolin N insulin and other medications as ordered.</p> <p>Note: The LN planned to administer the the insulin prior to re-checking the resident's current BG.</p> <p>The resident's Order Summary Report included the following orders: * "BG checks AC, HS and 0200...[Blood glucose checks before meals, at bedtime and at 2:00 a.m....]." It was ordered 5/23/14 and started 5/24/14. * Novolin N insulin 20 units subcutaneously (SQ) in the morning. It was ordered 6/6/14 and started 6/7/14.</p> <p>On 6/26/14 in the morning, the DNS was asked to provide the facility's policy regarding hypoglycemia.</p> <p>Later that morning, the DNS provided a Nursing Care of the Resident with Diabetes Mellitus policy which included a section titled Management of Hypoglycemia.</p> <p>The Management of Hypoglycemia section</p>	F 332			

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F 332	<p>Continued From page 33</p> <p>included, "2. ...For asymptomatic [absence of symptoms] and responsive residents with hypoglycemia (< [less than]70...or less than the physician-ordered parameter): a. give the resident an oral form of rapidly absorbed glucose...; b. recheck blood glucose in 15 minutes; c. if blood sugar is > [greater than]130... (rebound hyperglycemia) administer diabetic medications; d. if blood sugar is <70...repeat oral glucose and recheck blood glucose in 15 minutes;...; 3. For symptomatic (lethargic, drowsy but responsive (conscious) residents with hypoglycemia (<70...or less than the physician-ordered parameter): a. if he/she is able to swallow: (1) immediately give the resident an oral form of rapidly absorbed glucose...(2) recheck blood glucose in 15 minutes; (3) repeat juice if indicated, recheck blood glucose in 15 minutes. b. if he/she is unable to swallow: (1) immediately administer oral glucose paste to the buccal mucosa, intramuscular glucagon, or IV [intravenous] 50% dextrose...(2) recheck blood glucose in 15 minutes; (3) repeat protocol if indicated, recheck blood glucose in 15 minutes...g. if no improvement, notify the physician...; 4. For symptomatic and unresponsive residents with hypoglycemia (<70...or less than the physician-ordered parameter): a. immediately administer oral glucose paste to the buccal mucosa, intramuscular glucagon, or IV 50% dextrose, per facility protocol and notify the physician..."</p> <p>On 6/26/14 at 5:50 PM, the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility which resolved the issue.</p> <p>2. On 6/26/14 at 10:20 AM, LN #4 was observed</p>	F 332			

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F 332	<p>Continued From page 34</p> <p>to crush 12 different medications together in 1 plastic crush bag then mixed them with approximately 60 mL (milliliters) of water for resident #18.</p> <p>The medications crushed were as follows: Aspirin Chewable 81 mg - 1 tablet Levothyroxine 25 mcg - 1 tablet Lexapro 10 mg - 2 tablets Omeprazole 20 mg - 1 tablet Multi-Vitamin - 1 tablet Vitamin B-1 - 1 tablet Busipar 15 mg - 1 tablet Cranberry 450 mg - 1 tablet Docusate 100 mg - 2 tablets Hydrocodone/APAP 5/325 mg - 1 tablet Levetricetam 250 mg - 1 tablet Metformin 500 mg - 1 tablet</p> <p>On 6/26/14 at 10:30 AM, LN #3 flushed the residents's PEG tube with approximately 30 mL of water, administered all 12 crushed and mixed together medications (a total of 14 tablets) into the PEG tube, flushed with approximately 30 mL more of water and then administered approximately 300 mL of free water. The resident was lying flat in bed with only 2 pillows underneath her head. The resident stated, "It makes me want to throw up. I'm sick to my stomach." The LN #3 replied, "I know you don't like this, but you are not drinking enough water." (Note: Refer to F281, Professional Standards, for details regarding the positioning issue.)</p> <p>LN #3 was interviewed immediately after the medication administration. When asked if she had crushed all the medications together, the LN stated, "Yes, I crushed all the morning medications together and then mixed them with</p>	F 332			

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F 332	Continued From page 35 water." The DNS provided the facility's policy and procedure "Administering Medications through an Enteral Tube" on 6/26/14 at 11:40 AM. The policy documented, "...Dilute the crushed or split medication with 30ml water...If administering more than one medication, flush with 5 to 10ml (or prescribed amount) warm water between medications. When the last of the medication begins to drain from the tubing, flush the tubing with 30 to 50 ml of warm water (or prescribed amount)..." The resident's Order Summary Report and June 2014 MAR included the orders, "Enteral Feed Order as needed[.] May receive medications through peg tube. Flush PEG tube with 30 cc water before and after meds [medications] with 15ccs between meds." and "Enteral Feed Order[:] four times a day for Supplement Flush PEG tube with 300mL of water." Note: Ref: S&C: 13-02-NH stated regarding medication administration via tube feeding, "For administering medications via tube feeding, the standard of practice is to administer each medication separately and flush the tubing between each medication. An exception would be if there is a physician's order that specifies a different flush schedule for an individual resident, for example because of a fluid restriction." On 6/26/14 at 5:50 PM, the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility which resolved the issue.	F 332			
F 371	483.35(i) FOOD PROCURE,	F 371	Please see p. 37		

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F 371 SS=E	Continued From page 36 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, staff interview and facility policy review, it was determined the facility did not ensure food was prepared and stored in a sanitary manner. This had the potential to affect 18 out of 18 sampled resident's (#s 1-13 and 16-20). This failed practice created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included: On 6/23/14 at 9:20 AM, during the initial tour of the kitchen with the Dietary Manager (DM) in attendance, the following concerns were identified: *A sanitizer bucket in the dish room was observed to contain a solution concentration of 100 ppm (parts per million), which was below the minimum requirement of 150 ppm. *The DM was observed in the kitchen with an uncovered moustache and goatee. When asked if he should be wearing a facial hair net, the DM stated, "I know I should wear one when in the kitchen" and went to get a facial hair net.	F 371	Corrective Action: 1. Solution in Sanitizer bucket identified in 2567 was changed out immediately upon notification of deficiency. 2. DM covered facial hair immediately during kitchen tour of Survey as noted in the 2567. 3. All items identified in 2567 from Refrigerator "B" were discarded, or covered immediately, as noted in 2567. 4. All items identified in 2567 from Refrigerator "E" were discarded immediately, as noted in 2567. Refrigerator was also cleaned immediately. 5. Food items identified in 2567 as undated in Freezer #1, were discarded immediately. 6. Food items identified in 2567 as undated in Freezer #2 were discarded immediately. 7. Food items identified in 2567 as undated in Chest Freezer were discarded immediately. 8. Food items identified in 2567 as undated in Dry Storage Room were dated according to policy and procedure immediately. Identification: All residents are identified as possibly being affected by this deficiency. Systemic Changes: Dietary staff inserviced regarding policies and procedures for the management of food products, proper sanitizing procedures, and hair/facial hair coverings. Continued on p. 38	

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F 371	<p>Continued From page 37</p> <p>The 2009 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles...</p> <p>The following concerns were identified in the facility refrigerators, freezers and dry storage room:</p> <p>*Refrigerator B -5 lbs. of ham, wrapped in plastic wrap without an open date; -8 oz. bowl of cottage cheese, not dated; -Diced tomatoes with a discard date of 6/21/14; and, -A plastic container of cherry tomatoes with a cracked plastic lid.</p> <p>The DM asked a staff member to throw the cottage cheese and ham away since they were wrapped in plastic wrap and did not contain a date. The DM stated, "the staff should be dating items when opened." The DM asked a staff member to throw away the diced tomatoes since it was beyond the discard date of 6/21/14. The DM asked a staff member to throw away the cracked plastic lid and to put the tomatoes in a container with a proper lid.</p> <p>The 2009 FDA Food Code chapter 4 Equipment, Utensils, and Linens, Subpart 4-202 Cleanability documented, "4-202.11 Food-Contact Surfaces.</p>	F 371	<p>Monitor:</p> <ol style="list-style-type: none"> DM to conduct audits of sanitizing buckets and sanitizing procedures, hair / facial hair coverings, and management of food products. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> Daily x two (2) weeks. Monday and Friday x two (2) weeks. Weekly x six (6) weeks. Monthly x three (3) months Administrator to review audits and report findings to the QA Committee. 	8/1/2014

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F 371	<p>Continued From page 38</p> <p>(A) Multiuse food-contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections..."</p> <p>*Refrigerator E -A one gallon container of Vinaigrette with an expiration date of 10/16/13 and a case of yogurt on the same shelf with a defrosting pork loin. -Blood was found on the bottom shelf of the refrigerator due to the pork loin which defrosting on a metal container. The pork loin was hanging over the edge of the container approximately 1-1/2. When the DM saw the pork loin on the same shelf as the yogurt and Vinaigrette, he immediately removed them and stated he would dispose of them and stated those items should not be together on the same shelf. When he saw the blood on the bottom shelf, the DM stated, "I'll have that cleaned up right away."</p> <p>*Freezer #1 contained the following undated items: -10 pizza crusts sealed in a plastic bag; -3 dozen cake donuts in a plastic covered box; -2 loaves of banana bread; -A plastic bag of chicken tenders; and, -4 quart plastic container of beef tips, had a dissolvable sticker which was unreadable.</p> <p>*Freezer #2 contained the following undated items: -A blue plastic bag tied in a knot with contained peas; -8 chicken tenders in a plastic bag; -10 egg rolls in a plastic bag; -3 dozen cinnamon rolls; and, -5 packages (12 per package) hamburger buns.</p>	F 371		

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F 371	Continued From page 39 *Chest Freezer contained the following undated item: -4 10 lb. packages of boneless chicken thighs. *Dry Storage Room, Bread Rack, contained the following undated items: -11 packages of hamburger buns (12 per package) -2 packages of hot dog buns (24 per package) -2 loaves of wheat bread -6 packages Hoagie Buns (12 per package) When asked about the lack of date marking the DM stated, "All of these items should have a date. The problem is the boxes have the dates on them and staff have opened the boxes and removed the contents and didn't check to make sure there was a date on the item itself." He stated he would definitely have an inservice to re-educate his staff. The DM provided a copy of the facility's policy on Storage of Frozen and Refrigerated Foods which documented: *"Foods should be stored in approved tightly covered containers. Each item should be clearly labeled and dated before being refrigerated. *Properly reseal packages of frozen foods that have been opened to prevent freezer burn and spoilage. *All foods which need to be kept in the freezer can be stored frozen for six months with the following exceptions: -Leftovers 1 month; -Processed meats (bacon, sausage, ham, hot dogs, luncheon meats, etc.) 1 month; -Casseroles, gravies 2 months; -Soups, stews 2 months;	F 371			

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F 371	Continued From page 40 -Ice cream 3 months; -Bread and bread products 3 months; and -Baked goods (pies, pastries, cakes, waffles) 3 months."	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	Corrective Action: 1. The multi-dose vial for insulin, as noted in this citation, was correctly labeled with an order change alert sticker, in accordance to pharmacy and facility policy, and state/federal regulations. No action/change required. 2. Expired Medications disposed of when found during survey as noted in 2567. Identification: All residents are identified as possibly being affected by this deficiency. Systemic Changes: LN Staff received inserviced regarding Storage of Medications and auditing of expired medications. Continued on p. 42		

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F 431	<p>Continued From page 41</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medication prescription labels matched the physicians' orders, an insulin vial was not available for use more than 28 days after it was opened, and a medication without an expiration date was available for use. This was true for 1 sample resident (#11) and 1 random (#17) during inspection of 2 of 4 medication carts and for 1 random (#17) and 1 sample (#7) during medication pass observations. These failed practices created the potential for more than minimal harm if Residents #7 and #17 were administered the wrong dose of insulin, reduced efficacy of Resident #11's insulin that was available for use more than 28 days, and Resident #17 was administered less than optimal efficacy of glucose tablets with an unknown expiration date. Findings included:</p> <p>1. On 6/24/14 at 8:40 AM, LN #2 was observed as she drew up and administered 20 units of Novolin N insulin per subcutaneous injection to Resident #7.</p> <p>The prescription label on the resident's Novolin N insulin documented, "...Inject 24 units subcutaneously 2 times daily." The insulin was dispensed on 5/6/14 and opened on 6/4/14.</p>	F 431	<p>Monitor:</p> <ol style="list-style-type: none"> 1. IDT (specific title of staff person noted in parentheses next to frequencies listed below) to conduct audit of random medications to ensure to ensure compliance with regard to expired medications. 2. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> • Weekly x four (4) weeks (AC) • Q two (2) weeks x four (4) weeks (LSW) • Monthly x three (3) months (RCM) 3. DNS to review audits and report findings to the QA Committee. 	8/1/2014

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F 431	<p>Continued From page 42</p> <p>Before the LN administered the insulin, she was asked about the discrepancy between the dose drawn up and the prescription label. The LN said the insulin order had been changed numerous times.</p> <p>Reconciliation of the resident's Order Summary Report revealed the order for Novolin N insulin was 20 units in the morning and evening. The start date was 6/7/14.</p> <p>Note: The Novolin N prescription label did not match the physician's order that was started on 6/7/14.</p> <p>2. On 6/25/14 at 11:50 AM, LN #3 was observed as she performed a blood glucose (BG) check for Resident #17. The BG was 167. The LN administered 2 units of Humalog insulin per subcutaneous (subq) injection per sliding scale.</p> <p>The prescription label on the resident's Humalog insulin documented, "...Inject 12 units subq before breakfast; inject 6 units subq before lunch; inject 4 units subq before supper." The insulin was dispensed on 6/1/14 and opened date on 6/11/14.</p> <p>Before the LN administered the insulin, she was asked about the discrepancy between the sliding scale dose drawn up and the instructions on the prescription label. The LN said she goes by the instructions on the MAR and this was the only Humalog insulin in the drawer for the resident.</p> <p>Reconciliation of the Resident's Order Summary Report revealed the order for Humalog insulin was, "...Inject as per sliding scale: if 0.0 - 150.0 =</p>	F 431		
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F 431	<p>Continued From page 43</p> <p>0 units; 151.0 - 200.0 = 2 units; 201.0 -250.0 = 4 units..." The start date was 4/4/14.</p> <p>On 6/25/14 at approximately 3:00 PM, when LN #13 was asked if there was any other Humalog insulin for resident #17, he looked through the medication cart and said, "No."</p> <p>Note: The Humalog prescription label dated 6/1/14 did not match the physician's order dated 4/4/14. Almost 2 months after the 4/4/14 sliding scale insulin order was started, the pharmacy dispensed Humalog insulin with instructions for scheduled times.</p> <p>3. On 6/25/14 at 2:45 PM, during inspection of the 200 Hall Medication Cart with LN #5 present, an open vial of Humalog insulin with an opened date of 5/20/14 was discovered for Resident #11. Note: Regarding Humalog insulin, the Humalog.com and Drugs.com web site both stated, "Once opened, Humalog vials...should be thrown away after 28 days."</p> <p>Immediately following discovery, LN #5 was interviewed. He acknowledged the vial had been opened for more than 28 days. He said he would dispose of it and get a new vial for the resident.</p> <p>4. On 6/26/14 at 11:50 AM, during inspection of the Friendship House Medication Cart with LN #4 present, an opened bottle of Fast Acting Glucose tablets was discovered with no expiration date for Resident #17. The bottle in hand writing had, "Opened 10/24/12."</p> <p>Interviewed LN and she stated, "These came with him on admit and so I will have pharmacy check and label for expiration. He had a low blood</p>	F 431			

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F 431	Continued From page 44 glucose [BG] about a month ago and they were used then. His BG was 65 at 16:07 [4:07 PM] and he was given 16 grams and his BG was 84 at 16:30 [4:30]." The resident's Order Summary Report included an order for Glucose tablets 16 grams (4 tablets) as needed for diabetes with a start date of 4/4/14. On 6/26/14 at 5:50 PM, the Administrator and DNS were informed of the issue. No other information or documentation was received from the facility which resolved the issue.	F 431			
F 441 SS=F	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 isolate the resident. (2) The facility must prohibit employees with a	F 441	Corrective Action: 1. During Survey, LNs #2 and #3 received inservice from DNS regarding facility glucometer policy and procedure. 2. During Survey, LNs #2 and #3 received inservice from DNS regarding facility Infection Control policy and procedures, specifically, hand washing procedures. 3. During Survey, CNA #6 received inservice from DNS regarding facility Infection Control policy and procedures, specifically hand washing procedures. Identification: All residents are identified as possibly being affected by this deficiency. Systemic Changes: 1. Nursing Staff inserviced regarding facility Infection Control policy and procedures. 2. LN Staff inserviced regarding facility Glucometer handling policy and procedure. Continued on p. 46		

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F 441	<p>Continued From page 45</p> <p>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 policies and procedures (P and P), it was determined the facility failed to ensure: * Multi-resident use glucometers were protected from cross-contamination; * Staff turned off water faucets with a paper towel then dried their hands; * Staff performed hand hygiene after toileting assistance; and, * Staff were monitored to ensure they implemented infection control measures. This was true for 2 of 13 sample residents (#s 3 and 7), 2 random residents (#s 17 and 18), and had the potential to affect all resident's who lived in the facility. Failure to adhere to standard infection control measures increased the risk for residents to develop infections. Findings included:</p> <p>Note: The facility's P and P included: * Obtaining a Fingerstick Glucose Level - "...Steps in the Procedure[:] Place the equipment on the bedside stand or over-bed table upon a</p>	F 441	<p>Monitor:</p> <ol style="list-style-type: none"> RCM to conduct audits of random blood glucose testing, to ensure compliance with respect to facility Infection Control policy and procedure related to multi-resident use glucometer handling. IDT (specific title of staff person noted in parentheses next to frequencies listed below) to conduct random audits of staff hand washing to ensure compliance. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> Weekly x four (4) weeks (AD) Q two (2) weeks x four (4) weeks (AC) Monthly x three (3) months (LSW) DNS to review audits and report findings to the QA Committee. 	8/1/2014

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F 441	<p>Continued From page 46 clean/protective surface..."</p> <p>* Handwashing/Hand Hygiene - "...When to Wash Hands...Before and after direct contact with residents...After glove removal; After handling items potentially contaminated with blood, body fluids, or secretions...Steps in the Procedure[:] Washing Hands...Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel..."</p> <p>* Infection Control Committee - Duties and Responsibilities - "...Duties of the Committee...Help monitor and assess facility-wide environmental infection control practices...Risk Exposure Categories...Monitoring the effectiveness of work practices and protective equipment. This includes: (1) Surveillance of the workplace to ensure that required work practices are observed and that protective...equipment are provided and properly used..."</p> <p>1. On 6/24/14 at 8:30 a.m., the following was observed for Resident #7:</p> <p>a) LN #2 placed a multi-resident use glucometer on the counter by the sink in the resident's room while she washed her hands. The LN did not cleanse the counter or use any type of barrier under the glucometer. The LN used the glucometer to check the resident's blood glucose (BG) level then placed the used glucometer on the counter by the sink. The LN did not cleanse the counter or use any type of barrier either time when she placed the glucometer on the counter by the sink.</p> <p>b) LN #2 washed her hands at the sink in the resident's room while she prepared to perform the aforementioned BG check and administer the resident's morning medications. The LN turned</p>	F 441		

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F 441	<p>Continued From page 47</p> <p>off the water faucet with her bare hand then dried her hands with paper towels.</p> <p>2. On 6/25/14 at 11:50 a.m., the following was observed for Resident #17:</p> <p>a) LN #3 placed a multi-resident use glucometer on the sink in the resident's semi-private room while she washed her hands. The LN did not cleanse the sink or use any type of barrier under the glucometer. The LN used the glucometer to check the resident's blood glucose (BG) then placed it on a paper towel on the sink.</p> <p>b) LN #3 completed the resident's aforementioned BG check then washed her hands at the sink in the resident's room. The LN turned off the water faucet with her bare hand then dried her hands with paper towels.</p> <p>LN #3 was interviewed immediately afterward. When informed of the observations, the LN acknowledged that she did not utilize a barrier under the glucometer the first time she put it on the sink. The LN also acknowledged that she did not use a paper towel to turn off the faucet. She stated, "Sometimes I don't when I'm leaving the room.</p> <p>3. On 6/26/14 at 11:30 a.m., LN #4 was observed as she administered medications through Resident #18's PEG (percutaneous endoscopic gastrostomy) tube then washed her hands at the sink. The LN turned off the water faucet with her bare hand then dried her hands with paper towels.</p> <p>On 6/26/14 at 11:50 a.m., LN #4 was interviewed. When informed of the handwashing observation,</p>	F 441		

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F 441	<p>Continued From page 48</p> <p>the LN acknowledged that she did not use a paper towel to turn off the faucet and stated, "Oh yeah."</p> <p>4. On 6/25/14 at 10:40 a.m., CNA #6 was observed as she applied a barrier cream to Resident #3's peri-rectal area after the resident used a bedside commode that was positioned next to her bed. The CNA then removed her right hand glove, pulled up the resident's incontinence brief, and assisted the resident to pull up her black sweat pants. Then, the CNA removed her left hand glove, and while the resident stood, the CNA moved the bedside commode and positioned a wheelchair (w/c) behind the resident. The CNA then removed the resident's oxygen (O2) nasal cannula (NC), disconnected the O2 tubing from the O2 concentrator next to the bed, coiled up the O2 tubing, and placed it and the NC on top of the concentrator, then applied the O2 NC connected to a portable tank on the back of the resident's w/c. The CNA then washed her hands and informed the resident the portable O2 tank was low and she would get another one before the resident left her room.</p> <p>5. On 6/27/14 at about 9:00 a.m., during the Infection Control Program interview with the DNS, the DNS was informed of the observations regarding possible contamination of multi-resident use glucometers, improper handwashing technique, and lack of hand hygiene after toileting assistance (as noted in examples 1, 2, and 3 above). When asked how staff were monitored regarding the implementation of infection control measures, the DNS said staff were monitored "randomly." When asked for evidence that staff were monitored, the DNS said there was no documentation. He</p>	F 441			

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F 441	Continued From page 49 added, "I can see I need to do more."	F 441		
F 468 SS=E	<p>The facility did not provide any other information that resolved the infection control issues.</p> <p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</p> <p>The facility must equip corridors with firmly secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all corridors were equipped with handrails. This affected 13 of 13 (#s 1-13) sampled residents and had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents to not have a handrail for stability when and if needed. Findings included:</p> <p>On 6/23/14 at 9:23 AM and 11:02 AM, the following handrails were observed to be missing: * Approximately 6 feet between the bathtique and internal exit door in the Friendship House unit; * Approximately 5 feet between Resident Room #9 and the "bathtique" in the Friendship House unit; * Approximately 2 feet between the second lounge entrance and public bathroom in the Friendship House unit; * Approximately 4 feet between the public bathroom and the first lounge entrance in the Friendship House unit; * Approximately 4 feet between the chart room and the dining room in the Friendship House unit;</p>	F 468	<p>Corrective Action: Handrails have been installed in areas identified in 2567.</p> <p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: ESS to continue to conduct monthly audits to ensure handrails are compliant.</p> <p>Monitor:</p> <ol style="list-style-type: none"> TC to conduct audit handrails to ensure compliance. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months Administrator to review audits and report findings to the QA Committee. 	8/1/2014

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F 468	Continued From page 50 * Approximately 10 feet between the Table Rock Dining Room doors; * Approximately 10 feet and 7 feet on each side between the main dining room and the administrative office reception desk; and, * Approximately 6 feet between the drinking fountain and admissions office in the corridor leading to the main patio. On 6/25/14 during the environmental tour from 3:00-4:05 PM with the Maintenance Director, the missing handrails were brought to his attention. While outside of the Table Rock Dining Room he acknowledge the lack of handrails and stated, "i can't argue." In the Friendship House unit he said of the missing handrails, "I see where it should be." On 6/25/14 at 6:55 PM, the Administrator and DNS were informed of the issue. No further information was provided by the facility.	F 468		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	Corrective Action: EMAR updated to indicate which nostril was used to administer nasal spray. Identification: All residents with Physician Orders for nasal spray are identified as possibly being affected by this deficiency. Systemic Changes: LN Staff inserviced regarding facility policy and procedure for Documentation of Medication Administration, specifically to document site used for prescribed medication. Continued on p. 52	

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F 514	<p>Continued From page 51</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure medical records were complete for 1 of 15 sample residents (#7). Failure to document which nostril was used each day when calcitonin nasal spray was administered increased the potential for nasal irritation if the nostrils were not alternated, as ordered, and the medication was administered in the same nostril repeatedly. Findings included:</p> <p>Resident #7 was admitted to the facility on 5/6/14 with multiple diagnoses which included osteoarthritis.</p> <p>The resident's Order Summary Report included, "Calcitonin (Salmon) Solution 200 unit/act[ivation] 1 spray Alternating nostrils one time a day..." It was ordered on 5/6/14 and started on 5/7/14.</p> <p>On 6/24/14 at 8:30 a.m., LN #2 was observed as she administered #7's morning medications. After all of the oral medications were administered, the LN handed the calcitonin nasal spray container to the resident and the resident sprayed 1 spray into her right nostril. The LN was asked how she kept track of which nostril was used. The LN stated, "I depend on her [the resident] to tell me." However, when asked which nostril she had just used, the resident pointed to the right nostril and said, "The left."</p> <p>Upon return to the medication cart in the hallway, LN #2 signed off on the resident's electronic MAR (e-MAR) all of the medications that were administered. When asked to see documentation</p>	F 514	<p>Monitor:</p> <ol style="list-style-type: none"> DNS to conduct audits of random nasal spray administration and documentation to ensure site of administration is documented. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> Weekly x four (4) weeks Q two (2) weeks x four (4) weeks Monthly x three (3) months Administrator to review audits and report findings to the QA Committee. 	8/1/2014	

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F 514	<p>Continued From page 52</p> <p>regarding which nostril was used for the calcitonin nasal spray that morning, the LN said there was no place to document it on the e-MAR. The LN said she would make an entry in the progress notes which nostril was used, and she did.</p> <p>The resident's e-MARs for May and June 2014 documented calcitonin nasal spray was administered to the resident daily at 8:00 a.m. from 5/7 - 5/31/14 and 6/1 - 6/24/14. However, the site (which nostril) of administration was not included in the e-MARs.</p> <p>The resident's Progress Notes (PNs), dated 5/6/14 through 6/24/14 at 8:42 a.m., documented only one entry regarding which nostril was used to administer the calcitonin nasal spray. That entry was dated 6/24/14 a 8:42 a.m.</p> <p>On 6/26/14 at 1:00 p.m., the DNS was asked for documentation regarding which nostril was used each day when calcitonin nasal spray was administered. The DNS reviewed the resident's aforementioned MARs and PNs then acknowledged the site of administration was not documented. The DNS stated, "It should be on the MAR together with the medication."</p> <p>The facility did not provide any other information which resolved the issue.</p>	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: WDS001790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2014
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NAME OF PROVIDER OR SUPPLIER
MARQUIS CARE AT SHAW MT

STREET ADDRESS, CITY, STATE, ZIP CODE
**909 RESERVE STREET
 BOISE, ID 83712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure and complaint survey of your facility. The surveyors conducting the survey were: Becky Thomas, RN, Team Coordinator Brad Perry, BSW, LSW Linda Kelly, RN Judy Atkinson, RN Linda Hukill-Neil	C 000	This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies. Survey Definitions: ESS = Environmental Services Supervisor TC = Transportation Coordinator	
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it relates to dignity.	C 125	See F 241	8/1/2014
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 as it relates to kitchen sanitation.	C 325	See F 371	8/1/2014

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 JUL 29 2014
 FACILITY STANDARDS

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

Joe F. [Signature]

TITLE

Administrator

(X6) DATE

7/29/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2014
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C 342	02.108,04,b,ii Toxics Stored Under Lock and Key ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F323 regarding chemicals in an unlocked shower room.	C 342	See F 323	8/1/2014
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F252 regarding marred doors, wall and ceiling gouges, spots on the ceiling, and worn chairs.	C 361	See F 252	8/1/2014
C 389	02.120,03,d Sturdy Handrails on Both Sides of Halls d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/residents. This Rule is not met as evidenced by: Refer to F468 regarding missing handrails.	C 389	See F 468	8/1/2014
C 411	02.120,05,k All Resident Rooms Numbered k. All patient/resident rooms shall be numbered. All other rooms shall be numbered or identified as to purpose. This Rule is not met as evidenced by:	C 411	Corrective Action: Rooms identified in 2567 have been labeled. Identification: All residents are identified as possibly being affected by this deficiency. Continued on p. 3	

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NAME OF PROVIDER OR SUPPLIER
MARQUIS CARE AT SHAW MT

STREET ADDRESS, CITY, STATE, ZIP CODE
**909 RESERVE STREET
BOISE, ID 83712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 411	<p>Continued From page 2</p> <p>Based on observation and staff interview, the facility failed to ensure five rooms in the facility were labeled. This had the potential to effect the residents or visitors who resided or came to the facility. Findings include:</p> <p>On 6/23/14 from 9:27 AM to 10:00 AM during the initial tour of the facility, the following rooms did not have any identification on them:</p> <ul style="list-style-type: none"> * A public bathroom in the Friendship House unit; * A dirty utility room in the Friendship House unit; * The Transportation coordinator's office; * The Beauty Parlor; and, * The dirty side of the laundry room. <p>On 6/23/14 from 10:50-10:58 AM, the Administrator was shown these rooms and he said he would find out why the doors were not labeled.</p>	C 411	<p>Systemic Changes: ESS to continue to conduct monthly audits to ensure signage is compliant.</p> <p>Monitor:</p> <ol style="list-style-type: none"> 1. TC to conduct audit of signage to ensure compliance. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> • Weekly x four (4) weeks • Q two (2) weeks x four (4) weeks • Monthly x three (3) months 2. Administrator to review audits and report findings to the QA Committee. 	8/1/2014
C 412	<p>02.120,05,I Cold Water Drinking Fountain Requirements</p> <p>I. A drinking fountain connected to cold running water and which is accessible to both wheelchair and nonwheelchair patients/residents shall be located in each nursing or staff unit.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not have a drinking fountain located on Friendship House unit which was connected to cold running water and that could be accessed by both residents who used wheelchairs and those who did not. Findings include:</p> <p>On 6/24/14 at 9:00 AM, it was noted there was no</p>	C 412	<p>Corrective Action: Water fountain installed in unit identified in 2567 as Friendship House.</p> <p>Identification: Residents in Friendship House are identified as possibly being affected by this deficiency.</p> <p>Systemic Changes: ESS to continue to conduct monthly audits to ensure fountain is operable.</p> <p>Monitor:</p> <ol style="list-style-type: none"> 1. ESS to conduct audit of drinking fountains to ensure compliance. Audits to begin on 7/28/2014 and continue at the following frequencies: <ul style="list-style-type: none"> • Weekly x four (4) weeks • Q two (2) weeks x four (4) weeks • Monthly x three (3) months 2. Administrator to review audits and report findings to the QA Committee. 	8/1/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2014
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C 412	<p>Continued From page 3</p> <p>water fountain available for residents on the Friendship House unit of the facility.</p> <p>On 6/25/14 from 3:00-4:05 PM during the environmental tour, the Maintenance Director was interviewed regarding the missing drinking fountain. He said there was not a drinking fountain, "...since I have been here."</p> <p>On 6/25/14 at 6:55 PM, the Administrator and DNS were informed of the issue. The Administrator asked the surveyor why this was an issue now, even after several years of surveys without it being cited. The surveyor explained they were just following the state regulations and it was found during this years survey.</p>	C 412		
C 644	<p>02.150,01,a,i Handwashing Techniques</p> <p>a. Methods of maintaining sanitary conditions in the facility such as:</p> <p>i. Handwashing techniques.</p> <p>This Rule is not met as evidenced by: Refer to F441 as it related to hand washing issues.</p>	C 644	See F 441	8/1/2014
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative.</p> <p>This Rule is not met as evidenced by: Based on staff interview, review of Infection Control Committee (ICC) meeting minutes and</p>	C 664	<p>Corrective Action: Pharmacist included in facility's Infection Control Committee. Meeting held on 7/22/2014.</p> <p>Identification: All residents are identified as possibly being affected by this deficiency.</p> <p>Continued on p. 5</p>	

Bureau of Facility Standards

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C 664	<p>Continued From page 4</p> <p>attendance logs, and policy review, it was determined the facility failed to ensure a pharmacist, a representative from housekeeping, and a representative from maintenance attended ICC meetings. In addition, the facility's ICC policy did not include a pharmacist as an ICC member. This failure created the potential for a negative effect for all residents including 13 of 13 sample residents (#s 1-13), staff, and visitors in the facility when a pharmacist was not included and facility management staff where not involved in the implementation of safe infection control practices. Findings included:</p> <p>Note: The facility's Infection Control Committee - Duties and Responsibilities policy and procedure, dated as revised "August 2009, included the following in the section Composition of the Committee, "1. If the Infection Control Committee is a separate entity, it will consist of the following individuals/ or as determined by facility Administration: a. Administrator (or designee); b. Medical Director; c. Director of Nursing Services; d. Infection Control Coordinator (or designee); e. Dietitian/Food Services Director; f. Environmental Services Director/Supervisor; g. Maintenance Director/Supervisor; h. Laundry Director/Supervisor; and i. Others as appropriate.</p> <p>On 6/27/14 at 8:40 a.m., the DNS was interviewed about the facility's Infection Control Program. The DNS said he was the Infection Control Coordinator and that the ICC met monthly during Quality Assurance (QA) meetings. When asked if a pharmacist attended the ICC meetings, the DNS said a pharmacist did not attend any ICC meetings. The DNS reviewed the aforementioned policy and procedure with the surveyor and acknowledged that a pharmacist was not included in the composition of the</p>	C 664	<p>Systemic Changes: Pharmacist included in Infection Control Committee meetings on at least a quarterly basis.</p> <p>Monitor: Administrator to audit Infection Control Committee minutes to ensure compliance.</p>	8/1/2014

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C 664	<p>Continued From page 5</p> <p>committee. ICC meeting attendance records for the last 2 quarters were requested at that time.</p> <p>On 6/27/14 at 10:30 a.m., the Administrator was also informed of the issue.</p> <p>On 6/27/14 at about 3:00 p.m., attendance records for 5 ICC meetings were provided. They were dated 1/21/14, 2/18/14, 4/15/14, 5/20/14, and 6/17/14.</p> <p>The aforementioned ICC attendance records documented the following ICC members did not attend/participate in the ICC meetings at least quarterly:</p> <ul style="list-style-type: none"> * Pharmacist - did not attend/participate in any of the meetings. * Maintenance representative - did not attend/participate in any of the meetings; and, * Housekeeping representative - did not attend/participate in any of the meetings. <p>The facility did not provide any other information regarding the issue.</p>	C 664		
C 670	<p>02.150,03,a Aseptic/Isolation Techniques</p> <p>a. Applied aseptic or isolation techniques by staff.</p> <p>This Rule is not met as evidenced by: Refer to F441 as it related to a clean/protective surface for blood glucose equipment.</p>	C 670	See F 441	8/1/2014
C 781	<p>02.200,03,a,iii Written Plan, Goals, and Actions</p> <p>iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for</p>	C 781	See F 280	8/1/2014

Bureau of Facility Standards

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C 781	Continued From page 6 each element of care; This Rule is not met as evidenced by: Refer to F280 as it relates to care plan revisions.	C 781		
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: Refer to F309 as it related to not following physicians' orders. Refer to F246 regarding call light placement.	C 784	See F 309 See F 246	8/1/2014
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 regarding threshold trip hazards and side rail safety assessment issues.	C 790	See F 323	8/1/2014
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following: a. Administered in accordance with physician's dentist's or nurse practitioner's written orders;	C 798	See F 281 See F 332	8/1/2014

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C 798	Continued From page 7 This Rule is not met as evidenced by: Refer to F281 as it related to professional standards of care regarding techniques for administration of eye drops, medications administration via an enteral feeding tube, and blood glucose testing. Refer to F332 as it related to medication errors.	C 798		
C 821	02.201,01,b Removal of Expired Meds b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days. This Rule is not met as evidenced by: Refer to F431 as it related to expired medications.	C 821	See F 431	8/1/2014
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F431 as it referred to prescription labels.	C 832	See F 431	8/1/2014
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD	C 881	Continued on p. 9	

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C 881	Continued From page 8 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it related to the site of administration of a nasal medication.	C 881	See F 514	8/1/2014



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
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July 23, 2014

Joe Rudd Jr., Administrator
Marquis Care at Shaw Mountain
909 Reserve Street
Boise, ID 83712-6508

Provider #: 135090

Dear Mr. Rudd Jr:

On **June 27, 2014**, a Complaint Investigation survey was conducted at Marquis Care at Shaw Mountain. Linda Hukill-Neil, R.N., Judy Atkinson, R.N., Becky Thomas, R. N., Bradley Perry, L.S.W., and Linda Kelly, R.N., conducted the complaint investigation.

This complaint was investigated during the annual Recertification and State Licensure survey conducted on June 23 through June 27, 2014.

The following documents were reviewed:

- The personal belongings inventory lists for the identified resident and one other resident;
- The entire medical record of the identified resident;
- The records of five residents with dementia or possible behavioral declines;
- The facility's grievance logs for May and June 2013 and February through June 2014;
- Resident council meeting minutes from February through June 2014; and,
- The facility's admission agreement forms were reviewed.

The following interviews were conducted:

- Nine residents in a group interview were interviewed about missing items, quality of care issues and having others contact them by phone in the facility;
- Four residents were interviewed individually about missing items and quality of care issues;
- Two residents' family members were interviewed about missing items and quality of care issues;

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- One resident's family member was interviewed on ease of contacting the resident by phone in the facility;
- The Business Office Manager and a nurse were interviewed regarding the procedure for receiving a phone call and getting messages to residents who were not available;
- The Social Worker, a housekeeper and two nurses were interviewed regarding missing items; and,
- The Administrator was interviewed regarding procedures and policies related to discharging residents.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID6089

ALLEGATION #1:

The complainant stated an identified resident reported to the complainant that several people had come into the resident's room and stolen the resident's personal property.

FINDINGS:

The identified resident was no longer residing in the facility at the time of the complaint investigation.

The resident's medical record documented the identified resident's personal belongings were returned upon discharge. The record also documented that the resident's mental cognition had declined, and the resident had become accusatory of staff, to include accusing staff of stealing personal items.

The facility's grievance file and resident council minutes did not reveal that there was an issue with stolen items in the facility.

Nine residents in a group interview were interviewed about stolen items and none of them expressed concerns.

Four residents were interviewed individually about stolen items and there were no concerns expressed.

Two residents' family members were interviewed about stolen items and there were no concerns expressed.

Joe Rudd Jr., Administrator
July 23, 2014
Page 3 of 5

The Social Worker, a housekeeper and two nurses were interviewed regarding procedures when missing or suspected stolen items were reported and they each were able to describe how missing items were to be treated.

Based on records reviewed, resident and staff interviews, the allegation could not be verified.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant said that when a family member told the Administrator they were going to come to the facility and remove the resident, and the Administrator told the family member s/he did not have the legal right to discharge the resident.

FINDINGS:

The identified resident was no longer residing in the facility at the time of the complaint investigation.

The resident's medical record documented that the identified resident's power of attorney was not the family member identified by the complainant.

The facility's admission agreement forms were reviewed for discharge procedures.

The Administrator was interviewed regarding who could discharge a resident from the facility's care, and he said only the resident and/or power of attorney could discharge a resident.

Based on records reviewed and staff interviews it was determined that the identified family member did not have authority to remove the resident, so the allegation could not be verified.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated they were told of a cognitive health decline in the resident, and the complainant stated they did not believe there was a decline.

Joe Rudd Jr., Administrator
July 23, 2014
Page 4 of 5

FINDINGS:

The identified resident's medical record documented the resident's mental cognition had declined soon after admission to the facility. The medical record also documented and confirmed by the resident's family; the resident had a history of rapid declines like the one documented.

The records of five residents with dementia or possible behavioral declines were reviewed.

Nine residents in a group interview were interviewed about quality of care issues and no concerns were noted.

Four residents were interviewed individually about quality of care issues and no concerns were noted.

Two residents' family members were interviewed about quality of care issues and no concerns were noted.

Based on records reviewed, residents' family interviews, residents and staff interviews, the allegation could not be verified.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated they tried to contact an identified resident by phone several times and was either placed on hold indefinitely or told the resident was not available.

FINDINGS:

The medical record of the identified resident documented several times when staff assisted the resident in calling various family members.

The facility's grievance logs for May and June 2013 and February through June 2014 did not document an issue with phone calls coming into the facility for residents.

Resident council meeting minutes from February through June 2014 did not document an issue with phone calls coming into the facility for residents.

Nine residents in a group interview were interviewed about others contacting them by phone at the facility and they did not express concerns.

Joe Rudd Jr., Administrator
July 23, 2014
Page 5 of 5

A residents' family member was interviewed on the ease of contacting the resident by phone at the facility and they did not express a concern.

The Business Office Manager and a nurse were interviewed regarding the procedure for receiving a phone call and/or getting messages to residents, and both said if the resident did not want to accept a phone call or was otherwise busy, a message would be written down and given to the resident as soon as possible.

Based on records reviewed, residents' family interview, residents and staff interviews, the allegation could not be verified.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, 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 signature is written in a cursive, slightly slanted style.

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

LK/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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September 5, 2014

Joe Rudd Jr., Administrator
Marquis Care at Shaw Mountain
909 Reserve Street
Boise, ID 83712-6508

Provider #: 135090

Dear Mr. Rudd Jr:

On **June 27, 2014**, a Complaint Investigation survey was conducted at Marquis Care at Shaw Mountain. Linda Hukill-Neil, R.N., Judy Atkinson, R.N., Becky Thomas, R.N., Bradley Perry, L.S.W. and Linda Kelly, R.N., conducted the complaint investigation.

The complaint was investigated during the Federal Recertification and State Licensure survey of the facility conducted June 23 through June 27, 2014.

The following documentation was reviewed:

The identified resident's medical record;
The medical records of twelve other residents reviewed for Quality of Life and Quality of Care concerns;
The closed medical record of one other resident who had been discharged;
The facility's grievance files;
The facility's Incident and Accident reports;
The facility's investigations of allegations of abuse;
Resident Council meeting minutes for September 2013 and monthly meeting minutes for February through May, 2014; and,
Staffing records for the days in question.

During the survey week, the survey team observed a lunch and an evening meal service in all dining rooms in the facility. Two surveyors observed a second lunch meal service in the assisted dining room.

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The following interviews were conducted with:

Nine residents in a Group Interview with two surveyors;
Four individual residents;
Two family members;
Eight Certified Nursing Aides (CNAs);
Five Licensed Nurses (LNs);
The Director of Nursing Services (DNS);
The Administrator; and
The Ombudsman.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006118

ALLEGATION:

The complainant stated a resident choked to death while eating a hot dog on June 6 or 7, 2014 at dinner time, and there was not enough staff to help the resident before the resident died. Other residents and resident's family members in the dining room at the time of the incident were shook up from the incident.

A similar incident with the same resident happened a week prior to this incident and staff were able to help the resident during that incident.

FINDINGS:

Review of the grievance files, incident and accident reports, and investigations of allegations of abuse, revealed there were no written complaints about insufficient staffing during dining.

Interviews with individual residents, the group of residents, family members, staff, and the Ombudsman revealed there were no complaints about insufficient during dining.

Review of the staffing records revealed the facility exceeded the minimum state requirement.

The identified resident's medical record contained documentation that the resident was on a regular diet with regular texture and consistency and was care planned for total assistance with meals "slowly" in the assisted dining room. The record also contained a Physician's Order for Scope of Treatment (POST) which directed Do Not Resuscitate. The POST was dated August 22, 2008.

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The resident's medical record also contained documented that the resident had 2 choking episode during the dinner meal on June 4 and four days later on June 7, 2013.

On June 4, the choking episode "lasted approx. (approximately) 10-12 minutes." The Heimlich maneuver was quickly performed and "some food" was dislodged. The resident was "still having difficulty breathing" and more food was removed with suctioning. Other residents were transferred out of the dining room during the episode. When the resident was "stable and breathing normal again," the resident was taken to the resident's room and changed then moved to a recliner by the nurses' station for "close" monitoring.

On June 7, "During dinner CNA notified this LN that res. (resident) was choking. This LN had done a visual check on res. 1-2 minutes prior and res. was eating and chewing food with no indications (sic) of issues." The Heimlich maneuver of abdominal thrusts was started "immediately" while the resident was in a Broda chair. The abdominal thrusts were performed for "approximately one minute" and "chunks" of hamburger were removed from the resident's mouth. The resident continued to choke and the abdominal thrusts were continued. Another LN was summoned and when the second LN arrived, the resident was moved out of the chair and the abdominal thrusts continued. Two more CNAs arrived. One of the CNAs brought the suction equipment. The LNs alternated between abdominal thrusts and suctioning the resident's mouth. However, their efforts were not successful and the resident died at 5:45 p.m.

The facility's staffing records and interviews with staff provided evidence of one LN and two CNAs in the assisted dining room during dinner meals. And, the resident's medical record provided documentation that facility staff responded timely and intervened appropriately during both of the resident's choking episodes.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



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

LKK/lj