



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0099
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 1550

July 10, 2014

Mindy R. Christopher, Administrator
Royal Plaza Retirement Center Lewiston LLC
2870 Juniper Drive
Lewiston, ID 83501

Provider #: 135116

Dear Ms. Christopher:

On **June 27, 2014**, a Recertification and State Licensure survey was conducted at Royal Plaza Retirement Center Lewiston LLC by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

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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 23, 2014**. Failure to submit an acceptable PoC by **July 23, 2014**, may result in the imposition of civil monetary penalties by **August 12, 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:

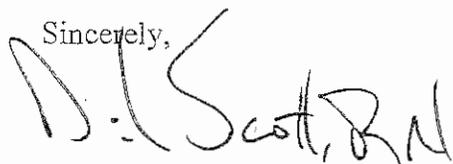
- BFS Letters (06/30/11)

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

This request must be received by **July 23, 2014**. If your request for informal dispute resolution is received after **July 23, 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,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 07/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2014
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NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA RETIREMENT CENTER LEWISTON LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501
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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
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during your annual Federal recertification survey.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Nina Sanderson, LSW Noel Mathews, MSW</p> <p>The survey team entered the facility on 6/23/14, and exited the facility on 6/27/14.</p> <p>Survey definitions: BID=twice a day BIMS = Brief Interview of Mental Status BP = Blood Pressure bpm = beats per minute CHF = Congestive Heart Failure CPFS=Care Plan Flow Sheet cm = centimeters DNS = Director of Nursing Services GI = Gastrointestinal LN = Licensed Nurse LTC = Long Term Care MAR = Medication Administration Record MG=milligram MI = Mental Illness ml = milliliters PASARR = Pre-Admission Screening and Resident Review PO=by mouth Q = Every RCM = Resident Care Manager SVN = Small Volume Nebulizer TID = Three times a day UTI = Urinary Tract Infection</p> <p>F 176 483.10(n) RESIDENT SELF-ADMINISTER SS=D DRUGS IF DEEMED SAFE</p>	F 000	<p>This Plan of Correction (PoC) is submitted as required under Federal and State regulations applicable to long term care providers. The submission of the plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p>Please accept this PoC as our credible allegation of compliance.</p>	
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RECEIVED
JUL 26 2014
JH per nm
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>M. Gustafson</i>	TITLE Administrator	(X6) DATE 7.22.14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	Continued From page 1 An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were assessed as safe to self-administer medications prior to being allowed to do so. This was true for 1 of 2 residents (Resident #4) sampled for the self-administration of medications. The deficient practice had the potential to cause more than minimal harm if a resident experienced negative effects from not administering medications properly. Findings included: Resident #4 was admitted to the facility on 6/10/14 with multiple diagnoses which included hypoxemia secondary to pneumonia, carbon dioxide retention, and opiate induced altered mental status. An MDS assessment had not yet been completed at the time of the survey. Resident #4's Physician Order Report, dated 6/10/14, documented, "Duoneb 3 ml inh/sol [inhaler solution], SVN [small volume nebulizer], administer 3 ml via HHN [hand held nebulizer] QID [four times daily]." [NOTE: The MD order did not include instructions for the resident to administer her own nebulizer treatment.] Resident # 4's care plan documented:	F 176	F176 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A Self-Administration of Medication assessment has been completed for resident #4 and the care plan updated accordingly. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All resident's charts were audited for current Self-Administration of Medication Assessments. Self-Administration of Medication Assessments will be completed as indicated and care plans updated accordingly. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. The Self-Administration of Medication Assessment policy and procedure was reviewed and updated.	8-1-14
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F 176	<p>Continued From page 2</p> <p>*Problem area of, "Self medication administration," initiated 6/23/14,</p> <p>*Interventions included, "Obtain MD order for self-medication administration," and, "Staff will do self-medication administration assessment and set up program if resident passes." Both interventions were implemented 6/23/14.</p> <p>On 6/24/14 at 11:05 AM, LN #1 was observed leaving Resident #4's room. Resident #4 was sitting in her recliner, unattended, holding a nebulizer mask on her face. Vapor was observed escaping from the perimeter of the mask. The nurse's medication cart was parked outside the doorway to the resident's room, but LN #1 was observed to enter the room across the hall with medications, close the door, and remained in the room for several minutes before exiting. This pattern was repeated with other resident rooms over the next several minutes. Throughout this time, the resident was unattended and unsupervised with her nebulizer treatment running. At 11:22 AM, LN #1 entered Resident #4's room again and closed the door. At 11:25 AM, LN #1 emerged from the room, and the nebulizer treatment had been removed from the resident.</p> <p>On 6/25/14 at 11:30 AM, RCM #2 was asked about Resident #4's ability to be left unattended with a nebulizer treatment. RCM #2 stated for a resident to administer their own nebulizer, a medication self-administration assessment should have been completed. RCM #2 stated Resident #4 had been a resident in the facility for over a year, and the assessment had previously been completed. However, RCM #2 stated the resident had become ill and was sent to the hospital on 6/3/14, and not re-admitted to the</p>	F 176	<p>Self-Administration of Medication Assessments will be completed at time of admission, quarterly and PRN by the Resident Care Manager (RCM).</p> <p>All new Self-Administration of Medication Assessments are brought to the daily Interdisciplinary Team (IDT) meeting and reviewed by the team.</p> <p>All Licensed nurses were in-serviced on the revised policy and procedure.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p> <p>The Self-Administration of Medication Assessments will be reviewed during the weekly Case Mix meeting by the IDT in conjunction with the MDS schedule and PRN.</p> <p>The Director of Nursing (DNS) will review all new admissions and their required assessments for completion for 3 months and PRN thereafter.</p> <p>Administrator to monitor via daily IDT meetings, weekly Case Mix meetings and quarterly QAPI meetings.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 176	Continued From page 3 facility until 6/10/14. The RCM stated the resident should have been re-assessed for her ability to administer her own nebulizer treatment upon her return, and until that assessment had been completed the resident should not have been left unattended with the treatment running. On 6/25/14 at 1:30 PM, RCM #2 provided the surveyor with an "Evaluation for Self-Administration of Medications" form, dated 6/25/14 for Resident #4. The RCM stated the form had not been completed until the surveyor had asked to see the assessment. The form documented the resident would administer inhalant medications with assistance from an LN, after the medications had been set up for her. The form further documented, "LN to assist [with] set-up of HHN."	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225	F225 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Bureau of Facility Standards (BFS) was made aware of the elopement by resident #8 during the annual survey (June 23-27, 2014). An Elopement/Wander Risk Assessment was completed for resident #8 and the care plan updated accordingly.	8-1-14

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F 225	<p>Continued From page 4</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, facility policy review, and review of the reportable incidents received from the facility, it was determined the facility failed to report a resident elopement to the Bureau of Facility Standards (BFS) as required. This was true for 1 of 10 residents (Resident #8) sampled for resident incidents. The deficient practice had the potential to cause more than minimal harm if the facility failed to identify, investigate, and report whether a resident had eloped as a result of possible neglect. Findings included:</p>	F 225	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All resident's charts were audited for current Elopement/Wander Risk Assessments. Elopement/Wander Risk Assessments were completed on all current residents and their care plans updated accordingly.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>The Elopement/Wander Risk Assessment policy and procedure was reviewed and updated to include BFS reporting.</p> <p>Elopement/Wander Risk Assessments will be completed at the time of admission, quarterly and PRN by the RCM.</p> <p>All staff, including management staff was in-serviced on the Informational Letter 2005-01 and 20014-04 and the facilities Abuse and Neglect reporting policy and procedure.</p>	

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F 225	<p>Continued From page 5</p> <p>Informational Letter 2005-01, in effect from 3/10/05 to 5/23/14, documented, "Specific Possible Neglect Situations that must be Reported...Resident elopement of any duration. Elopement is defined as when a resident who is unable to make sound decisions...physically leaves the skilled facility without the facility's knowledge..."</p> <p>The facility's policy for Elopements, Revised and Approved January 2012, did not address whether or not resident elopements should be reported to BFS.</p> <p>Resident #4 was originally admitted to the facility on 4/26/10. His multiple diagnoses included CHF, history of prostate cancer, lymphoma, diabetes, and tremors.</p> <p>Resident #8's Quarterly MDS assessment, dated 12/23/13, coded: *BIMS of 8, indicating moderately impaired cognitive skills; *Extensive assistance of 2 for bed mobility and transfers; and *Extensive assistance of 1 for wheelchair mobility.</p> <p>On 2/20/14 at 7:00 PM, a facility "Event Investigation Report" (EIR) documented Resident #8 was found in the parking lot, sitting on the ground in front of his wheelchair. The EIR documented the resident had increased confusion, had left the skilled nursing portion of the facility, and entered the "Retirement side" (independent and assisted living). The EIR documented the resident had exited that portion of the building from the front exit door, and fell from his wheelchair. The EIR documented the</p>	F 225	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p> <p>The Elopement/Wander Risk Assessments will be reviewed during the weekly Case Mix meeting by the IDT in conjunction with the MDS schedule and PRN.</p> <p>The Director of Nursing (DNS) will review all new admissions and their required assessments for completion for 3 months and PRN thereafter.</p> <p>Administrator to monitor via daily IDT meetings, weekly Case Mix meetings and quarterly QAPI meetings.</p> <p>The DNS and IDT to review the 24-hour report for any reportable incidents.</p> <p>The Administrator and DNS to review all incidents and report to the BFS accordingly.</p>	

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F 225	Continued From page 6 resident was not accompanied by staff, and staff had no awareness the resident had left the skilled nursing portion of the building until they were alerted he had fallen in the parking lot. [NOTE: Please see F 323 as it pertains to resident falls and supervision.] When reviewing the information on the reportable incident form received at BFS from the facility, there was no documentation of this elopement incident. On 6/26/14 at 9:25 AM, the DNS and RCM #2 were asked about the 2/20/14 incident for Resident #8. The DNS stated that since the resident had technically not left the "campus property" (including the assisted living portion), the facility did not feel the incident was "reportable." The DNS stated, "We were following our policy." The DNS did not have a response when asked about the BFS informational letter which defined "elopement" and the reporting requirements. On 6/26/14 at 5:45 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.	F 225			
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252	F252 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The linen barrel was removed from the alcove by rooms 9 and 11 and was placed in the soiled utility room.	7-31-14	

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F 252	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure residents were free from foul odors emanating from a dirty linen barrel. This was true for 2 of 2 sampled residents (Resident #'s 1 and 7), as well as any resident passing by or visiting Room #'s 9 and 11. The deficient practice had the potential to cause more than minimal harm when residents were exposed to the unpleasant odors from soiled laundry. Findings included:</p> <p>Throughout the survey, a large gray round trash bin (approximately 30 gallon size), marked as a soiled linen receptacle, was observed in the alcove for resident room #'s 9 and 11, as follows: *6/24/14 at 8:30 AM and 10:05 AM through 11:25 AM. *6/25/14 at 10:00 AM. *6/26/14 at 8:45 AM.</p> <p>With each observation, the barrel was covered. However, an odor consisting of urine, sweat, and bowel movement was noticeable in the immediate vicinity of the barrel.</p> <p>[NOTE: Please see F 323 as it pertains to equipment storage and accident hazards.]</p> <p>On 6/26/14 at 8:45 AM, the Maintenance Director and Housekeeper #3 were asked about the location of the soiled linen barrel. Housekeeper #3 stated, "They have to be stored there when they're giving showers," and pointed to a shower room which was located to the right of room 9. When asked about the appearance and odor of the barrel, Housekeeper #3 stated, "Well I don't know where else we should put them."</p>	F 252	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>The linen barrel was removed from the alcove and the Oak hallway and was placed in the locked soiled utility room.</p> <p>Measures the facility will take or the systems it will alter to ensure that he problem does not recur.</p> <p>All staff were in-serviced that the linen barrel is to be stored in the locked soiled utility room at all times.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p> <p>The DNS or their designee will complete walking rounds 3 X per week for 4 weeks, 1 X per week for 8 weeks and PRN thereafter to ensure that the linen barrel is appropriately stored in the locked soiled utility room.</p> <p>The Administrator to monitor via daily (5 x per week) walking rounds.</p>	

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F 252	Continued From page 8 On 6/26/14 at 5:45 PM, the Administrator and DNS were informed of the surveyor's findings. The Administrator stated, "That barrel has been there for years, even during previous surveys, and has not been a problem." The facility offered no further information.	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 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review the facility failed to: -revise residents' fall care plans to include increased supervision after residents fell multiple times.	F 280	F280 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents #3 and #6 care plans were reviewed and updated to reflect personalized and detailed interventions for each resident. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All current resident's care plans to be reviewed and updated to reflect personalized and detailed interventions for each resident. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. All licensed nurses were in-serviced on writing a personalized detailed interim care plan.	7-31-14

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F 280	<p>Continued From page 9</p> <p>- remove an intervention on a resident's alteration in mood care plan which did not apply to the resident.</p> <p>This was true for 2 of 10 (#s 3 & 6) sampled residents. This failed practice had the potential for more than minimal harm if residents continued to fall and became injured; and if a resident who was not suicidal was treated differently by staff related to an inaccurate intervention on his care plan. Findings include:</p> <p>1. Resident #3 was admitted to the facility with multiple diagnoses to include hip fracture, memory loss, Alzheimer's, and history of falls.</p> <p>The resident's Admission MDS, dated 4/9/14 coded the following:</p> <ul style="list-style-type: none"> - Cognition is severely impaired. - Extensive assist of 2 people for transfers and toileting. <p>A review of the resident's comprehensive care plan for falls dated 4/18/14 included the following interventions:</p> <ul style="list-style-type: none"> - Remind resident to use the call bell to summon assistance prior to attempting self transfers. - Perform a fall assessment quarterly and PRN after falls. - Appropriate footwear on at all times. <p>On 6/13/14 the resident fell while attempting to self transfer out of bed. A review of the resident's interim plan of care for falls dated 6/13/14 included the following intervention, "Frequent checks on patient." The facility did not identify how often frequent checks were to be done. Additionally, the interim fall care plan did not document the duration these checks were to be done or when the intervention would be</p>	F 280	<p>The IDT was in-serviced on writing personalized and detailed care plans.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p> <p>The Administrator and/or DNS to provide quality assurance oversight by reviewing residents care plans for detailed personalization during the weekly Case Mix meeting and after any incident/decline in condition and PRN.</p>	

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F 280	<p>Continued From page 10 re-evaluated.</p> <p>On 6/16/14, the resident fell while attempting to self transfer out of bed. A review of the resident's interim plan of care for falls dated 6/16/14 included the following intervention, "Res[ident] to be line of sight while out of bed." This intervention did not include how long the resident was to be line of sight, or when the intervention would be re-evaluated.</p> <p>NOTE: The interim fall care plan for 6/16/14 identified the resident would be line of sight while out of bed; however both documented falls occurred while the resident was attempting to transfer out of bed.</p> <p>On 6/26/14 at approximately 3:00 PM, the DNS and RCM #2 were interviewed. The surveyor asked how often "frequent" checks were completed on the resident after the fall on 6/13/14. Neither the DNS nor RCM #2 were able to identify how often the checks had been done or if the checks were still being done. The surveyor asked how the facility determined, the "Res[ident] to be line of sight while out of bed" was the most appropriate intervention, when the resident fell on 6/16/14 while attempting to self transfer out of bed. RCM #2 stated, "I understand what you are saying." RCM #2 stated it didn't make sense for the resident to be line of sight while up in her wheelchair, when she fell while trying to get out of bed.</p> <p>On 6/26/14 at 5:00 PM, RCM #2 stated she had no additional or supporting documentation to resolve the identified concerns.</p> <p>2. Resident #6 was admitted to the facility with multiple diagnoses to include macular</p>	F 280			

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F 280	Continued From page 11 degeneration, glaucoma, and cognitive deficit. The resident's most recent Quarterly MDS dated 6/3/14, documented the following: - Moderately impaired cognition; - Mild Depression; - Did not verbalize he would be better off dead or wished for death. The resident's Alteration in Mood care plan dated 6/3/14, documented the following intervention, "Monitor for expressions of suicidal tendencies, document and notify LN." The resident's social history assessment dated 12/16/13, documented under Psycho-Social Assessment: Resident has history of, "None," for depression, anxiety, adjustment issues, schizophrenia, or Bi-Polar. On 6/26/14 at 3:20 PM, the DNS was interviewed and asked if Resident #6 had ever made statements about suicide or if the facility was concerned about the resident committing suicide. The DNS stated, "No." The surveyor asked why it was listed on the resident's care plan. The DNS stated she had no idea and would speak to Social Services about it. No additional information was provided to resolve this concern.	F 280		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.	F 285	<p>F285 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents #1 and #4 had a new PASRR completed and it was faxed to the Bureau of Long Term Care (BLTC) for a Level II screening.</p>	7-31-14

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F 285	<p>Continued From page 12</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 285	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All resident's charts were audited for complete and accurate PASRRs. Any resident who was identified to require an updated PASRR had one completed and sent to BLTC for a Level II screening accordingly.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>The IDT was in-serviced on current PASRR regulations.</p> <p>The facility PASRR monitoring policy and procedure was reviewed and updated.</p> <p>The Social Service Director will include a "PASRR review" in her admission assessments.</p> <p>Medical Records to monitor for completed PASRR upon admission.</p> <p>The SSD to maintain a PASRR "tickler file" for all PASRR indicating short term placement and will facilitate the update of the PASRR accordingly.</p>	

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F 285	<p>Continued From page 13</p> <p>Based on record review and staff interview, it was determined the facility did not ensure residents received complete PASARR screening prior to placement in the skilled nursing facility, or had temporary screening authorization reviewed upon expiration. This was true for 2 of 7 residents (Resident #'s 1 and 4) sampled for PASARR screenings. The deficient practice had the potential to cause more than minimal harm if residents required, but did not receive, specialized services for their mental health needs while residing in the nursing home. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 1/28/14, with multiple diagnoses which included depression and anxiety.</p> <p>Resident #1's PASARR documented: *Many areas for the resident's demographic information were blank. Specifically, mailing address, telephone number, current location, proposed nursing facility admission date, receiving nursing facility and address, and the name, address, and telephone of the resident's legal representative. *Question #s 6, 7, and 8 were not answered. These questions referred to whether or not the resident had a history of difficulty adapting to change, and what, specifically, those difficulties might look like if that history was present. *Question #11, indicating whether or not the resident had a recent psychiatric evaluation, was blank. *Question #14 was blank. This question was to address whether or not a resident was receiving medications listed on the Beer's list. [NOTE: The Beer's list was a tool developed by the American Geriatrics Society for health care providers, with</p>	F 285	<p>All PASRR to be reviewed quarterly and PRN during the weekly Case mix meeting.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p> <p>Administrator to provide quality assurance oversight via weekly Case Mix meetings and monthly Social Service/PASRR reports.</p>	

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F 285	<p>Continued From page 14</p> <p>information about medications which may be inappropriate for use in geriatric patients due to the potential for adverse consequences. The list also contained special considerations for dosages of certain medications when used in the geriatric population.]</p> <p>*Question #15 was to document whether the resident received psychotropic medications not listed on the Beer's list. The question was not answered either yes or no, but the medications Venlafaxine 150 mg daily (an anti-depressant), and Depakote 125 mg twice daily (an anti-convulsant medication which can also be used for mania) were listed. The spaces within this question for the diagnosis, start and end date, were all blank.</p> <p>*The form had a signature in the area indicating either the physician or hospital discharge planner was to sign. However, it was not clear from the signature which of these persons had signed the form, and the area for the contact telephone number and date, were blank.</p> <p>*The instructions on the form directed it was to be forwarded to the Bureau of Long Term Care (BLTC) for further screening for specialized services, commonly known as a Level II PASARR, if any of the question #s 6, 7, or 15 were answered, "yes."</p> <p>*The form contained areas to confirm the BLTC had been forwarded the information, along with a signature and date from either the individual or their representative. This area of the form was blank.</p> <p>*There was no documentation that a Level II PASARR screening had been completed for this resident, or whether or not she required specialized services for her mental health issues. [NOTE: Of the areas on the form for the date of completion, all were blank. There was a date</p>	F 285		

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F 285	<p>Continued From page 15 stamp from the facility which indicated the form had been received via fax on 1/28/14 at 9:57 AM.]</p> <p>On 6/25/14 at 12:20 PM, the Administrator was asked about the PASARR for Resident #1. The Administrator stated the resident was admitted to the facility directly from the physician's office, so that office would have been responsible for ensuring the form was complete. When asked if the Administrator was aware of the regulatory requirement for the facility to ensure the form was complete and the resident had the appropriate screening and any identified specialized services arranged prior to admission, regardless of where the resident was admitted from, the Administrator stated, "I know." The Administrator stated she would look for additional documentation for this resident's PASARR. On 6/25/14 at 1:30 PM, the Administrator reported she had been unable to locate any additional information.</p> <p>2. Resident #4 had been admitted, discharged, and re-admitted to the facility on a number of occasions, with diagnoses which included depression and anxiety: *Admitted (Ad) 2/28/12, discharged (DC) 2/23/12. *Ad 7/31/12, DC 9/10/12. *Ad 9/25/12, DC 11/20/12. *Ad 12/22/12, DC 2/25/13. *Ad 2/26/13, DC 6/4/14. *Ad 6/10/14.</p> <p>The PASARR in Resident #4's record, dated 7/31/12, documented a positive response to question #15, regarding the use of psychoactive medications. A Level II PASARR screening form was attached. Question #29 on the Level II screening form documented the resident met nursing facility level of care and no further</p>	F 285			

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F 285	Continued From page 16 evaluation for specialized services was required at that time. The comments box underneath that question documented, "Less than 30 day NF (nursing facility) exemption," indicating the screening would need to be reviewed if the resident continued to reside in the facility beyond the 30 days (8/19/12). On 6/25/14 at 12:20 PM, the Administrator was asked about the PASARR screening for Resident #4. The Administrator stated, "I don't think we noticed that. She came from our assisted living and was supposed to go back, but they evaluated her and said she needed too much help. I'm pretty sure we never evaluated for another PASARR after that happened, but I'll look." On 6/25/14 at 1:30 PM, the Administrator stated there had been no additional PASARR screening for Resident #4 after the initial 30 days of her stay had passed. The facility offered no further information.	F 285			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff/resident interview, it was determined the	F 309	F309 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Monitoring of the thrill &bruit and blood pressure was initiated and placed on the facility medication administration record for resident #7. The care plan was updated accordingly. A request for the "heat/cold" pack treatment for resident #4 was sent to the physician for approval. The care plan was updated accordingly.	7-31-14	

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F 309	Continued From page 17 facility did not have systems in place to ensure medical information had been communicated between the facility and a dialysis center. As a result of this deficient practice, the facility did not monitor a resident's access site for the thrill/bruit daily, and failed to order heat and ice for a resident the intervention was determined clinically effective. This was true for 2 of 10 residents (#s 4 & 7) sampled residents. This deficient practice had potential to cause more than minimal physical harm if residents failed to receive treatment due to a lack of communication between agencies regarding dialysis care and a resident not receiving heat and ice upon re-admission. Findings include: 1. Resident #7 was admitted to the facility on 2/19/14 with multiple diagnoses, including renal failure and peripheral vascular disease. Resident #7's most recent Quarterly MDS assessment, dated 5/21/14, documented: *Cognition intact, *Extensive assist of 2+ persons with transfers, toileting, dressing, and personal hygiene, *Set-up with supervision for eating, and *Resident received special treatments. The Physician recapitulation orders for June 2014 documented on 2/19/14 the resident was started on, "Ergocalciferol (drisdol) 50,000 unit PO every other week; Midorine (Promatine) 10 MG PO at 10:00 AM; renvela 800 MG 1 tab PO with snacks; and renvela 800 MG 2 Tabs to = 1600 MG PO TID with meals." Note: The physician's orders did not articulate what measures should be taken after the resident returned from dialysis.	F 309	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. There are no other residents on dialysis at this time. All long term care residents who have been discharged to the hospital and re-admitted will have their prior stay physicians orders (POS) reviewed with their re-admission physician orders. Any discrepancies will be clarified and care planned accordingly. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. A "Dialysis Communication Form" was initiated to facilitate facility to dialysis communication. The Admission/Re-admission policy and procedure reviewed and updated. The RCMs in-serviced on the revised policy.	

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F 309	<p>Continued From page 18</p> <p>The Resident Care Plan documented on 2/19/14: *Problem-"Dialysis related to renal failure." *Goals-"No complication R/T [related to] dialysis and no complications with dialysis site between dialysis appointments." *Interventions-"Dialysis access site to be maintained by dialysis unit on treatment days, nursing home to monitor PRN S/S [signs/symptoms] infection, discomfort, dialysis on Tues/Thurs...resident has fistula to his right forearm. Monitor area for abnormal bruising, bleeding or swelling."</p> <p>Note: The resident's Care Plan did not document when the thrill & bruit and his blood pressure (BP) should be checked, or which agency was responsible for monitoring those clinical indicators.</p> <p>The Professional Service Agreement-Dialysis Services dated on 3/29/13 documented, "...To provide needed information as related to patient and staff training needs regarding dialysis services as needed in conjunction with the unit's care plan specific to each patient...assist in on-going development of the facility's care plan as applicable and necessary, to include the nursing facility in Interdisciplinary Team meeting as needed to ensure continuity of care...and notify dialysis unity of significant changes in patients condition as it relates to dialysis services." Note: Residents care plan did not identify how dialysis services are to be addressed prior to and/or after treatment.</p> <p>On 6/24/14 at 10:50 AM, the surveyor observed Resident #7 leaving for dialysis. Resident #7 was at the nurses station awaiting transport; he had a</p>	F 309	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p> <p>The DNS or designee will review all re-admissions prior physician orders with their re-admission physician orders for 3 months and then PRN.</p> <p>Administrator to provide quality assurance oversight via monthly nursing reports and quarterly QAPI meetings.</p>		

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F 309	<p>Continued From page 19</p> <p>lunch box strapped to the back of his wheel chair.</p> <p>Note: The resident's care plan did not document the resident's need for set-up assist and supervision with meals when he was outside of the facility for his dialysis treatments during lunch time. Additionally, there was not documentation in the resident's record indicating the facility had informed the dialysis center that resident required set-up assistance and supervision with meals.</p> <p>On 6/26/14 at 7:35 AM, the surveyor observed Resident #7 getting ready for dialysis. The resident stopped at the nurses station and received medications and had his blood pressure assessed on his left arm..</p> <p>On 6/26/14 at 4:30 PM, the RCM (resident care manager) #5 was interviewed regarding the dialysis procedures and policies. When asked if the facility had a policy in place regarding Resident #7's dialysis and how often the Thrill & Bruit was to be checked, he stated, "We usually pass information verbally and the dialysis center is responsible for monitoring his Thrill & Bruit. RCM #5 later provided additional information on the documentation sent with Resident #7. RCM #5 stated, "The resident is sent with an instructional packet which includes a copy of his MARS, BP reading, medications, and a synopsis of his morning."</p> <p>On 6/27/14 at 9:30 AM, the Administrator and the DON were informed of the lack of communication between agencies. No further information was provided.</p> <p>2. Resident #4 was admitted to the facility on 2/26/13 with multiple diagnoses which included severe osteoarthritis and spinal stenosis with post</p>	F 309			

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F 309	<p>Continued From page 20</p> <p>laminectomy pain syndrome on pain pump and opioid patches. The resident was discharged to an acute care hospital to be treated for pneumonia on 6/3/14, and was re-admitted to the facility on 6/10/14.</p> <p>Resident #4's most recent Quarterly MDS, dated 3/7/14, coded: *BIMS of 15, indicating the resident was cognitively intact; *Constant pain present, rated 10 out of 10; *Scheduled pain medications used; and *Non-medications used for pain.</p> <p>A re-admission MDS assessment had not been fully completed at the time of survey.</p> <p>Resident #4's Physician Order Report, dated 6/10/14, documented: *Prednisone 5 mg every third day, alternating with 7.5 mg for 2 days, for shoulder pain. *Salsalate 750 mg three times daily for chronic back pain. *Voltaren 1 percent gel four times daily to each knee, hand, or foot, or any affected joint of the lower extremities, for fibromyalgia. *Fentanyl patch 50 micrograms per hour, change every three days, for fibromyalgia. *Norco 10/325 (10 mg hydrocodone/325 mg acetaminophen) 1-2 tablets as needed every four hours for pain.</p> <p>Resident #4's care plan, dated 6/23/14, documented: *Problem area of, "Implanted interthecal pump for pain management." Interventions included instructions for the resident to receive PRN medications if the pump alone did not control her pain.</p>	F 309		

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F 309	<p>Continued From page 21</p> <p>*Problem area of, "Resident is at risk for pain," Interventions documented:</p> <p>- "Administer pain medications per current MD order..."</p> <p>- "If resident shows [signs and symptoms] pain: offer repositioning, toileting, food, fluids, temperature adjustment, clothing change...prior to offering pharmacological interventions."</p> <p>- "Review resident pain history, interventions and medications quarterly and as needed."</p> <p>On 6/23/14 at 12:30 PM, during the initial tour of the facility, Resident #4 was observed sitting in her recliner in her room. The resident stated she was in pain, "All the time. I have arthritis and my left shoulder is just bone on bone. And I have arthritis in my right shoulder too, just not as bad."</p> <p>On 6/24/14 at 12:35 PM, Resident #4 was sitting in her recliner in her room, eating lunch. She had a small bandage midway up on the outside of her right ear. The resident stated, "I have a little sore on my ear. It's been there for years. I have to lay on my right side, because my left shoulder hurts so bad. It's just bone on bone." The resident was asked if there was anything to help alleviate her pain. The resident stated, "I have a little towel I roll up under my neck sometimes to lift my head. And I used to get heat and ice, which helped a little. But I haven't had it in a while. I don't know why."</p> <p>On 6/25/14 at 11:30 AM, RCM #2 was interviewed regarding pain control for Resident #4. RCM #2 stated that in the past, the facility made a number of adjustments to the resident's pain control regimen in an effort to increase her comfort level, but the severity of her osteoarthritis made complete pain management a challenge.</p>	F 309		

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F 309	Continued From page 22 RCM #2 stated the facility eventually secured a referral to the pain clinic for the resident, and a pain pump implanted, as well as oral medication adjustments and a pain patch. When asked about the use of heat or ice to help alleviate the resident's pain, RCM #2 stated, "We do use PRN heat and ice, quite frequently, and it is helpful." RCM #2 stated the heat and ice were applied by the restorative nurse's aides, and it was documented each time it was used. RCM #2 stated she would bring the documentation to the surveyor. On 6/25/14 at 1:30 PM, RCM #2 informed the surveyor she could not find any documentation of the application of heat or ice for Resident #4 since her re-admission on 6/10/14. RCM #2 stated, "There was no order for it when she was re-admitted. We faxed the doctor for an order today, and we will start using it again once we get the order." On 6/26/14 at 5:45 PM the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.	F 309			
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F315 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents #1, 3, 6, 8, 9, 10 toileting program was reviewed/revised and care plans updated accordingly.	7-31-14	

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F 315	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to provide toileting programs. This was true for 6 of 10 (#'s 1, 3, 6, 8, 9, & 10) sampled residents. This deficient practice had potential to cause more than minimal psychosocial and/or medical harm if residents were unable to receive individualized toileting programs. Findings include: 1. Resident #9 was initially admitted on 4/7/13 and readmitted on 4/28/14 with multiple diagnoses including, renal failure and edema, peripheral. Resident #9's Annual MDS, dated 3/25/14, documented: *Cognition intact, *Extensive assist of 2+ for transfers, dressing, and toileting, *Frequently incontinent of bladder, *Always continent of bowel, and *Set-up with supervisor for eating. Note: Resident #9's Admission MDS, dated on 4/14/13, documented the resident was "always" continent of bladder. Resident #9's Care Plan initiated, 4/9/14, documented: *Problem-"Resident has functional self care/ADL deficit." *Goals-"Resident will participate in own ADL's on a daily basis." *Interventions-"Resident requires total assistance with transfers. Utilize appropriate assistive	F 315	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All current residents toileting programs were reviewed/revised and care planned accordingly. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. Bowel and Bladder policy and procedure was reviewed and revised. All nursing staff were in-serviced on the updated policy and procedure. RCM to complete the Bowel and Bladder assessments upon admission, quarterly, and PRN. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. DNS and/or designee to review Bowel and Bladder Assessments during the weekly Case Mix meetings and PRN.	

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F 315	<p>Continued From page 24 devices during transfers; sit to stand lift with two staff members."</p> <p>*Problem-"Resident is at risk for fluid volume deficit." *Goals-"Resident will not display S/S [signs/symptoms] fluid volume deficit." *Interventions-"...encourage fluids with each interaction and at meals, assist with fluid when in bed and at night."</p> <p>*Problem-"Resident is incontinent of bladder." *Goals-Resident will maintain current level of continence, will be free from odors, decreased dignity and skin impairments due to incontinence." *Interventions-"Document the number of urinary incontinent episodes each shift, document the number of continent urinary voids each shift, and resident is on a scheduled toileting program, offer assistance with toileting at the designated times and as needed. Resident prefers to wear briefs due to incontinence."</p> <p>Note: Resident #9's Care Plan did not document the designated toileting times.</p> <p>Resident's Physician Order Report for April 2014, documented, on 4/28/14 the resident started on, "Furosemide 20 MG (milligram) PO (by mouth) BID (twice a day), Spirodnlactone 25 MG PO BID, and Zaroxoly 5 MG PO PRN (as needed).</p> <p>Resident #9's Interdisciplinary Progress Notes for April 2014, May 2014 and June 2014, documented: *On 4/29/14, Resident #9 was incontinent of bladder, *On 4/30/14, Resident #9 was incontinent of</p>	F 315	Administrator to provide quality assurance oversight via weekly Case mix meetings, monthly nursing reports and quarterly QAPI meetings.		

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F 315	<p>Continued From page 25</p> <p>bladder, *On 5/5/14, Resident #9 was continent of bladder, *On 5/10/14, Resident #9 was continent of bladder, *On 5/11/14, Resident #9 was continent of bladder, and *On 5/14/14, Resident #9 was continent of bladder.</p> <p>Note: Resident #9 Physician's Order documented, on 4/28/14 Furosemide, Spironolactone, and Zaroxolyn were to be given for edema. The resident was incontinent on 4/29/14 and 4/30/14.</p> <p>Note: The Resident Interdisciplinary Progress Notes did not document the number of continent episodes per day.</p> <p>The resident's Care Plan Flow Sheet tracked voiding patterns and toileting schedules. documented the resident's toileting approximately every 2-4 hours per day from 6/1/14 through 6/26/14.</p> <p>Note: The Care Plan did not include designated time for toileting.</p> <p>On 6/26/14 at approximately 7:30 AM, the facility provided policy and procedures for Assessment and Management of Urinary Continence and Incontinence, which documented the following: *Policy-"The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence...The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function." *Procedure-...ongoing assessments, the nursing</p>	F 315		
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F 315	<p>Continued From page 26</p> <p>staff and physician will screen for information related to urinary continence, previous treatment/management attempts and response to interventions, pertinent diagnoses, observations, including wet bed or clothing, type and frequency of physical assistance necessary for the resident to assess the toilet." *Evaluation-"Will include a review for medications that might affect continence, such as diuretics."</p> <p>On 6/26/14 at 4:15 PM, the surveyor interviewed RCM #2 related to toileting programs and incontinence. The surveyor asked for an explanation related to toileting and how individualized routines are identified. The RCM #2 stated, "The resident let's us know when she needs to go and we have a bladder scheduling program. It gives us a baseline." When asked how a diagnosis is evaluated as a factor for incontinence RCM #2 stated, "It wasn't."</p> <p>On 6/27/14 at 8:30 AM, the surveyor interviewed Resident #9. When asked about daily routines regarding ADL's specific to getting to the toilet, the resident stated, "When I need something I ring the bell and they come. If I need to go to the bathroom they help me into the toilet." Resident stated her family is very involved in her care and participated with significant decision making issues related to her overall care.</p> <p>On 6/27/14 the Administrator and DON were informed of the toileting concerns. No further information was provided.</p> <p>2. Resident #3 was admitted to the facility with multiple diagnoses to include hip fracture, incontinence, UTI, and impaired skin integrity.</p>	F 315			

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F 315	<p>Continued From page 27</p> <p>The resident's admission Bladder Incontinence Evaluation dated 4/2/14 documented the following:</p> <ul style="list-style-type: none"> - Resident had the perception of the need to void. - Voiding Pattern - upon rising, and after meals. - Bladder Continence Scale - some control over daily episodes of incontinence. - Types of Programs - left blank. <p>The above evaluation contained an area for the facility to document whether the resident was evaluated and a bladder program implemented based on the resident's individual needs; the resident's ability to participate in the program; evaluation period for the program; the plan, if the resident was unable to participate and the reason why; re-evaluation date; and, whether or not the resident chose to participate in the program. This entire portion of the form was blank.</p> <p>The resident's most recent Admission MDS dated 4/9/14 documented the following:</p> <ul style="list-style-type: none"> - Severely impaired cognition. - Sometimes able to make self understood and to understand others. - Two person extensive assist for transfers, toilet use, and personal hygiene. - "No" trial toileting program. - Frequently incontinent of urine. - Continent of bowel. <p>The resident's Incontinence of Bladder care plan dated 4/18/14, documented the following:</p> <ul style="list-style-type: none"> - Document the number of urinary and bowel incontinent episodes each shift. - Document the number of continent urinary voids and continent bowel movements each shift. <p>NOTE: The Facility had identified the resident</p>	F 315		

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F 315	<p>Continued From page 28</p> <p>"had the perception of the need to void and her voiding pattern was upon rising and after meals," however this information was not used to establish a bladder program for the resident and was not documented on the resident's bladder care plan.</p> <p>On 6/26/13 at 3:20 PM, RCM #2 was interviewed. RCM #2 was asked if the resident's bladder care plan was individualized to the resident. The RCM stated it was not and it should be. The RCM was asked how it was determined the resident would or would not benefit from a toileting program. The RCM stated she did not know and would have to review the resident's record. No additional information was provided to resolve this concern.</p> <p>3. Resident # 10 was admitted to the facility with multiple diagnoses to include diabetes mellitus, bladder spasms, cardiomegaly, and coronary artery disease (CAD).</p> <p>The resident's admission Bladder Incontinence Evaluation dated 4/3/14 documented the following:</p> <ul style="list-style-type: none"> - Alert and Oriented. - Resident has the perception of need to void. - Voiding Pattern - upon rising, and after meals. - Bladder Continence Scale - Some control over daily episodes of incontinence. - Skin Status - Intact. - Types of Programs - left blank. <p>The above evaluation contained an area for the facility to document whether the resident was evaluated and a bladder program implemented based on the resident's individual needs; the resident's ability to participate in the program; evaluation period for the program; the plan, if the resident was unable to participate and the reason</p>	F 315			

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F 315	<p>Continued From page 29</p> <p>why; re-evaluation date; and whether or not the resident chose to participate in the program. This entire portion of the form was blank.</p> <p>The resident's most recent Admission MDS dated 4/10/14 code the following:</p> <ul style="list-style-type: none"> - Always continent of bladder. - Always continent of bowel. <p>The resident's Bladder Incontinence care plan dated 4/9/14 documented the following under interventions:</p> <ul style="list-style-type: none"> - Document the number of urinary incontinent and bowel incontinent episodes each shift. - Document the number of continent urinary voids and bowel movements each shift. <p>The resident's Interdisciplinary Progress Notes (IPN) documented the following:</p> <ul style="list-style-type: none"> - 4/4 through 5/6/14, resident, "continent of b & b." - 5/6/14 at 11:00 AM, "...New order Lasix 40 mg po [every] day x 5 days..." - 5/6 through 5/10/14, resident, "continent of b & b (Bladder and Bowel)." - 5/11/14, "Resident has been incontinent infrequently since starting Lasix. Midline area of buttocks excoriated without bleeding.." - 5/12/14 and 5/13/14, "Resident with incont[inent] dermatitis [sic] to midline [and] bilat[eral] gluteal, skin intact." <p>NOTE: The facility documented the resident became incontinent of urine after she was started on the Lasix and developed, "incontinence associated dermatitis [sic]"; however a Bladder Evaluation was not completed and the resident's care plan was not reviewed/ revised to reflect the resident's change in bladder continence. It is also</p>	F 315			

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F 315	<p>Continued From page 30</p> <p>documented on the IPN the resident was continent of b&b 5/6 - 5/10/14 which is incompatible with following the IPN as well as the development of incontinent dermatitis.</p> <p>On 6/26/13 at 3:20 PM, RCM #2 was interviewed. RCM #2 was asked if the resident's bladder care plan was individualized to the resident. The RCM stated it was not and it should be. The RCM was asked how it was determined the resident would or would not benefit from a toileting program. The RCM stated she did not know and would have to review the resident's record. No additional information was provided to resolve this concern.</p> <p>4. Resident #1 was admitted to the facility on 4/28/14 with multiple diagnoses which included a hip fracture and dementia.</p> <p>Resident #1's MDS assessments coded: *5/5/14 (Admission) - urinary catheter present. *5/12/14 (14 Day) - urinary catheter present. *5/26/14 (30 Day) - no urinary catheter present.</p> <p>A "Bladder Schedule" form in Resident #1's record, dated 4/28/14-4/30/14, contained columns for the resident's fluid intake, whether or not the resident had voided, and whether the resident had been incontinent, for a 7 day period. Only three of these columns contained data. Rather than the information specified in the instructions, the columns documented the resident had a foley catheter for the three dates listed above. The rest of the form was blank.</p> <p>On 4/28/14, a Bladder Incontinence Evaluation form for Resident #1 documented the resident had incontinence "PTA" [Prior to Admission], and</p>	F 315		

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F 315	<p>Continued From page 31</p> <p>currently used a foley catheter for a diagnosis of retention.</p> <p>On 4/28/14, Resident #1's care plan documented: *Problem of, "Resident is incontinent of bladder." *Goals were documented as, "Resident will maintain current level of continence," and, "Resident will be free from odors, decreased dignity and skin impairments due to incontinence." *Interventions included instructions for staff to document the number of urinary continent and incontinent episodes each shift, and to provide peri care after each incontinent episode. [NOTE: On the date this care plan was originated, the resident was documented to have a foley catheter.]</p> <p>On 5/6/14, a physician's order for Resident #1 documented, "Bladder retraining [and] catheter removed if tolerated."</p> <p>On 5/8/14, a Physician Communication form for Resident #1 documented, "As per your request bladder training started. Per facility protocol urinary cath[eter] clamped for 2 hours [and] open for 15 minutes. For 48 or 72 hours? Do you want to [discontinue] urinary cath after bladder training complete?" The physician's response documented, "[Discontinue] catheter after bladder training..."</p> <p>Resident #1's Interdisciplinary Progress Notes (Nurse's notes) documented: *5/9/14 at 4:00 AM, "[Resident's] cath [discontinued]...[Resident] stated, 'didn't know it had been done'..." *5/9/14 at 2:00 PM, "[One] large [incontinent] void..." *5/9/14 at 10:30 PM, "...[No] problems voiding.</p>	F 315		
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F 315	<p>Continued From page 32</p> <p>Res [continent and incontinent] of urine. [Discontinue] from alert at this time..."</p> <p>*5/10/14 at 8:30 PM, "Res cath [discontinued] voiding [continent/incontinent] of urine..."</p> <p>*5/11/14 at 1:40 PM, "...Resident voiding [with] no problems."</p> <p>*5/11/14 at 10:10 PM, "...voiding [without] difficulties."</p> <p>[NOTE: The above two entries did not specify whether the resident was continent or incontinent. None of the entries identified a pattern to the resident's voiding, if the resident was alerting staff of the need to urinate, or if she had been prompted, cued, or assisted to the toilet per a schedule in order to increase her episodes of continence. Similar entries to those noted above were in the resident's nurse's notes until 5/15/14.]</p> <p>On 6/26/14 at 2:40 PM, RCM #5 was asked about Resident #1's toileting assessments and plan. RCM #5 stated the resident's care plan was developed when she was re-admitted to the facility following a hospitalization for a hip fracture, and was based on the facility's previous knowledge of the resident's needs. When asked about the bladder assessment and evaluation forms completed for Resident #1 while her foley catheter was in place, and whether or not her patterns should have been re-assessed and re-evaluated once her foley had been discontinued, RCM #5 stated, "We re-trained her bladder before the catheter came out, by clamping it off and making sure she was voiding when it was unclamped." RCM #5 was unable to address how that activity helped the facility determine what the resident's bladder pattern was, once the catheter was discontinued. RCM #5 was unable to state how the resident's care plan, if followed as written, would help to reduce</p>	F 315			

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F 315	Continued From page 33 the resident's episodes of incontinence. On 6/26/14 at 5:45 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information. Similar findings for Resident # 8, in terms of assessments and evaluations completed while a foley catheter was present, and care plan development.	F 315			
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, staff and resident interview, and record review, it was determined the facility failed to: *Provide an adequate amount of increased supervision for residents experiencing acute mental status changes and falls or multiple falls, so as to prevent elopement and further falls. This caused the potential for more than minimal harm if residents became disoriented and lost, or injured from continued falls; *Assess side rails for residents for safety and necessity given their clinical condition, causing the potential for more than minimal harm should a resident feel confined or become entrapped in	F 323	F323 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? 1a) Resident #8 has had an Elopement/ Wander Risk Assessment and a Fall Risk Assessment completed and care plan updated accordingly. 2a) Resident #4 had a Side rail Assessment completed and care plan updated accordingly. 3a) The gray round trash bin and shower chair were removed immediately. 4a) Resident #3 care plan was reviewed and updated accordingly. 5a) Resident #7 had a Side rail assessment completed and care plan updated accordingly.	7-31-14	

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F 323	<p>Continued From page 34</p> <p>their side rails; and</p> <p>*Store equipment and supplies in such a way as to allow residents access to handrails in resident living areas, causing the potential for more than minimal harm if residents were unable to access certain areas of their living quarters. This was true for 4 of 7 sampled residents (Resident #s 3, 4, 7, & 8) and any resident wishing to access room #s 9 and 11. Findings included:</p> <p>1. Resident #8 was initially admitted to the facility on 4/26/10, with multiple diagnoses including CHF, history of prostate cancer, lymphoma, diabetes, and tremors.</p> <p>Resident #8's Quarterly MDS assessment, dated 12/23/13, coded:</p> <p>*BIMS of 8, indicating moderately impaired cognitive skills;</p> <p>*Extensive assistance of 2 for bed mobility and transfers; and</p> <p>*Extensive assistance of 1 for wheelchair mobility.</p> <p>Resident #8's Event Investigation Reports (EIR) and related care plan (CP) updates documented: *2/17/14 EIR at 9:30 PM, "Staff updated LN res[ident] was found on floor. LN entered room [2 CNAs] had res sitting on side of bed." Factors observed at the time of fall included, "Cognition change - [increased] confusion." The Event Investigation - Root Cause Analysis documented, "Resident [with increased] confusion R/T time of day [and] searching for wallet [and] deceased wife. Res reorientated [sic] to time of night then was assisted back to bed...[Resident] stayed up all night prior to...fall...Chem[ical] strip done for [possible] UTI." The "Interdisciplinary Team (IDT)</p>	F 323	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>1a) All residents have had an Elopement/Wander Risk Assessment and Fall Risk Assessment completed and their care plans updated accordingly.</p> <p>2a) A facility audit for side rails was completed and all residents with side rails had a Side rail assessment completed and their care plans updated accordingly.</p> <p>3a) The gray round trash bin and shower chair were removed immediately.</p> <p>4a) Please see "1a" under this section.</p> <p>5a) Please see "2a" under this section.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>1a) The Fall and Event policy and procedure was reviewed and revised.</p> <p>1b) The Fall and Event report forms were reviewed and revised to include analysis of data post event.</p>	

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F 323	<p>Continued From page 35</p> <p>Final Summary" documented, "[Resident] did have some increased confusion...add sleep monitor, make sure night light is on [and] working. [One hour] checks [times] 3 nights..."</p> <p>*2/17/14 CP update documented interventions of Neuro checks initiated, the physician was notified, the resident would be monitored for pain, and a chem strip was done to rule out a UTI.</p> <p>[NOTE: The CP update did not document any increased supervision for this resident, including the 1 hour checks recommended by the IDT summary.]</p> <p>*2/20/14 EIR at 7:00 PM, "Skin tear to L [left] wrist 5 cm, L elbow 5 cm, 10 cm blue bruise to R [right] inner thigh. Res was found in parking lot on ground beside WIC [wheelchair]. WIC [stopped] by drain [grate]...Res [with increased] confusion R/T someone 'messaging [with his [puzzle].'" The Event Investigation - Root Cause Analysis documented, "Res [with increased] confusion looking for the big room [with] his puzzle. Reorientated [sic] several times. Res was seen by the kitchen staff trying to go out the kitchen on the retirement side. Staff turned res around. Res apparently went out the front door on the retirement side...Res was talking about a different room and different [puzzle] of self. Staff still unaware of another puzzle...Please educate kitchen staff to alert nursing if a res from LTC is over by kitchen." The IDT Final Summary documented, "[Resident] has had confusion. Placed on [every] 15 minute checks. Requested order for [labs]...Inservice all staff March 7, 2014 All Staff meeting. Pending action R/T labs."</p> <p>*2/20/14 CP update documented interventions of Neuro checks, treatment as ordered, a UA [urinalysis] dip, and, "monitor."</p>	F 323	<p>1c) The 24-hour report form was reviewed and revised to include residents at high risk for incidents for the shift ("Safety huddle")</p> <p>1d) Facility implemented a revised resident monitoring (timed) checklist form.</p> <p>1e) All nursing staff was in-serviced on the revised policies and procedures, forms and requirement for supervision.</p> <p>1f) All residents who sustain an "event" will have their medical record and care plan brought to the daily IDT/Fall Reduction Action Team (FRAT) meeting for review and revision accordingly.</p> <p>2a) The facility Side rail policy and procedure was reviewed and revised.</p> <p>2b) The Side rail Assessment was reviewed and replaced with the Device Decision Guide algorithm (obtained from the Dept. of Health, BFS website).</p> <p>2c) All nursing staff were in serviced on the revised Side rail policy and assessment tool.</p> <p>2d) The "Safety Concerns about Bed Rails" (www.fda.gov) was included in the facility admission packet to provide to residents and families.</p>	

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F 323	Continued From page 36 [NOTE: The interventions following this fall were similar to the interventions from the previous fall. It was not clear from the care plan what "monitoring" was to be done. Although the resident had experienced a fall with increased confusion 3 days prior to this fall, the facility did not implement additional supervision when increased confusion was again noted, until after the resident fell again. There was no documented analysis of the data collected from the 1 hour checks implemented after the resident fell on 2/17/14. The final fall summary documented staff would be in-serviced on 3/7/14, more than two weeks after the resident fell. While the report does not make it clear, the area the resident was last observed in, and the parking lot in which he fell, were several hundred feet from the boundaries of the skilled nursing facility. Please see observations and interviews below for details.] *2/21/14 EIR at 6:20 PM, "Resident was self transferring from WIC to bed. [No] new injury noted. Resident found sitting on floor between WIC and bed. Lights in room off. Resident states he was trying to get into bed...Resident frequently self-transfers [without] calling for assist. Resident was weak R/T fall [with] injury on 2/21 and was unable to self transfer from WIC to bed...CNA and resident encouraged to have resident wait out in day room [after] supper until someone can assist him [with] getting ready for bed." The IDT Final Summary documented, "...[Resident] seems to have [no] factors leading to falls. Medical work-up completed. May be staying in disease process. CP updated."	F 323	3a) All staff were in serviced where the trash can (linen barrel) and shower chair are to be stored. 4a) Please see "1a through 1f" under this section. 5a) Please see "2a through 2d" under this section. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. 1a) The DNS and/or their designee and the Administrator will provide quality assurance oversight via daily IDT/FRAT meetings, weekly case mix meetings and quarterly QAPI meetings. 2a) The DNS and/or their designee will complete walking rounds 3 X per week for 4 weeks, 1 x per week for 8 weeks and PRN thereafter. 2b) The Administrator to monitor via daily (5 x per week) walking rounds.	

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F 323	<p>Continued From page 37</p> <p>*2/21/14 CP update documented interventions of monitoring pain, Neuro checks, monitoring for post trauma, and 15 minute checks beginning on 2/21/14. The 15 minute checks were documented as reviewed and discontinued on 3/4/14, although there was no documentation of an analysis of that data, nor of further CP updates as identified by the IDT in light of the presumptive progression in the resident's disease process.</p> <p>On 6/26/14 at 9:25 AM, the DNS and RCM #2 were interviewed regarding Resident #8's falls. The DNS stated: *Regarding the 2/17/14 fall, the resident had been having some confusion, looking for his wife and his wallet. The resident had been "up and down all night." After the fall, the facility implemented 1 hour checks of the resident's whereabouts, and completed a chem strip to determine if there was evidence of a possible UTI. The DNS reported the chem strip was negative. The DNS said she did not think the 1 hour checks on the resident had been documented, but would look. [NOTE: The facility ultimately did not provide documentation of these checks.] *Regarding the 2/20/14 fall, the DNS stated the resident had left the skilled nursing facility, gone through the door into the assisted living portion of the building, traveled to the "back door" by the kitchen, and was attempting to exit via the door by the kitchen when one of the staff in that area of the building noticed the resident, turned his wheelchair around, and pointed him back down the hallway. The DNS stated the resident had friends in the assisted living area of the building, and would go visit them from time to time. When asked if it would have been appropriate for the resident to exit the nursing facility unattended in light of his increased confusion and recent fall, as</p>	F 323		

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F 323	<p>Continued From page 38</p> <p>well as the fact the facility was concerned there may be an unaddressed medical issue developing at the time, the DNS stated, "I can't answer that." The DNS was asked if the facility had considered the resident's excursion to be an elopement at the time, and responded, "Well, we didn't know he was gone. We were looking for him but we didn't find him until someone told us he fell in the parking lot." The DNS stated the resident was sent to the ER for evaluation of his injuries, but returned to the facility within a short time with only bruises and skin tears noted.</p> <p>*Regarding the 2/21/14 fall, the DNS stated the CNA had taken the resident into his room, as was customary after dinner. The lights were off and the resident wanted to go to bed, so attempted to transfer himself. The DNS stated, "We did some education, to both the CNA and the resident, for him to remain in line of sight until we could put him to bed."</p> <p>On 6/26/14 at 10:00 AM, the surveyors re-traced the path identified by the facility as taken by the resident on 2/20/14 before he fell. The distance the resident would have traveled before exiting the building would have been approximately 1100 feet, and involved the resident opening and passing through a heavy metal door. It took the surveyors approximately 15 minutes to recreate walking, the path the resident covered in his wheelchair.</p> <p>On 6/26/14 at 5:45 PM, the Administrator and Director of Nursing were informed of the surveyor's concerns. The facility offered no further information.</p> <p>2. Resident #4 was admitted to the facility on 6/10/14 with multiple diagnoses which included</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>hypoxemia secondary to pneumonia, carbon dioxide retention, and opiate induced altered mental status.</p> <p>An MDS assessment had not yet been completed at the time of survey.</p> <p>Resident #4's care plan documented a problem area of, "Use of Side Rails," initiated 6/23/14. *The goals included, "Promote and maintain bed mobility," "To maintain psychosocial well-being R/T fear of falling out of bed," and, "Will have no adverse effect from siderail use." *Interventions included, "Side rails in bed: 1/2 rail, position per [resident's] request," "Resident requests side rails for movement," "Resident requests side rails for security in bed," and, "Assessment by interdisciplinary team [quarterly] for need."</p> <p>Resident #4's Side Rail Evaluation form, dated 6/10/14, documented: *The question, "Has resident ever expressed a desire to have side rails raised while in bed for their own safety and/or comfort?" was answered, "yes." The explanation was documented as, "Assist [with] bed mobility and repositioning." [NOTE: There was no documentation as to how or why the resident perceived the side rails to increase her safety. There was no documentation the facility had assessed the side rails to be safe.] *The question, "Is there evidence (reason to believe) the resident has (or may have) a desire or reason to get out of bed?" was answered, "yes." The explanation was documented as, "Gets up [with] assistance." *The question, "Does the resident receive any medications that would require safety precautions?" was answered, "yes." The</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>explanation was documented as, "Psychotropics in use - see MAR." [NOTE: There was no explanation as to how or why the use of side rails addressed any safety concerns related to the use of psychotropic medications.]</p> <p>*The question, "Do the side rail alternatives/interventions create more risks than side rail use?" was answered, "no."</p> <p>*The "Summary of Findings" documented:</p> <ul style="list-style-type: none"> -The areas to document the resident's BIMS score, CAM [Confusion Assessment Method] and PHQ-9 [MDS mood severity score for indication of depression], were all blank. -There was an area of the form with a list of 14 possible interventions to be attempted in lieu of side rails. The area of the form to document which of those interventions had been used, was blank. -The form was dated 6/10/14, but documented the resident's family/responsible party and physician had been notified on 1/25/13. [NOTE: The resident had been re-admitted from an acute care hospital on 6/10/14. These dates called to question whether or not the resident's physician and responsible party had been notified of continued side rail use after the resident's acute illness, and were in agreement as to whether or not the devices were necessary and safe for this resident.] <p>On 6/23/14 at approximately 12:30 PM, during the initial tour of the facility, Resident #4 was observed sitting in the recliner in her room. Her bed was noted to have 1/2 side rails up on both the right and left side of the bed. The resident was asked about the purpose of the rails. The resident stated, "Oh, they put those up there because it's supposed to help me move better." The resident was asked if she was able to use</p>	F 323		

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F 323	<p>Continued From page 41</p> <p>the rails to move more independently in bed. The resident stated, "Well, I can't use my left arm at all. The shoulder is just bone on bone. I can reach across with my right arm and grab onto the one on the left side of the bed (the resident made a gesture to show how she would reach across her torso with her right arm) which helps, but to be honest I'm not sure why they have that other one there. I can't reach across myself with this other arm at all, and I don't think I ever use that other one." The resident denied feeling fearful that she may inadvertently fall out of bed.</p> <p>On 6/25/14 at 11:30 AM, RCM #2 was asked about safety with the use of side rails for Resident #4, as well as the resident's statement that she only used one of the rails. RCM #2 stated the resident used the side rails not so much to move in bed, as to get back into bed more independently. RCM #2 stated the side rails would have been re-assessed when the resident returned from the hospital, but was not sure if safety with the use of side rails specifically were a part of that assessment.</p> <p>Federal Guidance under F 323, regarding side rail safety, documented, "Devices with Entrapment Risks...Regardless of the purpose for use, bed rails...can increase resident safety risk...In 1995, the FDA [Food and Drug Administration] issued a Safety Alert entitled "Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly..."</p> <p>On 6/25/14 at 1:30 PM, RCM #2 provided the side rail assessment for Resident #4. The RCM stated she thought the questions answered on the form constituted a safety assessment. The</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>RCM stated the facility's assessment did not include information as to the potential for entrapment when the side rails were in use.</p> <p>On 6/26/14 at 5:45 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information.</p> <p>3. A large gray round trash bin (approximately 30 gallon size), marked as a soiled linen receptacle, was observed in the alcove for resident room #'s 9 and 11, blocking access to the handrail on the left-hand side of that area, as follows: *6/24/14 at 8:30 AM and 10:05 AM through 11:25 AM. *6/25/14 at 10:00 AM. *6/26/14 at 8:45 AM.</p> <p>A shower chair was observed stored in the alcove for resident room #'s 9 and 11, blocking access to the handrail on the right-hand side of that area, as follows: *6/24/14 at 8:30 AM and 10:05 AM through 11:25 AM. *6/24/14 between 12:55 PM and 1:10 PM. *6/26/14 between 8:45 AM and 11:30 AM, and again at 12:30 PM.</p> <p>On 6/26/14 at 8:45 AM, the Maintenance Director and Housekeeper #3 were asked about the location of the soiled linen barrel and the shower chair. Housekeeper #3 stated, "They have to be stored there when they're giving showers," and pointed to a shower room which was located to the right of room 9. "I don't know where else we should put them."</p> <p>On 6/26/14 at 5:45 PM, the Administrator and DNS were informed of the surveyor's findings.</p>	F 323		

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F 323	<p>Continued From page 43</p> <p>The Administrator stated, "That barrel and that chair have been there for years, even during previous surveys, and has not been a problem." The facility offered no further information.</p> <p>5. Resident #3 was admitted to the facility with multiple diagnoses to include hip fracture, decreased ADLs (Activities of Daily Living) and mobility, Alzheimer's, and history of falls.</p> <p>The resident's most recent Admission MDS dated 4/9/14 documented the following:</p> <ul style="list-style-type: none"> - Severely impaired cognition. - Sometimes makes self understood. - Sometimes understands others. - Total dependence of 2 people for bed mobility. - Extensive Assist of 2 people for transfers, toileting, and personal hygiene. - Fall in the last month. - Fall in the last 2-6 months. - Fall with fracture. <p>The resident's ADL care plan dated 4/18/14 documented the resident required extensive assistance with mobility tasks and transfers.</p> <p>NOTE: It could not be determined if the resident required one or two person extensive assist with mobility as it was not clearly identified on the resident's care plan.</p> <p>The resident's Fall care plan dated 4/18/14, documented the following:</p> <ul style="list-style-type: none"> - Remind the resident to use the call bell to summon assistance prior to attempting self transfers. - Use a night light to illuminate the room at night. - Resident needs to have appropriate footwear on 	F 323		

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F 323	<p>Continued From page 44 at all times.</p> <ul style="list-style-type: none"> - Resident's bed is to be at the appropriate height for the resident to sit on the edge of the bed with knees bent at a 90 degree angle and feet flat on the floor. <p>The resident's History & Physical (H&P), Interdisciplinary Progress Notes (IPN), Falls Management (FM), Fall Risk Assessment Form (FRA), and Interim Care Plan were reviewed and documented:</p> <ul style="list-style-type: none"> * H&P, dated 3/25/14 - "The patient has multiple health problems. She has had a prior intertrochanteric hip fracture on the right and total left knee arthroplasty. More recently she fell and had an acute fracture and was seen in the Emergency Room with a chief complaint of left hip pain... She has a tendency to fall frequently. Her x-rays show an intertrochanteric hip fracture [left hip]." * The FRA dated 4/2/14 documented, - The resident had intermittent confusion, balance problems while standing and walking, incontinent of bladder and bowel, and the resident had 1-2 falls in the past three months. - The directions on the form indicated the protocol associated with the resident's Fall Risk Score was a "guideline only and not intended to replace clinical judgement..." The resident's score was 17, which indicated the resident was at moderate risk for falls. In the comment section on the form the following was hand written, "Moderate risk for falls - follow POC (Plan of Care), 15 min. checks x 24 [hours] for safety." <p>NOTE: The information documented on the Fall Risk Assessment related to the 15 minute checks was not documented on the resident's care plan. Additionally, the assessment did not indicate</p>	F 323		

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F 323	<p>Continued From page 45</p> <p>whether the need for continued 15 minute checks would be re-evaluated in 24 hours.</p> <p>* The IPN dated 6/13/14 at 9:45 PM documented, "Resident found on the floor next to her bed laying on her right side at 1855 [6:55 PM]. Res[ident] placed in bed at 1845 [6:45 PM] due to [increased] agitation." Resident stated, she "was trying to screw the light bulb to the light bulb."</p> <p>* The FM, dated 6/13/14 documented the resident fell at 6:55 PM and was last toileted at 6:40 PM. The resident stated she didn't know why she fell, what happened, or when she was last toileted. The nurse asked the resident where she was going and the resident stated, "I was trying to screw the light bulb to the light bulb."</p> <p>NOTE: The facility did not attempt to determine what the underlying cause of the resident's increased agitation was or what the resident meant by "screw the light bulb to the light bulb." Instead, the resident was put to bed and fell after she attempted to transfer herself out of bed.</p> <p>* The FRA dated 6/13/14 documented the resident's fall risk score was 20, which indicated the resident was at "moderate risk for falls." In the comment section on the form the following was hand written, "Had a fall out of bed. Moderate risk for falls."</p> <p>* The Interim Plan of Care dated 6/13/14 documented the following Approach (Intervention), "Frequent checks on patient."</p> <p>NOTE: The Interim Plan of Care did not define what frequent checks were nor did it include a date for the frequent checks to be reviewed to determine if the checks should be incorporated into the resident's Fall care plan or if the checks</p>	F 323		

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F 323	<p>Continued From page 46 were no longer necessary.</p> <p>* The IPN dated 6/16/14 at 1345 (1:45 PM) documented the following, "Res[ident] was found on the floor next to her bed at 1320 [1:20 PM]. Res[ident] was toileted at 1300 (1:00 PM). This LN asked res[ident] what happened and she just mumbled, was not able to understand res[ident]."</p> <p>* The FM dated 6/16/14 documented the resident fell at 1:20 PM and was last toileted at 1:00 PM. The form identified the resident as "high risk" for falls and she had a history of falling. The resident was asked, "Why do you think you fell, can you describe what happened, where were you going, and when was the last time you used the bathroom?" The LN documented the resident's response to be, "Res[ident] just mumbled - unable to understand."</p> <p>NOTE: The resident had a known diagnosis of Alzheimer's disease and cognitive impairment; it was difficult to determine whether or not she was able to understand the questions she was asked.</p> <p>* There was no FRA assessment completed after this fall.</p> <p>* The Interim Plan of Care dated 6/16/14 documented the following Approach (Intervention), "Res[ident] to be in line of sight while out of bed."</p> <p>NOTE: The facility did not identify the resident had any falls when she was up in her chair, therefore it was difficult to determine the appropriateness of this intervention. The Interim Plan of Care did not address the nature of the resident's continued falls while attempting to get</p>	F 323		

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F 323	<p>Continued From page 47 out of bed.</p> <p>On 6/26/14 at 3:20 PM, the DNS and RCM #2 were interviewed related to the above concern. The RCM was asked what "frequent checks" meant. She stated, "Good question, the time and duration should have been clarified." The RCM and DNS were asked, based on the facility's knowledge of the resident's increased risk for falls, what interventions were implemented at the time of admission to decrease the resident's risk for avoidable falls. The DNS and RCM identified the resident's Fall care plan was not individualized for the resident and should have been. The surveyor asked how "Resident to be in line of sight while out of bed," was determined to be the best intervention to prevent falls when the resident fell while attempting to transfer herself out of bed. The DNS did not respond and the RCM stated she would review the resident's record for further information.</p> <p>On 6/26/14 at 5:00 PM, RCM #2 informed the survey team she was unable to find any additional information to resolve the concern.</p> <p>4. Resident #7 was admitted to the facility on 2/19/14 with multiple diagnoses, including, renal failure and peripheral vascular disease.</p> <p>Resident #7's Quarterly MDS, dated 5/21/14, documented: *Cognition intact, *Extensive assist of 2+ for transfers, toileting, and personal hygiene, *Set-up with supervision for eating, and *Section O, documented resident as receiving</p>	F 323		

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F 323	Continued From page 48 special treatments. The Side Rail Evaluation, dated on 4/10/14, documented, "To help increase bed mobility, resident has poor eye sight, resident able to get in/out of bed safely, resident uses side rails for position or support, and side rails used for bed mobility, most appropriate for intervention." Note: The side rail evaluation did not assess weather the side rails were safe prior to their placement on the resident's bed. On 6/25/14 at 11:00 AM, RCM #2 was interviewed regarding weather side rails were safe for Resident #7's use.. When asked if Resident #7's side rails had been assessed for safety, she sated, "There is an evaluation in his record, that is what we use." When the surveyor asked if there was anything else, the RCM stated, "No." On 6/27/14 at 9:30 AM, the Administrator and DON were informed of the concerns regarding side rails safety. No additional information was provided.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care;	F 328	F328 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #2's physician was notified of the Oxygen discrepancy and order was clarified. Medication administration record (MAR) and care plan were updated accordingly.	7-31-14	

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F 328	<p>Continued From page 49 Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure residents received proper treatment and care for oxygen (O2) use. This was true for 1 of 7 (#2) sampled residents. This deficient practice had the potential to cause medical harm if residents were unable to receive oxygen. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 6/7/14 with multiple diagnoses including Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>The resident's Admission MDS, dated 6/14/14, documented: *Cognition intact, *Extensive assist of 2+ persons for transfers, toileting, dressing, and personal hygiene, and *Set-up with supervision for eating.</p> <p>Resident #2's Physician orders for June 201, documented on 6/7/14 the resident's oxygen flow at "1 liter per minute per nasal cannula continuous."</p> <p>Note: MARS for June 2014 documented on 6/14/14 the resident's oxygen at "2 liters per minute per nasal cannula PRN and with ambulation, titrate to keep sates [blood oxygen saturation level] greater or equal to 88%." The resident's Care Plan documented, on 9/10/13, "O2 per MD orders-See MAR."</p>	F 328	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All Oxygen orders on the MAR were compared to the original physician order to ensure no other discrepancies. None were found.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>Medication policy and Oxygen policy and procedure were reviewed and updated.</p> <p>RCM's in-serviced on the updated policies.</p> <p>A second licensed nurse will review all physician orders on new admissions after data entry.</p> <p>IDT to review all Oxygen orders during the weekly Case Mix meeting.</p>	

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F 328	Continued From page 50 On 6/24/14 at 9:10 AM, Resident #2 was observed exercising in the common area without oxygen; at 9:40 AM, the resident was observed in her room without oxygen; at 11:00 AM, the resident was observed attending pastoral services without oxygen; at 1:00 PM, the resident observed in the dinning area without oxygen; and at 3:00 PM, resident observed without oxygen in the activities room. On 6/25/14 at 9:45 AM, Resident #2 was observed in her room without oxygen and at 12:45 the resident was observed in the dinning area without oxygen. On 6/25/14 at 9:45 AM, Resident #2 was interviewed regarding her oxygen use. When the resident was asked when and how often she uses her oxygen, she stated, "I only use it at night." On 6/26/14 at 3:35 PM, RCM #2 was interviewed regarding the resident's oxygen orders; the resident's oxygen orders and oxygen use Care Plan were not consistent. When RCM #2 was asked whether she was aware of the inconsistencies related to the oxygen orders and Care Plan, she stated, "I'm confused, these should be the same. I'll have to check." On 6/27/14 at 9:30 AM, the administrator and DON were informed of the oxygen concerns. No further information was provided.	F 328	How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. DNS and/or designee will review physician orders of all residents who are on oxygen weekly x 4 weeks and monthly x 2 months and PRN thereafter. The Administrator to provide quality assurance oversight via weekly case mix meetings, monthly nursing reports and quarterly QAPI meetings.		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329	F329 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	7-31-14	

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F 329	<p>Continued From page 51</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it, was determined the facility failed to ensure a resident's systolic blood pressure and apical heart rate were checked before administering two blood pressure medications. Additionally, the facility failed to identify specific indications for use, target behaviors, and non-pharmacological interventions prior to administering an anti-anxiety medication. This was true for 2 of 7 (#3 and #4) residents reviewed for medication use. This failed practice had the potential to cause harm if the resident received a medication for hypertension when her blood pressure or pulse were not within the</p>	F 329	<p>Resident #3 physician orders were reviewed for appropriate blood pressure and pulse parameters.</p> <p>The licensed nurse who administered the medication without documenting the blood pressure and/or pulse was counseled.</p> <p>Resident #4 behavior monitor sheets were reviewed and updated with specific behaviors relative to this resident. The care plan was updated accordingly.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All current residents' physician orders were reviewed to ensure that appropriate parameters for blood pressure and pulse were present.</p> <p>All resident's behavior monitor sheets were reviewed and updated with specific behaviors relative to the resident. The care plans were updated accordingly.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p>		

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F 329	<p>Continued From page 52</p> <p>defined parameters; and if a resident who received anti-anxiety medications experienced impaired motor function, altered appetite and/or urinary changes for symptoms that may have been adequately addressed through non-pharmacological interventions. Findings include:</p> <p>1. Resident #3 was admitted to the facility with multiple diagnoses to include atrial fibrillation, aortic stenosis, and paroxysmal SVT (Supraventricular tachycardia).</p> <p>The resident's Physician Order Report dated 6/1/14, documented the following medication was started on 4/2/14, with the following parameters; Verapamil 120 mg ER po QAM - Hold if BP (blood pressure) is less than 100 [systolic] and/or [apical] pulse is less than 50 bpm (beats per minute).</p> <p>Resident #3's Medication Administration Record (MAR) dated 4/2/14 documented an order for Verapamil 120 mg ER po QAM. A hand written entry dated 5/23/14 documented, hold if B/P (blood pressure) is less than 100 [systolic] or [apical] pulse is less than 50 bpm.</p> <p>The resident's MAR for May 2014, documented the Verapamil should be given once daily in the AM (morning). The MAR included boxes for the nurse to document the systolic and diastolic blood pressure, in addition to the pulse. The resident's blood pressure and heart rate were not taken for 5 doses prior to administration of the medication for the period of 5/1/14 through 5/31/14.</p> <p>The resident's Physician Order Report, dated 6/1/14, documented the following medication was</p>	F 329	<p>The Behavior Tracking policy and procedure was reviewed and update.</p> <p>The Medication Administration policy and procedure was reviewed and updated.</p> <p>The Social Service Director was in-serviced on the importance of monitoring behaviors specific to individual residents.</p> <p>All licensed nurses were in-serviced on the Behavior Tracking policy and procedures, and monitoring of medications with blood pressure and pulse parameters.</p> <p>The licensed nurses will complete a shift to shift audit of the MAR for complete and accurate documentation of blood pressures and pulses x 3 months.</p> <p>The IDT will review resident specific behavior tracking during the weekly Psychotropic and Case Mix meetings.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p>		

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F 329	<p>Continued From page 53</p> <p>started on 4/2/14: Digoxin Liquid 50 mcg/ml solution 0.125 mg = 2.5 ml po QAM. The following manufacture's specifications for this medication included - Monitor apical pulse for 1 minute before administering; hold if pulse is less than 60.</p> <p>The resident's MAR for May 2014, documented the Digoxin should be given once daily in the AM. The MAR included boxes for the nurse to document the systolic and diastolic blood pressure, in addition to the pulse. The resident's blood pressure and heart rate were not taken for 5 doses prior to administration of the medication for the period of 5/1/14 through 5/31/14.</p> <p>On 6/26/14 at approximately 3:30 PM, the DNS was informed and interviewed related to the above issue. The DNS reviewed the MAR and confirmed the blood pressures and pulses were not documented. The DNS stated the blood pressure and pulse should have been checked prior to administering the medication. The DNS asked LN #10 if she had checked the resident's blood pressure and pulse before she had administered the above medications. LN #10 stated she had taken the BP and pulse and written them down on the vitals sheets for those days. LN #10 was asked to produce the vitals sheets and she stated she did not have the sheets anymore. LN #10 stated, "I throw them away at the end of my shift because we are not supposed to take that information out of the facility." No further information was provided to resolve this concern.</p> <p>2. Resident #4 was admitted to the facility on 6/10/14 with multiple diagnoses which included</p>	F 329	<p>The DNS and/or their designee to audit the MAR 1 time per week x 4 weeks, then q 2 weeks x 4 weeks, then monthly X 3 months.</p> <p>The Administrator to provide quality assurance oversight via weekly Case Mix meetings, monthly nursing reports and quarterly QAPI meetings.</p>		

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F 329	<p>Continued From page 54</p> <p>hypoxemia secondary to pneumonia, carbon dioxide retention, and opiate induced altered mental status.</p> <p>An MDS assessment had not yet been completed at the time of survey.</p> <p>Resident # 4's Physician Order Report, dated 6/10/14, documented: *Alprazolam 0.125 mg at bedtime for anxiety; and *Buspar 10 mg three times daily for anxiety.</p> <p>Resident #4's care plan documented: *Problem area of, "Resident requires monitoring for behavioral disturbances...related to...chronic pain...exhibited by [resident] is unable to wait until call light is answered for help, [resident] will enter the hallway wearing only a shirt (no pants) stating she needs help, [resident] will demand medications and refuse to wait for the nurse." Initiated 6/24/14. [NOTE: Please see F 353 as it pertains to facility staffing. It was unclear how long the facility expected to wait for her call light to be answered or her medications to be delivered before her actions were considered a "behavior." It was unclear why the resident would at times be in the hallway without her pants on, or why it was inappropriate for the resident to ask for help at these times.] *Goals included, "Resident behavioral patterns will be monitored and moderated by staff interventions," and, "Resident will have a decrease in adverse and abnormal behavioral patterns with staff interventions." Interventions included: -"Utilize the interventions listed for new onset, acute behavioral disturbances when initially observed..." [NOTE: This intervention included 9 possible interventions, which were the same 9</p>	F 329			

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F 329	<p>Continued From page 55</p> <p>interventions listed in the care plans for other sampled residents. The date this intervention was initiated was also documented as 2/13/14, more than 4 months before the problem onset date.] -"Document the behavior, potential triggers observed, interventions attempted, and the outcome of interventions in the resident chart..." This intervention was also dated 2/13/14. -"In a calm voice ask [Resident #4] to go back to her room and you will assist her shortly. Give [resident] multiple choices." Initiated 2/13/14. [NOTE: The problem area of the care plan identified the resident had difficulty waiting for assistance. It was unclear how directing the resident to return to her room and further wait for assistance was an effective intervention for the identified behavior.] -"Assess resident for other possible needs." Initiated 2/13/14.</p> <p>On 6/25/14 at 11:30 AM, RCM #2 was asked about Resident #4's behavioral history and the use of anti-anxiety medication. RCM #2 the resident would typically "start obsessing about health issues or something of that nature. Sometimes she does self-identify (her anxiety) and ask for meds. It is usually re-directable, but sometimes she wants something right now, and follows staff into other resident rooms." RCM #2 was asked how the resident's behavioral episodes were tracked. RCM #2 stated there were behavioral flow sheets in the resident's MAR, and she would provide them to the surveyor.</p> <p>On 6/25/14 at 2:35 PM, MSW #11 provided the surveyor with behavior flow sheets for Resident #4. The flow sheets were initiated on 6/24/14. The resident's behavior was identified as,</p>	F 329		

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F 329	Continued From page 56 "anxiety," but none of the details as specified in the resident's care plan or the interview with RCM #2 were present on the form. The "Interventions Specific to the Resident" documented, "Offer medications," "Redirect," "Assess pain," and, "Reassure." [NOTE: The first listed intervention was a pharmacological intervention. There were no interventions to anticipate the resident had difficulty waiting once she had identified the need for help. There were no interventions directing the staff how to respond to the resident given that tendency.] MSW #11 was asked if she felt the items on the behavioral flow sheet were specific to Resident #4, and a specific reflection of the clinical symptoms requiring anti-anxiety medication. MSW #11 stated, "It could be more specific."	F 329			
F 332 SS=D	On 6/26/14 at 5:45 PM, the Administrator and DNS were informed of the surveyor's findings. The facility offered no further information. 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, and staff interview, it was determined the facility failed to maintain a medication error rate of less than 5%. This was true for 3 of 32 medications (9.375%) which affected 1 sampled resident (#4) observed during the medication pass. This failed practice created the potential for harm if the resident	F 332	F332 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #4 medication regimen was reviewed and revised to accommodate for taking medications with or without food.	7-31-14	

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F 332	<p>Continued From page 57</p> <p>experienced increased GI disturbance and/or peptic ulcer formation when the medications were not administered with food as ordered.</p> <p>Resident #4 was admitted to the facility with multiple diagnoses to include peptic ulcer disease, diverticulitis, nausea, constipation, and fibromyalgia.</p> <p>On 6/26/14 the following was observed:</p> <ul style="list-style-type: none"> - 7:10 AM: The resident was observed laying down in her bed. LN #1 approached the resident and asked the resident if she was ready for her morning medication. - 7:25 AM: LN #1 was observed as she poured and then administered the following medications: <ul style="list-style-type: none"> - Micro-K (Potassium) 10 meq po QAM; Administer with food. - Salsalate 750 mg po TID; Administer with food. - Prednisone 7.5 mg po x 2 days alternating with 5 mg on 3rd day - Repeat; Administer with food. <p>NOTE: LN #1 did not provide or offer the resident any food when the above medications were administered. The resident did not receive her breakfast tray until 7:50 AM, approximately 25 minutes after the medication was administered.</p> <p>On 6/26/14 at approximately 9:00 AM, reconciliation of the identified medications with the resident's recapitulation of Physician Order Report for June 2014 revealed the Micro-K, Salsalate, and Prednisone were to be given with food.</p> <p>On 6/26/14 at 1:45 PM, the DNS and RCM #5 were informed of the issue.</p> <p>On 6/26/14 at 2:20 PM, LN #1 was interviewed.</p>	F 332	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All current residents' medication regimens were reviewed and revised to accommodate for taking medication with or without food.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>The Medication Administrator policy and procedure was reviewed and updated.</p> <p>All licensed nurses were in-serviced on the Medication Administration policy.</p> <p>RCM's to review all residents physician orders q month.</p> <p>Monthly Pharmacy review of medications for interactions and contraindications.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p>	

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F 332	Continued From page 58 The surveyor asked LN #1 if she was aware the identified medications were to be administered with food. The LN stated, "Yes." The LN was asked why the resident was not offered food, for example yogurt or applesauce with her medication. The LN stated she had been working with the resident a long time and was aware of her routine and the resident did not like to use yogurt or applesauce when taking her medication. The nurse stated the resident keeps crackers in her room and eats a cracker after she takes her meds. Additionally, The LN stated, "The resident had never complained of GI (gastrointestinal) discomfort before" when taking her medication in the morning without food. NOTE: The LN could not confirm the resident ate a cracker every morning after the administration of the identified medication. On 6/26/14 at 5:10 PM, the facility was unable to provide additional information to resolve this concern.	F 332	DNS and/or designee will review all physician orders 5 times per week x 4 weeks, monthly x 8 weeks and PRN thereafter. The Administrator will provide quality assurance oversight via daily IDT meetings, weekly case mix and quarterly QAPI meetings.		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353	F353 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No negative outcome was observed related to this deficiency. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.	7-31-14	

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F 353	Continued From page 59 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, resident group interview, and record review, it was determined the facility did not ensure nursing staff were responsive to residents' needs for assistance and answered call bells promptly in the evening. This was true for 5 of 5 residents in the resident group, and Resident #s 4. The deficient practice had the potential to cause more than minimal harm if residents fell or became incontinent when the staff did not respond to their need for assistance. Findings included: 1. On 6/24/14 at 2:00 PM during the resident group interview, 5 of the 5 residents present stated they had a difficult time getting assistance after the dinner meal. Specifically, the residents stated if they needed help to get to their room or to use the bathroom, they frequently were made to wait until all the other residents had finished dining. The residents stated when they did get assistance, it frequently felt "rushed" and it was not uncommon for a staff member to be assisting them, but be summoned away before their needs were met to help another staff member care for another resident.	F 353	No negative outcome was observed related to this deficiency. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. All staff were in-serviced on the facility expectation that ALL staff are to answer resident call lights, ensure resident safety, assist the resident if possible, if not, notify the licensed nurse so that someone can assist the resident. All nursing staff were in-serviced on the expectation that staff do not take breaks after the evening meal until all call lights have been answered and residents needs are met. Licensed nurses were in-serviced that they are expected to answer call lights when multiple lights are going off at the same time. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.		

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NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA RETIREMENT CENTER LEWISTON LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501		
(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 353	<p>Continued From page 60</p> <p>2. On 6/25/14 at 9:30 AM, during a resident interview, Resident #4 stated sometimes she could take herself to the restroom, but sometimes she needed assistance from staff. The resident stated when she did need assistance, it was not uncommon for her to either wait for half an hour to get assistance to get onto the toilet, or once she was there she sometimes she had to sit on the toilet for "half an hour or so before they come and help me off." The resident stated when these events occurred, it was usually after dinner. [NOTE: Please see F 329 as it pertains to the identified behaviors for this resident.]</p> <p>3. On 6/25/14 at 6:42 PM, the surveyors entered the facility to observe assistance being offered the residents after the evening meal: *LN #10 identified the facility currently had 4 CNAs and 2 LNs working, with a facility census of 43. *Resident #4's call light was on when the surveyors entered the facility. It was answered by LN #4 at 6:53 PM. There was a call light monitoring screen at the nurses station, which indicated the call light was on for 37 minutes before being answered. *Between 6:56 PM and 7:02 PM, LN # 10 was sitting at the nurse's station charting. At 7:00 PM, an alarm sounded indicating an exit door at the end of the hall had been opened. LN #10 stood, silenced the alarm, and sat back down to chart without checking to see what had triggered the alarm, such as a resident eloping from the facility. In the time LN #10 sat at the desk charting, 7 resident call lights were activated. At 7:02 PM, RCM # 5 arrived at the nurse's station, spoke quietly to LN #10, who then rose from the nurse's station and began responding to resident call</p>	F 353	<p>DNS and/or their designee to complete 3 times per week "call light" audits x 4 weeks, then weekly audits x 4 weeks, then monthly audits x 3 months on varying shifts.</p> <p>The Administrator to complete weekly audits during the daily walking rounds X 3 months and then PRN.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 353	Continued From page 61 lights. On 6/25/14 at 7:05 PM, RCM #5 was asked about the facility's expectation for responding to resident requests for assistance. RCM #5 stated, "A lot faster than what you've seen. They know they need to stay on top of this. I chased [LN #10] out of here [the nurse's station]. She knows she needs to answer those call lights. I'll take care of it, and I'll let [the DNS] know."	F 353		
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.	F 431	F431 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The eye drops observed in Resident #7's room were removed and placed in the locked medication cart. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All resident rooms were assessed for storage of prescription medication as well as over the counter medications.	7-31-14

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F 431	<p>Continued From page 62</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews, it was determined the facility failed to ensure the residents' medications were stored in a locked compartment. This was true for 1 of 10 (#7) sampled residents. This deficient practice had the potential to cause harm if residents were to access to medications without the facility's knowledge. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 2/19/14 with multiple diagnoses, including dialysis and glaucoma.</p> <p>Resident #7's Quarterly MDS, dated on 5/21/14, documented: *Cognition intact, *Extensive assist of 2+ with transfers, toileting, and dressing, and *Set-up with supervision for eating.</p> <p>The resident's Physician Recapitulation Orders for June 2014, documented on 2/19/14, "Resident may self administer, medication is to be stored in the med [medication] cart - wait 10 minutes</p>	F 431	<p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>Storage of Medication policy and procedure was reviewed and revised.</p> <p>All staff was in-serviced regarding the Storage of Medication policy in resident's rooms as well as the facility policy on Self Administration of Medications.</p> <p>The Admission Packet that is provided to new admissions and their families will be updated to reflect the regulations regarding prescription and over the counter medications in resident rooms.</p> <p>All current residents will be provided a copy of the information from the Admission packet.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p> <p>The DNS and/or their designee will complete resident room audits 3 times per week x 4 weeks, weekly x 4 weeks, monthly x 3 months and PRN.</p>	

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F 431	Continued From page 63 before administering other eye meds." Note: Resident #7's 's eye drops were stored in an unlocked dresser next to his bed. The dresser was open and accessible to other residents in the facility, as well. On 6/24/14 at 8:30 AM, while inspecting the resident's room, the surveyor observed medication (Travatan) in an open drawer next to the resident's bed. On 6/24/14 at 8:55 AM, the surveyor interviewed CNA #4 regarding the medication in the room. When CNA#4 was asked about the medication being stored in the room, she stated, "Good question," and took the medication to the nurses station. CNA #4 stated, "[name] said it is care planned and as long as it is in the drawer it's okay." On 6/24/14 at 9:00 AM, RCM #5 was interviewed regarding the unattended medication observed in Resident #7's room. RCM #5 stated, "I doubled checked the orders, it says the resident can self administer but it needs to stay in the medication cart." On 6/27/14 at 9:30 AM, the Administrator and DON were informed of the concerns regarding the medication in Resident #7's room. No additional information was provided by the facility.	F 431	The Administrator to provide quality assurance oversight during daily (5 days per week) walking rounds.		
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	F 514	F514 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	7-31-14	

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F 514	<p>Continued From page 64 standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>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.</p> <p>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 complete medical records were maintained on each resident. This was true for 1 of 7 residents (Resident #4) sampled for completeness of medical records. The deficient practice had the potential to cause more than minimal harm if a provider needed to access historic medical information on a resident in order to assess the effectiveness of an ongoing treatment plan. Findings included:</p> <p>Resident #4 was initially admitted to the facility on 6/10/14 with multiple diagnoses which included hypoxemia secondary to pneumonia, carbon dioxide retention, and opiate induced altered mental status.</p> <p>An MDS assessment had not yet been completed at the time of survey.</p> <p>On 6/23/14 at approximately 1:00 PM, during the initial tour of the facility, RCM #2 stated Resident #4 had a sore on her ear, which had been present off and on in the past, as the resident</p>	F 514	<p>No negative outcome related to this deficiency.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>The DNS selected a sample group of residents with previous skin related issues with random dates of treatments and requested medical records to locate corresponding Skin Assessment Flow Sheets (SAFE). All SAFEs were located. No negative outcome identified.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>Based on diagnosis, the DNS will select residents for appropriate flow sheet (i.e., SAFE, Behavior tracking) documentation 3 months post treatment and/or discharge 1 time per week X 4 weeks, then q 2 weeks X 4 weeks, then 1 X per month X 4 weeks.</p> <p>The licensed nurse who completes with SAFE will also make a note in the Interdisciplinary progress notes that the SAFE was completed.</p>	

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F 514	<p>Continued From page 65</p> <p>was unable to lie on her left side. RCM #2 stated the sore had been healed when the resident was recently sent to an acute care hospital on 6/3/14, but present when the resident was re-admitted on 6/10/14.</p> <p>On 6/24/14 at 12:35 PM, Resident #4 was observed sitting in a recliner in her room. A small bandage was noted approximately half way up her right ear. The resident stated she had a sore on her ear from not being able to lie on her left side. The resident stated, "It's been there for years. It never heals. I even had a biopsy done once, but it was nothing."</p> <p>On 6/24/14 at approximately 3:00, Employee #13 was asked for documentation as to whether or not Resident # 4 had the sore on her ear when she was discharged to the hospital on 6/3/14.</p> <p>On 6/24/14 at 3:50 PM, Employee #13 returned with physician's orders and skin tracking sheets for Resident #4 beginning with her admission on 6/10/14. However, the employee stated, "We have a problem. We have the one [skin tracking sheet] for April [2014], but not anything for May." When asked for any documentation before the resident was sent to the hospital in June, Employee #13 stated, "I can't find that either. They're not in here."</p> <p>On 6/25/14 at 9:50 AM, Employee #13 stated she had found Resident #4's TARs for May of 2014, but could not find any documentation on the area on her ear from that time.</p> <p>On 6/25/14 at 4:35 PM, the Administrator and DNS approached the surveyor regarding the missing documentation. The DNS stated, "I know</p>	F 514	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.</p> <p>The Administrator will provide quality assurance oversight via daily IDT meeting, reports from DNS and monthly Medical Records reports.</p>	

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F 514	Continued From page 66 it was there. I saw it. I look at the skin documentation every week. We just can't find it." The Administrator stated the requested documentation, "Could not be located." The facility offered no further information.	F 514		

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NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA RETIREMENT CENTER LEWIST	STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Nina Sanderson, LSW Noel Mathews, MSW</p> <p>The survey team entered the facility on 6/23/14, and exited the facility on 6/27/14.</p>	C 000	<p style="text-align: center;">RECEIVED JUL 25 2014 BY PR NM FACILITY STANDARDS</p>	
C 111	<p>02.100,02,f Provide for Sufficient/Qualified Staff</p> <p>f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT is not met as evidenced by: Please see F 353 as it pertains to facility staffing.</p>	C 111	Please see F 353 POC.	8-1-14 7-31-14 dy
C 132	<p>02.100,04,a Appropriate Level of Care/Services</p> <p>a. The administrator shall not accept or keep patients/residents for whom the appropriate care level and services are not provided, or for which the facility is not licensed except in an emergency. This Rule is not met as evidenced by:</p>	C 132	Please see F 285 POC.	8-1-14 7-31-14 dy

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

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

7.22.14

Bureau of Facility Standards

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C 132	Continued From page 1 Please see F 285 as it pertains to PASARR screenings.	C 132		
C 147	02.100,05,g Prohibited Uses of Chemical Restraints g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please see F 329 as it pertains to psychotropic medications.	C 147	Please see F329 POC.	7.31.14
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F280 as it relates to care plans being periodically reviewed and revised.	C 782	Please see F280 POC.	7.31.14
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F329 as it relates to administration	C 788	Please see F328 + 329 POC.	7.31.14

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C 788	Continued From page 2 of medication per order. Please refer to F328 as it relates to oxygen use.	C 788		
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F323 as it relates to accidents/falls.	C 790	Please see F323 POC.	7/31/14
C 792	02.200,03,b,viii Comfortable Environment viii. Maintenance of a comfortable environment free from soiled linens, beds or clothing, inappropriate application of restraints and any other factors which interfere with the proper care of the patients/residents; This Rule is not met as evidenced by: Please refer to F323 as it relates side rails.	C 792	Please see F323 POC.	7-31-14
C 795	02.200,03,b,xi Bowel/Bladder Evacuation/Retraining xi. Bowel and bladder evacuation and bowel and bladder retraining programs as indicated; This Rule is not met as evidenced by: Please refer to F315 as it relates to bladder and bowel training programs.	C 795	Please see F315 POC	7-31-14
C 797	02.200,03,c Documentation of Nursing Assessments c. Nursing staff shall document on the patient/resident medical record,	C 797	Please see F309 POC.	7-31-14

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C 797	Continued From page 3 any assessments of the patient/resident, any interventions taken, effect of interventions, significant changes and observations and the administration of medications, treatments and any other services provided. Entries shall be made at the time the action occurs and shall be signed by the person making the entry and shall provide the time and date of the occurrence. At a minimum, a monthly summary of the patient's/resident's condition and reactions to care shall be written by a licensed nursing staff person. This Rule is not met as evidenced by: Please refer F309 as it relates to lack of documentation of care interventions.	C 797		
C 811	02.200,04,g,vii Medication Errors Reported to Physician vii. Medication errors (which shall be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Please refer to F332 as it relates to medication error.	C 811	Please see F332 POC	7-31-14
C 835	02.201,02,i Meds in Possession of Resident Limitations i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually	C 835	Please see F176 POC.	7-31-14 8-1-14

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C 835 Continued From page 4
packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record.

This Rule is not met as evidenced by:
Please see F 176 as it pertains to self-administration of medication.

C 835

C 838 02.201,02,1 Secure Storage of Medications
i. All medications in the facility shall be maintained in a locked cabinet located at, or convenient to, the nurses' station. Such cabinet shall be of adequate size, and locked when not in use. The key for the lock of this cabinet shall be carried only by licensed nursing personnel and/or the pharmacist.

This Rule is not met as evidenced by:
Please refer to F431 as it relates to secured medication storage.

C 838

Please see F431 POC. 7.31.14

C 881 02.203,02 INDIVIDUAL MEDICAL RECORD
02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following:
This Rule is not met as evidenced by:
Please see F 514 as it pertains to complete

C 881

Please see F514 POC. 7.31.14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2014
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NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA RETIREMENT CENTER LEWIST	STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 881	Continued From page 5 medical records.	C 881		