



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

CERTIFIED MAIL: 7012 3050 0001 2128 3634

July 29, 2014

Brent Schneider, Administrator  
Karcher Estates  
1127 Caldwell Boulevard  
Nampa, ID 83651-1701

Provider #: 135110

FILE COPY

Dear Mr. Schneider:

On **July 11, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Karcher Estates by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 11, 2014**. Failure to submit an acceptable PoC by **August 11, 2014**, may result in the imposition of civil monetary penalties by **August 31, 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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July 29, 2014  
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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 15, 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 15, 2014**. A change in the seriousness of the deficiencies on **August 15, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 15, 2014** includes the following:

Denial of payment for new admissions effective **October 11, 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 **January 11, 2015**, 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

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Office of the State Medicaid Agency beginning on **July 11, 2014** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

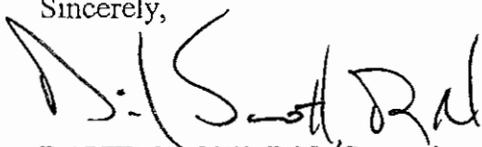
[2001-10 Long Term Care Informal Dispute Resolution Process](#)

[2001-10 IDR Request Form](#)

This request must be received by **August 11, 2014**. If your request for informal dispute resolution is received after **August 11, 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/lj  
Enclosures

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

PRINTED: 07/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/11/2014
NAME OF PROVIDER OR SUPPLIER  KARCHER ESTATES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Sherri Case, LSW/QIPD, Team Coordinator Amy Barkley, RN, BSN, Judy Atkinson, RN, Susan Gollobit, RN</p> <p>The survey team entered the facility on July 7, 2014 and exited on July 11, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living AIT = Administrator in Training AROM = Active Range of Motion BID = Twice a day BIMS = Brief Interview for Mental Status CHF = Congestive Heart Failure CNA = Certified Nurse Aide CP = Care plan CVA = Cerebrovascular Accident DNS = Director of Nursing Services FSI = Fall Scene Investigation HOB = Head of bed info. = information LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment MCG = Microgram MG = Milligram PROM = Passive Range of Motion POA = Power of Attorney PRN = As Needed PVR = Post Void Residual RD = Registered Dietitian</p>	F 000	<p>Preparation or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies.</p> <p>The Plan of Correction is prepared and/or executed solely because it is required by law.</p>	

RECEIVED  
SEP 25 2014  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* ADMINISTRATOR TITLE 9-25-14 (X6) DATE

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

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F 000	Continued From page 1 R/T = Related to SDC = Staff Development Coordinator S/SX, S/S = Signs and symptoms TAR = Treatment Administration Record TID = Three times per day UTI = Urinary Tract Infection	F 000			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a resident who laid in bed with her breasts and incontinent brief exposed was covered to prevent her from being visible to other residents, family, and/or staff as they passed by her room. This was true for 1 of 12 (#10) sampled residents sampled for dignity. This failed practice had the potential for psychological harm if the resident experienced embarrassment or a decrease in her self-esteem. Findings include:  Resident #10 was admitted to the facility with multiple diagnoses to include dementia with behavioral disturbance, non-organic psychosis, colostomy, and history of falls.  The resident's most recent Admission MDS dated 6/19/14, coded the following: - Severely impaired cognition. - Extensive assist of two staff for bed mobility,	F 241	-On 7/8/2014 resident #10 was clothed to cover breasts and incontinent brief. CNA #2 and 3 were educated on the importance of maintaining the dignity of resident #10 by making sure she is covered at all times and the privacy curtain is pulled while she is in bed.  -All care giver staff was in-serviced on Patient Dignity & Respect on 7/9/2014.  -Agency Company contact and the CNA was in-serviced on 7/9/2014 on Patient Dignity & Respect.  -All residents have the potential to be affected. An inservice on Dignity & Respect will be held for all care giver staff on 8/6/2014.  -UM will do audits on patient rooms to ensure if residents are in bed they are clothed and have the privacy curtain pulled to maintain their dignity weekly x4, then monthly x3. Start date 8/11/2014.  -Results of audit will be given at monthly QA meeting x3 months, then quarterly.  -Completion date 8/15/14		

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F 241	Continued From page 2 transfers, and toileting. - Functional limitation, in range of motion of an upper extremity.  On 7/8/14 the following was observed: - 6:55 AM, Resident #10 was observed laying her bed, uncovered, with her breasts and incontinent brief exposed. A male and female resident were observed sitting in their wheelchairs across the hall from Resident #10's room. Resident #10's roommate activated her call light and stated, "Resident #10 needs a nurse." Resident #10 stated, "Please help me." - 6:56 AM, CNA #2 walked down the hall passed Resident #10's room and did not stop. Resident #10's roommate stated, "Resident #10 needs a nurse," followed by Resident #10 stating, "Please help me." - 6:57 AM, CNA #2 walked up the hall passed Resident #10's room with the call light going off and did not stop. - 7:05 AM, Resident #10's call light was still on, and with an escalated tone, the resident's roommate stated, "Resident #10 needs a nurse," followed by Resident #10 in an escalated tone repeating, "Please help me." The male resident was observed sitting in his wheelchair across the hall from the resident's room. - 7:06 AM, CNA #2 walked into Resident #10's room, turned off the call light and left the resident's room. CNA #2 did not cover the resident's exposed breasts and/or incontinent brief prior to leaving the resident's room. - 7:07 AM, Resident #10's roommate re-activated the call light. CNA #3, with dirty linen in hand, walked past the resident's room, discarded the linen, in the linen barrel and proceeded to walk down the hall passed the resident's room. - 7:10 AM, CNA #2 walked into Resident #10's	F 241			

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F 241	Continued From page 3 room and shut the door. -7:11 AM, UM #4 was asked to accompany the surveyor to Resident #10's room. The surveyor knocked, identified self and opened the resident's door. The UM observed the resident's breasts and incontinent brief were exposed. The surveyor informed the UM about the above observation. The UM shook his head back and forth and stated he did not know why the resident was not covered up or the privacy curtain pulled. He stated, "It is absolutely not okay for any resident to be left like that."  On 7/9/14 at 9:45 AM, the Regional Nurse and DNS were informed about the above concern. The DNS stated the facility would provide staff with additional training and education.	F 241			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	-Resident#1 care plan has been updated to include use of motorized scooter.  -The facility will develop comprehensive care plans for each resident following the results of assessments. The objectives will be measurable and will include timetables to meet the needs identified in the comprehensive assessments, The care plan will describe the services furnished to the resident to maintain their optimal physical, mental and psychosocial well-being.  -All residents have the potential to be affected. There are no other residents currently using electric mobility devices.  -A new electric mobility device policy will be developed.		

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F 279	<p>Continued From page 4</p> <p>§483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a care plan was developed for the use of a motorized scooter after being assessed as safe to use. This was true for 1 of 8 (# 1 ) sampled residents. This failure created the potential for harm when staff did not have direction to meet the resident's needs related to the use of the motorized scooter. Findings included:</p> <p>Resident #1 was admitted to the facility on 1/28/14 and readmitted on 2/16/14 with diagnoses including chronic kidney disease, history of falls, acute respiratory failure and venous insufficiency.</p> <p>The resident medical record included a Progress Note, dated 5/20/14 which stated the resident had been assessed as having "good awareness" with the scooter. The note included the resident was to have family with her when using the scooter outside the facility. The Progress Note was signed by the physical therapist.</p> <p>The resident stated on 7/8/14 at 11:30 a.m. she would like to use her electric scooter to go to her bank, which was next door to the facility, but some of the nurses would not let her use her scooter.</p> <p>The resident did not have a care plan which documented she was allowed to use her electric scooter outside the facility.</p>	F 279	<p>-Continued</p> <p>-An in-service on updating care plans will be held on 8/13/2014.</p> <p>-The UM will update all care plans for any changes, quarterly and annually.</p> <p>-DON will complete audits of care plans to make sure the assessment results are addressed in the care plan and the residents physical, mental, and psychosocial needs are being met. The audits will be weekly x 4, then monthly x 3. Start Date 8/11/2014</p> <p>-The results of the audit will be given at the monthly QA meeting x 3 months.</p> <p>-Completion date 8/15/2014</p>	

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F 279	Continued From page 5  On 7/9/14 at 4:20 p.m. the Administrator stated the resident was able to go to the "Mall" next door on her motorized scooter but was not to cross any main streets. The Administrator stated the resident had been allowed to leave the facility property on her scooter for "about a month." The Administrator stated the facility was currently in the process of developing policies and procedures for the use of electric wheelchairs and scooters.  On 7/11/14 at 10:35 a.m. the Administrator and the DON were informed of the concern. The facility provided no further information.	F 279			
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.	F 280	-Resident #2 care plan was updated to include current weight loss interventions, to include heel protectors while in his wheelchair, and 15 minute checks at night for fall prevention. Resident #6 care plan was updated to reflect the discontinuation of an antidepressant medication. Resident # 12 care plan has been updated to include weekly cleaning of the CPAP machine.  -All residents have the potential to be affected  -The UM will update all care plans for any changes, quarterly and annually, and as needed.  -An in-service on updating care plans will be held on 8/13/2014.		

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F 280	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to revise care plans for 3 of 12 sampled residents (#'s 2, 6, 12). The care plan: *failed to include current weight loss interventions for Resident #2; *failed to include heel protectors were to be when the resident was in his wheelchair *failed to include 15 minute checks at night for fall prevention for Resident #2; * failed to document Resident #6 was no longer to receive an antidepressant medication; and, *failed to include weekly cleaning of Resident #12's CPAP (Continuous Positive Airway Pressure) machine. These failures had the potential to result in harm if residents did not receive appropriate care due to lack of direction in their respective care plans. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 10/31/13 with diagnoses including Alzheimers, acute kidney failure, closed fracture and chronic airway obstruction.</p> <p>The resident's 7/1/14 Physician Orders included an order for Remeron (antidepressant) 7.5 mg (start date 11/15/13) to stimulate the resident's appetite.</p> <p>The resident's Nutritional Status Care Plan, dated 3/11/14 documented a goal to have no significant weight loss. The "Approach" section included the resident ate with assistance in the dining room, had dietary supplements, preferred food, a</p>	F 280	<p>-Continued</p> <p>-DON will complete audits of care plans to make sure changes in the residents care plan have been assessed and included in the care plan, weekly x4, then monthly x 3. Start date 8/11/2014.</p> <p>The results of the audit will be given at the monthly QA meeting x3 months.</p> <p>-Completion date 8/15/2014</p>	

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F 280	<p>Continued From page 7</p> <p>divided plate, puree diet, snacks as requested and to monitor the resident's weight.</p> <p>On 7/9/14 at 4:20 p.m. the Dietitian stated the resident was discussed at the Nutrition at Risk Review every 2 weeks. When asked about interventions the Dietitian stated the resident's interventions were implemented and were documented on his/her Nutrition Risk Review Progress Notes (NRPN). The Dietitian was informed the Care Plan for nutrition did not include the use of an antidepressant as an appetite stimulant.</p> <p>On 7/10/14 the facility provided the NRPN for 5/13/14 which documented in the summary section that the resident was offered 3500 K-Cal nutritional supplement. The new intervention section directed staff to add yogurt to meals three times per day. The 5/27/14 NRPN documented in the recommendations to continue all current interventions. The Dietitian provided the 3/11/14 "Psychotropic Drug Use" Care Plan which documented the resident was at risk for adverse reaction due to the use of the antidepressant for an appetite stimulant.</p> <p>Resident #2's 3/11/14 Care Plan for Urinary Incontinence included in the "Approach" section in A to toilet the resident during rounds and PRN and in B to assist, "with checking and changing if needed when toileting..."</p> <p>During an observation on 7/8/14 at 6:38 a.m., CNA#7 was observed assisting the resident to get out of bed for breakfast. The surveyor asked if the resident had been toileted and CNA #7 stated he had checked the resident and "he was dry." At 1:00 p.m. CNA #7 and CNA #3 were</p>	F 280			

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F 280	<p>Continued From page 8</p> <p>assisting the resident to lie down after lunch. CNA #3 stated she had checked the resident and his adult brief did not need changed as he was dry.</p> <p>On 7/10/14 at 1:00 p.m. LN #8 stated Resident #2 was no longer toileted and the Care Plan needed to be revised.</p> <p>The resident's 3/11/14 Care Plan for falls documented interventions of transfers with a mechanical lift, high-back wheel chair, bed in low position, alarms placed on the wheelchair and bed.</p> <p>An Occurrence Report, dated 5/25/14 documented the resident was sleeping and had fallen from his bed. The intervention section of the report documented 15 minute checks during the night were initiated.</p> <p>On 7/10/14 at 11:30 a.m. LN #4 stated the facility was monitoring the resident every 15 minutes but the care plan had not been revised. Later that day LN #4 provided documentation since 6/3/14 of the 15 minute checks on the night shift.</p> <p>Resident #2's Care Plan for skin breakdown included in the approach section the resident was to wear heel protectors while in bed. The Care Plan did not include the resident was to wear the boots while in his wheelchair.</p> <p>During the mid-day meal observations on 7/7/14 through 7/9/14 Resident #2 was observed in his wheelchair, wearing protective boots.</p> <p>On 7/10/14 at 8:20 a.m. LN #8 stated the resident was to wear the boots at "all times."</p>	F 280		

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F 280	<p>Continued From page 9</p> <p>2. Resident #6 was admitted to the facility on 10/24/10 and readmitted on 8/11/11 with diagnoses which included senile dementia, muscle weakness and adult failure to thrive.</p> <p>The resident's 7/1/14 Physicians Orders did not include an order for an antidepressant.</p> <p>The resident's 9/25/13 Care Plan for Mood state included in the "Approach" section to "Administer antidepressant medication as ordered by the Physician."</p> <p>On 7/9/14 at 3:30 p.m. the Social Worker stated the Care Plan needed to be revised as the antidepressant had been discontinued "at least 1 year."</p> <p>3. Resident #12 was admitted to the facility on 1/4/14 with diagnoses which included chronic airway obstruction and sleep apnea.</p> <p>During an observation on 7/9/14 a CPAP machine was observed to be in Resident #12's room. When asked if the machine had been cleaned the resident replied it was "supposed to be cleaned sometime today."</p> <p>The resident's 7/14 Physician Orders (recapitulation) included in the treatment section to "Clean CPAP once weekly with soapy water, shake and air dry...."</p> <p>The resident's 4/15/14 Care Plan for Management of Medical Condition included in section E in the Approach section, "I have sleep apnea and use a CPAP at night..." There was no further information regarding the cleaning or maintenance of the CPAP machine.</p>	F 280			

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F 280	<p>Continued From page 10</p> <p>The resident's Treatment sheets for 5/1/14 through 7/10/14 included to clean the CPAP with soapy water weekly with a start date of 1/4/14. The time section documented, "FYI" (for your information). The treatment sheets were blank in the area which was to be initialed when the machine was cleaned.</p> <p>On 7/10/14 at 11:30 a.m. LN #4 stated the Treatment sheet should not have been marked FYI since there was a Physician order to clean the machine weekly.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents with dementia had adequate diagnosis and monitoring for the use of an antipsychotic. This was true for 2 of 8 sampled residents (#s 2 &amp; 6) reviewed for medications. Additionally for 1 of 8 sampled residents, the facility failed to ensure the care plan was followed to have Resident #6's bed in the lowest position. These failures placed the residents at risk for side effects of unnecessary medications and to not</p>	F 280	<p>-Residents #2 &amp; 6 care plans have been updated to reflect the appropriate use and need of antipsychotic medications following physician's orders and according to the diagnosis obtained by the physician. The two resident's medical record reflects the proper diagnosis is documented. Their behaviors are addressed; interventions are included in the care plans. Behaviors are being monitored and interventions for the behaviors are also being monitored for effectiveness for both residents.</p> <p>-Resident #6 bed will be in the lowest position when resident is in bed.</p> <p>-All residents have the potential to be affected. All residents who require the bed to be in the lowest position have been identified, assessed by a Physical Therapist, and care planned to address this concern. Staff checked each resident and made sure the bed was in the lowest position for safety.</p> <p>-Resident #6 will have a pain assessment completed by the UM.</p>	
F 309 SS=D		F 309		

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F 309	<p>Continued From page 11</p> <p>receive fall prevention interventions. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 10/31/13 with diagnoses including Alzheimers, acute kidney failure, closed fracture and chronic airway obstruction.</p> <p>Resident #2's 7/1/14 Physicians Orders (recapitulation) included an order for Risperdal (antipsychotic) 0.25 MG at bedtime (start date 5/15/14) for dementia with agitated features.</p> <p>Resident #2's 3/11/14 Care Plan for Behavioral Symptoms documented behaviors of "throwing food, twisting a staff member's wrist, threatening to hit, using foul language." The goal was for the resident to cooperate with care.</p> <p>The Approach section included interventions to assess for pain, approach in a calm manner, explain care prior to providing care, leave and re-approach as appropriate , praise for appropriate behavior, quiet surroundings and to redirect by talking about movie industry, grandchildren and bowling.</p> <p>Behavior/Intervention Monthly Flow Records (BIMF) for 6/14 and 7/1/14 through 7/8/14 documented the following: 6/14 Combative with cares - 6 incidents with 4 on evening shift and 2 on night shift Hitting, grabbing, twisting staff wrists - 5 incidents with 1 on evening shift and 4 on night shift Hallucinations - 13 incidents with 10 occurring on evening shift and 3 on night shift 7/1/14 - 7/8/14 Combative with cares - 0 incidents</p>	F 309	<p>-Continued</p> <p>-The UM will update care plans as needed to make sure they include the diagnosis obtained from the physician for psychotropic medication use, behavior interventions for target behavioral symptoms for the use of an anti-psychotic as identified by the physician prescribing the medication, beds in lowest position for safety as the needs of the resident change.</p> <p>-Social Service will review and update all resident care plans with each quarterly assessment. The review will include making sure residents using psychotropic medications have the proper diagnosis that the care plan addresses any behaviors and the interventions are being monitored.</p> <p>- All LN and Social workers will have an in-service from our Licensed Pharmacy on Psychotropic Drug monitoring and the Policy and Procedures.</p> <p>-An in-service on updating care plans will be held on 8/13/2014.</p> <p>-Social Services Director will complete audits of the care plans of all residents on psychotropic medications to determine the proper diagnosis is documented, that the resident has been assessed for the use of the antipsychotic medication, that the care plan includes goals and interventions to address target behaviors, weekly x4, then monthly x3. Start date 8/11/2014.</p>

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F 309	<p>Continued From page 12</p> <p>Hallucinations - 0 incidents Grabbing, pushing or striking out- 0 incidents Argumentative - 0 incidents</p> <p>A 5/27/14 Social Service Progress Note documented, "...appear to be having hallucinations and appears to be talking to air, mostly at night...Generally does not appear distressed, but at times verbalize some things..."</p> <p>On 7/9/14 at 4:00 p.m. the Social Worker (SW) was asked about the diagnosis for the use of Risperdal. The SW stated the resident did have hallucinations which were occasionally distressful regarding his wartime experiences. The SW stated the resident's care plan did not include hallucinations or interventions to implement for the hallucinations. When asked what the BIMF for "Argumentative" behaviors meant the SW stated the resident did not have argumentative behaviors anymore and needed to be discontinued. The SW stated the care plan did not include information regarding what the resident was trying to communicate when he was grabbing, pushing or striking out. The SW stated baseline information regarding the hallucinations may be in notes by the former social worker but was not included in the care plan. The SW stated she was aware the resident's resistance to cares was not, on its own, adequate justification for the use of an antipsychotic. When asked if the BIMF's documented the behaviors were harmful to the resident/others or if they occurred often enough to document the need for the antipsychotic she stated the resident was now on hospice and his behaviors had decreased.</p> <p>2. Resident #6 was admitted to the facility on 10/24/10 and readmitted on 8/11/11 with</p>	F 309	<p>-Continued</p> <p>-The results of the audit will be given at the monthly QA meeting x3 months.</p> <p>-The UM will monitor the care plans of all residents who require the bed to be in lowest position for safety, that the resident has been assessed by a Physical Therapist quarterly and as needed and interventions are included in the care plan weekly x4, then monthly x3. Start date 8/11/2014.</p> <p>-The results of the audit will be given at the monthly QA meeting x3 months.</p> <p>-Completion date 8/15/2014</p> <p><i>9/24/14 per conversation over via telephone @ Brent Schneider on 10/3/14 @ 11:05AM</i> <i>B. Schneider</i></p>	

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F 309	<p>Continued From page 13</p> <p>diagnoses which included senile dementia, muscle weakness and adult failure to thrive.</p> <p>The resident's 7/1/14 Physicians Orders (recapitulation) included an order for Seroquel (antipsychotic) 25 MG daily at bedtime for dementia with agitated features.</p> <p>The resident's 9/25/13 Care Plan for Behavioral Symptoms documented behaviors of, "yelling out, crying, uncooperative with cares with a history of paranoia, delusional thinking."</p> <p>The Approach section included (all dated 9/20/14) interventions to: assess for pain, be aware to needs, discuss sewing, doll making and grandchildren, and to praise for appropriate behavior.</p> <p>Behavior/Intervention Monthly Flow Records (BIMF) for 5/14 through 7/8/14 documented the following:</p> <p>5/14 Crying/yelling out - 23 incidents with 13 on day shift, 2 on evening shift and 8 on night shift Uncooperative with cares - 0 incidents Excessive demandingness - 7 incidents all on day shift</p> <p>6/14 Excessive demandingness - 0 incidents Crying/yelling out - 12 incidents with 2 on evening shift and 10 on night shift Uncooperative with cares - 0 incidents Hallucinations - 13 incidents with 10 occurring on evening shift and 3 on night shift</p> <p>7/1/14 - 7/8/14 Crying/yelling out - 7 incidents with 4 on day shift and 3 on night shift Uncooperative with cares - 0 incidents</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>Assess for pain - 0 incidents Excessive demandingness - 0 incidents</p> <p>During an observation on 7/7/14 at 2:25 p.m. Resident #6 was in bed and yelling. The surveyor went into her room and asked if something was wrong. The resident stated her catheter was not working and she was in pain. CNA #7 was informed and stated the nurse was aware.</p> <p>On 7/9/14 at 11:45 a.m. the resident told LN #6 the catheter was not happy and indicated she was in pain.</p> <p>Note: The BIMF did not document the resident was in pain on 7/7/14 or the reason the resident was crying.</p> <p>On 7/9/14 at 3:30 p.m. the Social Worker (SW) was asked what the resident was trying to communicate by "crying/yelling out." The social worker stated she believed the resident was trying to communicate pain. When asked if this was an appropriate use for the antipsychotic she stated it was not. When ask if the data had been evaluated to determine the cause for the behaviors, such as the time of day, staff working with the resident, etc. she stated, "No." When asked for prior effectiveness and interventions tried prior to the medication she stated she had not been at the facility when the medication was started. The social worker stated excessive "demandingness" was not in the care plan with appropriate interventions. The social worker stated the hallucinations/delusions were about babies but there was not documentation if they were stressful to the resident.</p> <p>Resident #6's 12/26/13 Care Plan for Falls due to</p>	F 309			

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F 309	Continued From page 15 weakness included an intervention to, "Keep my bed in the lowest position when I am in it."  On 7/7/14 at 1:13 p.m., 2.25 p.m. and on 7/8/14 at about 10:30 a.m. the resident was observed in her bed. The bed was observed to be in a higher position than her roommate's bed. During the 7/8/14 observation CNA #10 was asked if the bed was in the lowest position. The CNA went over to the bed, adjusted it and said, "It went down about 4 inches."  On 7/10/14 at 5:15 p.m. the Administrator and the DON were informed of the above concerns. The facility provided no further information.	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on record review, the facility's UTI Protocol Map and staff interview, it was determined the facility failed to ensure a resident receiving prophylactic antibiotic treatment for re-current UTI's received additional evaluation to rule out causative factors such as structural	F 315	-Resident #3 has been offered a urology consult; however, resident's family has declined urology consult. Order has been received to discontinue routine antibiotic and nursing will monitor Post Void Residuals. Resident #3 is being monitored for signs & symptoms of a UTI.  -All residents have the potential to be affected.  -All residents scheduled on a routine medication for UTI's have been offered a urology consult.  -All residents with a UTI have been evaluated by our Infection Control nurse using the new UTI Protocol Map. The evaluation was used to rule out causative factors such as structural abnormalities, medical conditions and medication use.		

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F 315	<p>Continued From page 16</p> <p>abnormalities, medical conditions, and/or medication use. This was true for 1 of 2 (#3) residents sampled for UTI's. This failed practice placed the resident at risk for yeast infections, drug resistant bacteria, and/or clostridium difficile colitis. Findings include:</p> <p>Federal Regulation F315, Urinary Incontinence documented the following, "The goal of treating a UTI is to alleviate systemic or local symptoms, not to eradicate all bacteria. Continued bacteriuria without residual symptoms does not warrant repeat or continued antibiotic therapy. Recurrent UTI's (2 or more in 6 months) in a non-catheterized individual may warrant additional evaluation (such as determination of an abnormal post void residual (PVR) urine volume or a referral to an urologist) to rule out structural abnormalities..."</p> <p>Resident #3 was admitted to the facility on 10/7/05 and re-admitted on 4/17/08 with multiple diagnoses to include right sided hemiplegia, aphasia due to CVA, urinary incontinence, and osteoarthritis.</p> <p>The resident's most recent Quarterly MDS dated 4/26/14, coded: - Short Term/ Long Term memory intact. - Extensive assist of two people for toileting. - Extensive assist of one person for personal hygiene.</p> <p>The resident's Urinary Incontinence care plan documented the following: - Problem dated 2/7/14, "I have a hx [history] of recurrent UTI's." - Approach dated 2/11/14, "Observe for s/sx [signs and symptoms] of UTI's: burning on</p>	F 315	<p>-Continued</p> <p>-A new policy is being completed for UTI's. The policy includes ruling out causative factors such as abnormalities, medical conditions and medication use. LN staff will be in-serviced on 8/13/2014 on the new policy and UTI Protocol Map.</p> <p>-The Infection Control nurse will monitor all residents who have signs &amp; symptoms of UTI to make sure the Protocol Map and policy are being followed weekly x4, then monthly x3.</p> <p>-The results of the audit will be given at the monthly QA meeting x3 months.</p> <p>-Completion date 8/15/2014</p>		

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F 315	<p>Continued From page 17</p> <p>urination, increased frequency, foul odor, hematuria, cloudy urine etc. BE AWARE: I often have very strong smelling urine so this is not a reliable predictor of a UTI."</p> <p>The Facility's UTI Protocol Map for a resident without an indwelling catheter documented the following:</p> <ul style="list-style-type: none"> <li>* Does the resident have an oral fever greater than 100 degrees Fahrenheit.</li> <li>- Oral fever repeatedly greater than 99 degrees Fahrenheit.</li> <li>-OR-</li> <li>- Leukocytosis.</li> <li>* If the answers to the above questions are, "No,"</li> <li>- THEN-</li> <li>* Does the resident have two or more of the following signs, suprapubic pain, gross hematuria, new or increased incontinence, new and increased urgency or frequency.</li> <li>* If the answer is, "No,"</li> <li>- THEN-</li> <li>- No urinalysis needed.</li> </ul> <p>The resident's Physician Orders dated 4/1/14 documented an order for, "Macrochantin 50 mg - Take by mouth daily at bedtime for chronic urinary tract infection." This medication had an original start date of 5/6/11.</p> <p>A Physician Telephone Order dated 4/28/14 documented, "Bactrim SS qd [every day]." The order did not document the reason for the change in antibiotic.</p> <p>The Interdisciplinary Progress Note dated 4/28/14 documented, "Due to lack of insurance coverage, for Macrochantin, med[ication] [changed] to Bactrim SS. [One] po [by mouth] daily."</p>	F 315		

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F 315	Continued From page 18  The resident's Physician Orders dated 7/1/14 documented an order for, "Septra 400/80 mg QHS [every night at hour of sleep] for chronic urine infection."  NOTE: There was no documentation in the resident's record to indicate the resident had received additional evaluation to rule out causative factors such as structural abnormalities, medical conditions, and/or medication use.  On 7/10/14 at 2:23 PM, UM #4 was interviewed related to the resident's continued use of prophylactic antibiotic treatment. UM #4 stated he could not find documentation for justification of the use of antibiotic treatment in the resident's record. The UM stated the only place he found documentation was on the Physician's Orders related to the diagnosis. The surveyor asked if the resident had a post void residual done, further evaluation or a referral to see an urologist. The UM stated, "No," the facility had not considered those things for Resident #3 because she was on an antibiotic.  On 7/10/14 at 5:15 PM, the administrator and the DNS were informed about the continued use of antibiotic treatment. No additional information was provided to resolve the issue.	F 315			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase	F 318			

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F 318	<p>Continued From page 19 range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review it was determined the facility failed to ensure residents with limited range of motion and contractures received necessary services to prevent further decline in Range of motion (ROM). This affected 2 of 7 (#3 &amp; #11) residents sampled for limited ROM, which had the potential to lead to functional decline, increased depression, withdrawal, social isolation and complications of immobility, such as increased incontinence and or pressure sores. Findings include:</p> <p>1. Resident #3 was admitted to the facility with multiple diagnoses to include right sided hemiplegia, CVA, aphasia due to CVA, osteoarthritis, knee joint replacement, and muscle weakness.</p> <p>The resident's most recent Quarterly MDS assessment dated 4/26/14, coded the following:</p> <ul style="list-style-type: none"> <li>- Extensive assist of two people for bed mobility, transfers, toilet use, and bathing.</li> <li>- Functional limitation in range of motion on one side in upper and lower extremities.</li> <li>- The resident was not receiving passive range of motion.</li> <li>- The resident received 6 days of active range of motion in the previous 7 calendar days.</li> <li>- The resident received 6 days of training and skill practice in dressing and/or grooming.</li> </ul>	F 318	<p>-Resident #3 &amp; 11 have been evaluated by a therapist for ROM and the need for a restorative program. Both resident's care plans have been updated to reflect the findings of the evaluations. A restorative program is in place to provide specific interventions for identified concerns for both residents.</p> <p>-All residents on a RNA program could be affected.</p> <p>-All residents on the RNA program will be evaluated by a therapist.</p> <p>-The RNA sheets will be updated to follow the instructions of therapy.</p> <p>-A staff RN has been assigned to oversee the RNA program. The nurse will evaluate present RNA programs and reassess quarterly. The resident's MDS, care plan and therapy sheets will accurately reflect the resident's restorative needs and the care that is being given.</p> <p>-DON will complete audits of care plans and therapy sheets weekly x4, then monthly x3. Starting date 8/11/2014.</p> <p>-The results of the audit will be given at the monthly QA meeting x3 months.</p> <p>-Completion date 8/15/2014</p>		

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F 318	<p>Continued From page 20</p> <p>CMS's RAI Version 3.0 Manual, Section O 0500, page O-36 documented the following, "Measurable objective and interventions must be documented in the care plan and in the medical record. Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity."</p> <p>The resident's ADL/ Rehabilitation care plan dated 2/11/14 documented the following: - "I am working with RNA on ROM and dressing/grooming. Please encourage me to do as much as possible for myself before providing hands on assistance so I can maintain my ability to participate in my own care." - "Restorative Nursing Program for ROM and dressing/grooming 6-7 x weekly."</p> <p>NOTE: The resident's ADL/Rehabilitation care plan and medical record lacked documentation the resident was receiving any ROM therapy to address the resident's right sided deficit or contractures of the resident's right wrist and fingers. Additionally, it did not document whether the resident was supposed to receive AROM or PROM.</p> <p>On 7/10/14 at 9:50 AM a Physical Therapist #17 was interviewed about the RNA program and stated after a resident completed physical therapy and continued to be a willing participant then a restorative nursing program was recommended. The therapist stated P.T. and/ or O.T. would assist in the development of the initial program, but the Restorative Nurse and the RNA would be responsible for continuation and modification of</p>	F 318			

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F 318	<p>Continued From page 21 the program.</p> <p>On 7/10/14 at 2:30 PM the Restorative Nurse (R.N.) was asked if Resident #3 had a restorative program in place to address contractions and decreased mobility in her right hand, wrist, and arm. The RNA program for the resident, as documented on the Care Plan, was for ROM and dressing/grooming 6-7 x weekly as tolerated and for communication as tolerated 6-7 times a week. The surveyor asked how the R.N. determined the appropriate program for Resident #3. The R.N. stated she and the restorative CNA discuss it and then start the program. The surveyor asked how they knew it was the appropriate program and would not cause pain, injury, or further decline to the resident. The R.N. stated, "Honestly, I don't know." The R.N. said she had not received any education or training to be the Restorative Nurse, but had been reading articles and teaching herself.</p> <p>On 7/10/14 at 3:00 PM the DNS was informed related to the above concern. The DNS stated the facility was working on the development and implementation of a better Restorative Program for the residents. No further information was provided to resolve this concern.</p> <p>2. Resident #11 was admitted to the facility on 5/29/13 with multiple diagnoses to include Sclerosis, amyotrophic lateral (ALS or Lou Gehrig's disease), and arthropathy.</p> <p>The resident's most recent Quarterly MDS dated 5/11/14 coded the following: - One person extensive assist with bed mobility. - Two person extensive assist with transfers, dressing, toileting, and hygiene.</p>	F 318			

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F 318	<p>Continued From page 22</p> <p>- Functional limitation in ROM in bilateral upper and lower extremities.</p> <p>NOTE: The resident's MDS did not code she had received restorative nursing services, though the facility had identified the resident had functional limitation in her ROM in both upper and lower extremities.</p> <p>The resident's ADL Functional/Rehabilitation care plan documented the following: * 2/5/14 - "CNA will do 5-10 min[utes] ROM [upper and lower] extremities Q [every] AM [with] cares, ADLS."</p> <p>NOTE: The resident's ADL care plan did not include what ROM would be provided for the resident, nor did it include a program for the resident's bilateral upper extremity contractures in the resident's fingers, hands, wrists, arms, and elbows.</p> <p>On 7/10/14 at 2:30 PM the Restorative Aide (RA) and R.N. were interviewed about the above concern. The RA stated she had started a Restorative Program for the resident on 6/24/14. The surveyor identified the ADL Functional/Rehabilitation care plan documented the resident had been receiving restorative nursing since 2/5/14. The RA and R.N. stated they were unaware that was listed on the resident's care plan. The RA stated she had not provided restorative nursing for the resident until 6/24/14. The surveyor asked the RA to provide a flow sheet and/or written program documenting the resident's restorative program. The resident's Therapies flow sheet dated 07/01/14 was provided and documented the resident was to receive a restorative program for PROM for LE</p>	F 318			

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F 318	Continued From page 23 [lower extremity as tolerated 6-7 times a week and for communication as tolerated 6-7 times a week. The surveyor asked the RA and R.N. what restorative therapy program had been developed for the resident to address her bilateral upper extremity contractures. The RA stated, she was not receiving restorative therapy for her upper extremities. The RA stated when the resident admitted to the facility on 5/29/13 the family told the facility they did not want the resident to receive therapy because it would cause her pain.  NOTE: The resident's medical record was reviewed and did not document the resident had been asked if she wanted to participate in therapy or not.  On 7/10/14 at 3:00 PM the DNS was informed related to the above concern. The DNS stated the facility was working on the development and implementation of a better Restorative Program for the residents. No further information was provided to resolve this concern.	F 318		
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, record review and staff	F 323	-All resident care staff were in-serviced on hazardous chemicals being kept behind locked doors on 8/6/2014 by Staff Development. Keypad locks are being installed on doors where chemicals are being stored.  -All residents have the potential of being affected.  -The Chemical in the Soiled Utilities closet was removed on 7/31/2014.	

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F 323	<p>Continued From page 24</p> <p>interview, it was determined the facility failed to ensure harmful chemicals were secured behind a locked door. This failure created a potential for harm for any independently mobile, cognitively impaired resident who could access the unsecured chemicals. This was true for 4 of 12 (#s 1, 4, 6, and 10) sampled residents and any other cognitively impaired resident. In addition, it was determined the facility failed to ensure a side rail was assessed as safe for resident use. This was true for 1 of 12 (#3) sampled residents and placed the resident at risk for entrapment and potential harm should the resident become entrapped in the side rail. Findings included:</p> <p>1. The facilities Material Safety Data Sheet for the chemical "STA Carpet Sanitizer Plus" document's , "Potential acute health effects, Eyes: Corrosive to eyes. Skin: Corrosive to skin. Inhalation: Severely irritating to the respiratory system. Ingestion: Causes burns to mouth, throat and stomach."</p> <p>On 7/10/14 at 11:05 AM, Room 595 in Hallway D Labeled "Soiled Utility Room/Biohazard" was observed left unattended with the key in the door. Several staff members were observed passing by the door, 6 minutes later CNA #1 opened the door, put the key on the hook above, went into the room and dumped some trash. She then shut the door, making sure the door was locked. The Surveyor unlocked the door, went inside and found 2 plastic bottles on the counter top, one labeled "H2O only," and the other was labeled with a handmade label taped to a plastic bottle that read, "STA Carpet Sanitizer Plus." This bottle had approximately 10 ounces of clear liquid in it.</p> <p>On 7/11/14 at 9:30 AM, the DON was informed of</p>	F 323	<p>-Continued</p> <p>-All soiled utility doors &amp; other rooms containing chemicals will be audited by the administrator to make sure that they are locked weekly x4, then monthly x3. Start date 8/11/2014.</p> <p>-Resident #7 has been reassessed for side rail safety.</p> <p>-A new side rail assessment form was implemented on 8/8/2014. All residents with side rails have been assessed for side rail safety using the new assessment form.</p> <p>-All residents with side rails will be assessed quarterly by the Unit Manager.</p> <p>-All residents will be assessed upon admission for side rail safety. The assessment will be placed in their medical record. The Medical Records Specialist will monitor all admissions for side rail safety assessments weekly x4, then monthly x3. Start date 8/11/2014.</p> <p>-The results of the audit will be given at the monthly QA meeting x3 months.</p> <p>-Completion date 8/15/2014</p>	

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F 323	<p>Continued From page 25 the observation and acknowledged the sanitizer should not be in an unlocked room.</p> <p>2. Resident #3 was admitted to the facility with multiple diagnoses to include history of CVA with right sided hemiplegia, aphasia, and osteoarthritis.</p> <p>The resident's most recent Quarterly MDS dated 4/26/14 coded the following: - Short Term/Long Term memory intact. - Extensive assist of two people for bed mobility and transfers. - Functional limitation in upper and lower extremity. - Restraint in bed - none.</p> <p>The resident's Skin care plan dated 2/11/14 documented, "I use one side rail on the window side of my bed so I can assist in cares, repositioning, etc. a [sic] well as having easy access to my controls."</p> <p>The facility's Policy and Procedure for the use of side rails documented the following: - A Physician Order and signed Informed Consent form were required for the use of side rails. - All beds were supplied with side rails. - When a need for side rails arises, residents were to be instructed as to their purpose and correct use. - When side rails are indicated, bed must be kept in the lowest position, except when care is being provided. - The date the family was contacted about signing the informed consent form was reflected on the form and clinical notes. - Informed consent form was placed in the health</p>	F 323		

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F 323	<p>Continued From page 26 care directives section of the medical record.</p> <p>Note: The facility's policy did not document the side rail should be assessed for safety prior to resident use.</p> <p>A restraint consent form dated 6/21/10 documented the following: - Reason for use: "To promote [Independent] bed mobility and to allow resident to have bed controls available for use." - Duration of use: "While in bed - rail is considered an enabler. This is not a physical restraint." - Potential Risk - hand written, "Family/Resident given Entrapment Hazard info..." - Potential Risk - hand written, "1 rail could be considered restrictive but is not in this case." - "AN EVALUATION OF THE SIDE RAIL/MATTRESS CONFIGURATION HAS BEEN DONE THERE IS MINIMAL RISK OF ENTRAPMENT." There was an area after this sentence for the assessor to initial and/or date which was blank.</p> <p>NOTE: There was nothing documented in the resident's record from the time the side rail was applied to the resident's bed on 6/21/10 through 7/8/14 to indicate the side rail was assessed for safety.</p> <p>Resident #3's bed was observed to have a 1/4 side rail in the upraised position on 7/8/14 at 5:00 AM and 7:00 AM.</p> <p>On 7/10/14 at 2:25 PM UM #4 was interviewed related to the above findings. The UM stated he was not sure if a safety assessment had been completed prior to the application of the side rail.</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>UM #4 stated he would need to look at the resident's medical record. No further information was provided to resolve this concern.</p> <p>On 7/10/14 at 5:30 PM the Administrator was informed of the above concern. The Administrator stated the facility was using a new form for side rail assessments. The surveyor showed the Administrator the form found in the resident's medical record and he indicated the form was the old form. No additional information was provided to resolve this concern.</p> <p>On 7/14/14, additional information was received from the facility including a blank, "New Equipment Assessment Tool." The document was reviewed and did not include an area to address the side rail(s) were assessed for safety prior to placement on a resident's bed.</p> <p>F 325 SS=D 483.25(j) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff</p>	F 323	
		F 325	<p>-Resident #2 was assessed on 7/8/2014 and was without distress, and has since been consuming adequate amounts of meals. His dining experience has been improved by giving him time to eat and not rushing him.</p> <p>-LN was in-serviced on 7/8/2014 on correct feeding assist guidelines and assisting residents with eating in a dignified manner.</p> <p>-All residents have the potential to be affected. All caregiver staff were in-serviced on feeding residents in a dignified, unhurried manner on 8/6/2014.</p>

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F 325	<p>Continued From page 28</p> <p>interview, it was determined the facility failed to ensure a resident with weight loss had a pleasant dining experience for 1 of 8 sampled residents (#2). This failure created the potential for Resident #2 to experience a compromised nutrition status. Findings included:</p> <p>Federal guidance at F 325 included in the Environmental Factors "Resident-specific facility practices that may help improve intake include providing a pleasant dining experience..."</p> <p>Resident #2 was admitted to the facility on 10/31/13 with diagnoses including Alzheimers disease, acute kidney failure, closed fracture and chronic airway obstruction.</p> <p>Resident #2's 5/19/14 quarterly MDS assessment documented: Severely impaired cognitively. Weight loss of 5% in last month or loss of 10% or more in past 6 months. Therapeutic diet.</p> <p>During an observation on 7/7/14 at 1:18 p.m. CNA #7 was assisting the resident to eat. The CNA would pause after each bite and wait at least 10 seconds before offering another bite to the resident. The resident was quiet during the meal. The resident was observed to eat approximately 90% of his meal.</p> <p>During an observation of the mid-day meal on 7/8/14 at 12:30 p.m. LN #6 was observed assisting Resident #2 to eat. LN#6 would give a bite of food to the resident, wait less than 5 seconds and again offer the resident a bite. The LN was also tapping the resident's stomach asking him if he was full, stating 1 more bite and,</p>	F 325	<p>-Continued</p> <p>-Caregiver staff will be audited during meal times to make sure they are taking their time while feeding residents and not rushing them by the UM weekly x4, then monthly x3. Start date 8/11/2014.</p> <p>-The results of the audit will be given at the monthly QA meeting x3 months.</p> <p>-Completion date 8/15/2014.</p>		

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F 325	Continued From page 29 "that's good stuff. The LN was observed to be offering bites while making these statements and offering bites in quick succession. The resident became agitated as demonstrated by moaning, verbal utterances, and moving in his wheelchair. The Meals and Fluids Detailed Entry report documented the resident ate 75% of the meal.  During an observation of the mid-day meal on 7/9/14 at 12:05 p.m. CNA #11 was observed assisting the resident to eat. The CNA would offer the resident a bite and pause at least 10 seconds before offering another bite. The CNA would talk to the resident in a calm, quiet manner. The resident consumed 100% of his meal.  After the above observation, at 1:07 p.m. CNA #11 was asked if the resident usually ate all of his meal. She responded, "If you take time with him he will eat, you just got to do it on his terms."  The Administrator and the DON were informed of the above concern on 7/9/14 at 5:45 p.m. The facility provided no further information.	F 325			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION  The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident received adequate hydration. This was true for 1 of 8 sampled residents (#6).	F 327	-Resident #6 will be offered fluid every time a staff member enters their room.  -All residents have the potential to be affected. All caregiver staff were in-serviced on fluid intake and offering fluid to all residents when they enter their rooms on 8/6/2014.		

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F 327	<p>Continued From page 30</p> <p>This failure had the potential to cause physical harm if the resident experienced thirst, urinary tract infections and catheter drainage problems. Findings include:</p> <p>Resident #6 was admitted to the facility on 10/24/14 and readmitted on 8/11/11 with diagnoses which included senile dementia, muscle weakness and adult failure to thrive.</p> <p>The resident's 12/26/13 Care Plan for an Indwelling Catheter included an intervention to encourage fluids frequently throughout the day and when awake at night.</p> <p>During the initial tour observation on 7/7/14 at 9:30 a.m. a 380 ml (milliliters) glass full of water was observed to be on the residents night stand. The resident was not able to reach the water. On 7/7/14 at 1:13 p.m. the glass was still full and at 1:55 p.m. CNA #7 and CNA #2 were observed as they provided cares to the resident. The CNAs were not observed to offer the resident a drink of water. At 2:29 p.m. LN #12 was observed leaving the resident's room. The resident's water glass was observed to contain at least 350 mls. At 3:20 p.m. the glass was observed to contain at least 350 mls.</p> <p>During observations on 7/8/14 at 6:30 a.m. and at 7:10 a.m. the resident was observed in her room and the water glass was full. At 7:40 a.m. the resident was observed to have red tinged urine in her catheter and the water glass was still full. At 7:45 a.m. the resident was taken to a table in the dining room. Resident #6 did not have a drink placed in front of her, however, 4 other residents in the dining room were offered drinks. At 8:12 a.m. the restorative aide gave the resident a 120</p>	F 327	<p>-Continued</p> <p>-All staff will be audited to make sure they are offering water to residents when they answer call lights by the infection control nurse weekly x4, then monthly x3. Start date 8/11/2014.</p> <p>-The results of the audit will be given at the monthly QA meeting x3 months.</p> <p>-Completion date 8/15/2014</p>		

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F 327	<p>Continued From page 31</p> <p>ml glass of juice. Resident #6 drank 60 mls of the juice, took a few bites of food and then drank the rest of the juice. The resident was then given a 240 ml glass of water and drank about 210 mls of the water. The restorative aide was asked if the resident had a special diet. She replied the resident received mechanical soft food and regular liquids, but did not mention fluids were to be encouraged. At 8:10 a.m. on 7/8/14 the resident was observed asleep in her bed, the water glass was full.</p> <p>On 7/9/14 at 9:15 a.m. the resident's water glass was observed to be full. CNA #10 and CNA #13 assisted the resident to bed, but did not offer a drink to the resident. A strong odor was observed in the room and the resident's urine was observed to be deep red in color. CNA #10 stated the urine was "not always purple... the room stinks because of the catheter." At 11:45 a.m. the resident was sitting with other resident's by the television in the common area. A urine odor was emanating from resident #6. At 12:20 p.m. the resident was observed sitting in the dining room but did not have anything to drink in front of her. At 12:30 p.m. she was given apple juice and by 12:33 p.m. she had drunk all of the apple juice. The restorative aide assisted the resident to eat and the resident stated she could not lift the 240 ml glass of water. The restorative aide brought a 120 ml glass of water to the resident, the resident then drank at least 60 mls of water and 100 mls of milk. At 2:20 p.m. LN #6 was observed in the resident's room and stated she had just flushed the resident's catheter. As she left the room LN #6 told the resident to drink more water but did not offer the resident a drink. At 3:15 p.m. CNA #15 and CNA #16 were observed leaving the room and stated they had just helped the resident</p>	F 327		

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F 327	<p>Continued From page 32</p> <p>out of bed. The resident's water glass was observed to be full. CNA #14 was observed refilling the water for the resident, but stated she had not "got to" resident #6's room.</p> <p>On 7/10/14 at 8:20 a.m. the resident was observed being assisted to eat by the restorative aide. The resident's 120 ml juice glass and 240 ml water glass were empty. The resident's catheter bag tubing was observed to be clear. The resident was assisted to her room and was noted to have approximately 120 mls of water in the glass. The glass was refilled at 10:00 a.m. and still had approximately 210 mls at 10:45 a.m.</p> <p>On 7/10/14 LN#4 stated when staff are providing cares, to all residents, they (staff) should offer fluids to everybody. Additionally LN #4 stated all residents should have fluids to drink when they are waiting to be served their meals. LN #4 also stated the urine smell could possibly be from a lack of fluid intake. When asked about the care plan the LN stated it should include measuring the resident's intake of fluids.</p> <p>The Interdisciplinary Progress Notes ((IPN) documented: 7/7/14 at 4:35 a.m. - " conts (continues) this shift with blood in urine. Res (resident) fluids increased..." 7/7/14 at 12:10 p.m. - increased fluids encouraged 7/7/14 at 11:30 p.m. - "Cath flush ...fluids encouraged." 7/8/14 at 4:30 a.m. - "...fluids given 30 mls, fluids continued to be encouraged." 7/8/14 - 2:00 p.m. - "...Foley tubing remains dk (dark) hematuria with tubing being a purple tinge color. Fluids encouraged."</p>	F 327		

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F 327	Continued From page 33 7/8/14 at 11:45 p.m. - "... dark hematuria in color urine.....Fluids encouraged." 7/9/14 at 5:30 a.m. - The note documented the resident was given 300 mls of water for the shift.  The above notes all documented fluids were to be encouraged, however only 2 of the notes documented the resident was given fluids.  On 7/10/14 at 5:45 p.m. the Administrator and the DON were informed of the above concern. The facility provided no further information.	F 327			
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; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure oxygen was administered per physician orders. This was true for 2 of 12 (#s 2 and 4) sample residents. This failure created the potential for more than minimal harm when both residents went without oxygen for an unspecified amount of time, when Resident #2 was found with	F 328	-Residents #2 & 4 oxygen tank deficiencies were corrected.  -All residents with oxygen have the potential to be affected. All caregiver staff will be in-serviced on oxygen tanks on 8/6/2014 & 8/8/2014.  -CNA's will check oxygen tanks during room rounds every shift and LPN's will make random checks throughout the day.  -Residents with oxygen tanks will be audited by the infection control nurse weekly x4, then monthly x3. Start date 8/11/2014.  -The results of the audit will be given at the monthly QA meeting x3 months.  -Completion date 8/15/2014.		

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F 328	<p>Continued From page 34</p> <p>his portable oxygen tank turned off, and Resident #4 was found with her portable oxygen tank empty.</p> <p>1. Resident # 4's physicians order dated 11/16/13, documented, "Oxygen at 1 to 4 liters per minute via nasal cannula to maintain a sat[uration] at 90% or greater, may titrate as necessary."</p> <p>On 7/8/14 at 1:05 PM, Resident #4 was observed in one of the common areas of the facility. Her nasal cannula was in position and the portable oxygen was turned on and set at 2 liters, however the gage indicated the tank was empty.</p> <p>When Unit Manager #4 was informed of the empty oxygen tank on 7/8/14 at 1:05 PM, he tested it and stated, "It is empty; I will go fill it." On 7/8/14 at 1:10 PM Unit Manager #4 measured the resident's oxygen saturation at 91%.</p> <p>On 7/11/14 the Administrator and DON were informed of the above concerns. No additional information provided by the facility.</p> <p>2. Resident #2 was admitted to the facility on 10/31/13 with diagnoses including Alzheimers disease, acute kidney failure, closed fracture and chronic airway obstruction.</p> <p>The resident's 7/1/14 recapitulation Physician Orders included an order for oxygen at 4 liters per minute per nasal cannula to maintain saturation levels at 90% or greater.</p> <p>On 7/8/14 at approximately 7:00 a.m. the resident was observed in the common area with a portable oxygen canister and his nasal cannula on. The resident's oxygen was not turned on. LN #4 was</p>	F 328		



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F 332	<p>Continued From page 36</p> <p>medication dispensing card was: -Furosemide 20 MG 0.5 tablet (10 MG) by mouth 2 times daily. NOTE: The resident was administered 10 MG instead of the 20 MG documented on the Doctor's orders.</p> <p>On 7/8/14 at 10:50 AM, after the surveyor had completed the medication reconciliation of the resident's chart, LN #5 was asked about the medication. LN #5 verified the MAR documented 20 MG. However, the medication card documented, ".5 Tablet (10 MG) by mouth 2 times daily." When UM #4 reviewed the orders he said, the discharge order from the hospital was for .5 tablet at 10 MG, however, the admission order was transcribed incorrectly.</p> <p>2. Resident #16's Physician orders dated July 2014, documented: -Glipizide 5 MG Take by mouth once daily for Diabetes.</p> <p>On 7/8/14 at 7:10 AM, LN #9 was observed administering medications to the resident, however she said the Glipizide was not available at the time of medication pass nor was it available in the PYXIS dispensing machine. LN #9 said the pharmacy usually brought it in the morning and that she would give it to the resident when it came in. At 10:15 AM and 11:50 AM, LN #9 was asked by the surveyor if the morning dose had come yet and she stated, it had not come in yet, at both times.</p> <p>On 7/8/14 at 1:50 PM, LN#9 approached the surveyor and stated the Glipizide had arrived and she was administering the medication at that time.</p>	F 332	<p>-Continued</p> <p>-All admit orders and new Medication orders will be signed by two LN to verify the orders were transcribed correctly to prevent errors.</p> <p>-A medication audit by the UM will be completed weekly x4, then monthly x3. Start date 8/11/2014. The UM will make sure the nurse is following the eight rights of medication administration (listed above) are being followed, that the medication is being ordered following facility procedures and that the medication is available and given within the correct time frame. The UM will also audit the medications on the medication cart to ensure the medications are being ordered and are in place and available when needed.</p> <p>-The results of the audit will be given at the monthly QA meeting x3 months.</p> <p>-Completion date <del>8/15/2014</del></p> <p><i>9/24/14 per telephone conversation with Brent Schneider 10/3/14 @ 11:05 AM</i> <i>A. Anderson</i></p>	

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F 332 Continued From page 37

F 332

On 7/9/14 at 12:15 PM, the DON was interviewed regarding the late medication, which was not administered until 1:50 PM on 7/8/14. The DON acknowledged the late medication was a problem.

On 7/9/14 at 5:45 PM, the Administrator and DON were informed of the issues. No further information was provided.

F 333 483.25(m)(2) RESIDENTS FREE OF SS=D SIGNIFICANT MED ERRORS

F 333

The facility must ensure that residents are free of any significant medication errors.

-Resident #17 received the correct dosage of their medication on 7/8/2014.

This REQUIREMENT is not met as evidenced by:

-All residents have the potential to be affected. All LN's have been in-serviced on the 8 rights of a med pass on 8/8/2014.

Based on medication pass observation, staff interview, and medical record review it was determined the facility failed to ensure a resident was free from significant medication errors. This was true for 1 random resident (#17) observed for medication pass. This deficient practice had the potential for more than minimal harm if the resident experienced confusion, disorientation, cerebral embolism, shock, and/or coma due to an overdose.

-A medication audit by the UM will be completed weekly x4, then monthly x3. Start date 8/11/2014. The UM will make sure the nurse is following the eight rights of medication administration (listed above) are being followed and the medication is available and given within the correct time frame.

Resident #17 was readmitted to the facility on 5/21/12 with multiple diagnoses including hypothyroidism.

-The results of the audit will be given at the monthly QA meeting x3 months.

The resident's July 2014 Physician's Orders included an order with a start date of 5/21/12 for, "Levothyroxine 0.1 MG, Take by mouth once daily on empty stomach for hypothyroidism." Note 0.1

-Two LN's will restock medications in the PYXIS to ensure the accuracy of the medication, dosage and placement into the PYXIS is correct.

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F 333 Continued From page 38  
MG is the equivalent of 100 MCG.

On 7/8/14 at 6:35 AM, LN #5 was observed by 2 surveyors during medication pass. LN #5 obtain the above medication from the PYXIS machine which dispensed two 75 MCG tablets and two 25 MCG tablets of the Levothyroxine and began to administer all four tablets.  
Note: This was 200 MCG which was twice the prescribed dose.

Prior to the administration of the medication, one surveyor stopped the LN from giving the medication. The surveyor asked if the medication dose was correct and the LN agreed the dose was twice the prescribed dosage and stated, "Yup, they were in the wrong place [in the PYXIS machine]."

On 7/8/14 at 6:35 AM, the DON came to the med cart and was informed of the issue. The DON stated she, "I will check it."

On 7/8/14 at 2:00 PM, the Administrator, DON and Corporate Nurse Consultant were informed of the issue. No further information was provided.

F 371 483.35(i) FOOD PROCURE, SS=E STORE/PREPARE/SERVE - SANITARY

The facility must -  
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and  
(2) Store, prepare, distribute and serve food under sanitary conditions

-Continued

F 333 -A medication audit by the DON of the PYXIS will be completed weekly x4, then monthly x3. Start date 8/11/2014. The DON will make sure that two LN's are restocking the PYXIS and that the medication is placed correctly in the PYXIS.

-The results of the audit will be given at the monthly QA meeting x3 months.

-Completion date ~~8/15/2014~~

*9/24/14*  
*per telephone conversation with Brent Schneider 10/3/14 @ 11:05 AM*  
*[Signature]*

F 371

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F 371	Continued From page 39  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure cereal bowls used by residents were free of food debris and able to be sanitized. Also an ice machine scoop was found on an unclean surface. This had the potential to affect many of the residents in the facility, including 12 of 12 (#s 1-12) sampled residents, by creating the possibility for food-borne illness from bacteria remaining on unsanitary surfaces. Findings include:  On 7/7/14 at 9:15 AM during the initial tour of the kitchen, 10 plastic bowls were observed. Upon checking the bowls, 2 out of 10 bowls sampled were found to have flakes of food inside them and 4 out of 10 bowls had scratches inside of them. The Dietary Manager (DM) was present during the observation and stated, "Yes, they got past her [the dishwasher]." Regarding the scratches the DM stated they were, "...from the microwave."  During the initial tour of the kitchen an ice machine scoop was found on a wire shelf instead of the plastic holder near the ice machine. The DM removed the ice scoop and had it cleaned.  The 2009 FDA Food Code, Chapter 4, part 4-2, Design and Construction, Subpart 202.11 Cleanability, indicated, "(A) Multituse Food contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, inclusions, pits, and similar imperfections..." and part 4-7, Sanitization of Equipment and Utensils, Subpart 701.10 Food-Contact Surfaces and Utensils, indicated,	F 371	-Cereal bowls have been replaced with new ones.  -An ice scoop holder has been purchased and is being used.  -An in-service with dietary staff was held on 8/5/2014.  -The cooks will monitor bowls each meal to make sure they do not have defects & the cooks will also monitor the ice scoop to make sure it is stored in the container. This monitoring will occur weekly x4, then monthly x3. Start date 8/11/2014  -The results will be reported in the monthly QA meeting x3 months.  -Completion date 8/15/2014.		



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  07/11/2014
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F 431	<p>Continued From page 41 quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were stored in locked areas and not accessible to residents. This was true for 1 of 2 medication carts, which was left unlocked and unattended in a hallway while medications were being administered. This created the potential for a negative effect for any cognitively impaired and independently mobile residents if they ingested the accessible medications. Findings included:</p> <p>On 7/8/14 at 6:00 AM, during the Medication Pass observation, the surveyor observed LN #5 dispense medications into a medication cup and take the medications into the resident's room to administer to the resident. The LN left the cart unlocked while in the resident's room. Upon returning to the medication cart the surveyor asked the LN if she normally leaves the cart unlocked. LN#5 stated, "Oh was it unlocked. Usually I lock it, or if I can look around and see it."</p> <p>The medication cart contained: Right side 2 top drawers were filled with resident medication dispensing cards. Right side 3rd drawer contained wound care medications and dressings. Left side top drawer contained syringes, insulins and eye drops. Left side second drawer was double locked narcotics. Left side drawers 3 and 4 were over the counter</p>	F 431			

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F 431	Continued From page 42 medications.  On 7/9/14 at 12:15 PM, the surveyor informed the DON of the unlocked cart while the LN was in the resident's room. The DON agreed this was not good practice. No further information was provided.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	-CNA #10 was in-serviced on proper hand washing techniques on 7/8/2014.  -All residents have the potential to be affected. All caregiver staff were in-serviced on proper hand washing techniques on 8/6/2014.  -The Staff Development nurse will now oversee the infection control, and monitoring and tracking staff illness and infections. She will assume these new duties on 8/11/2014.  -The infection control nurse will audit proper hand washing techniques and proper peri care weekly x4, then monthly x3. Start date 8/11/2014.  -The results of the audit will be given at the monthly QA x3 months.  -Completion date 8/15/14		

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F 441	Continued From page 43 professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to: - Ensure proper hand washing was performed while staff provided peri-care to a resident. - Monitor and track staff illness and infections. This was true for 1 of 12 (#3) sampled residents and any staff with an undocumented infection. This failed practice had the potential for more than minimal harm if a resident dependent of staff for cares developed a UTI from improper hand washing and/or residents being placed at risk for infection by an infected staff member.  1. Resident #3 was admitted to the facility with multiple diagnoses to include history of CVA with right sided hemiplegia, aphasia, and osteoarthritis.  The resident's most recent Quarterly MDS dated 4/26/14 coded the following: - Extensive assist of two people for bed mobility, transfers, and toileting. - Functional limitation in upper and lower extremity.  On 7/8/14 at 7:20 AM, CNA #10 was observed with gloved hands to wash the front peri-area of Resident #3. The CNA disposed of the soiled	F 441			

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F 441	<p>Continued From page 44</p> <p>incontinent wipes and with the contaminated gloves assisted the resident to roll over onto her right side. Peri-care was then performed to residents backside. After the CNA cleaned the resident's backside the CNA identified the resident required additional peri-care to her front peri-area and with the contaminated gloves, the CNA wiped the resident's front peri-area. The CNA then applied a new incontinent brief and pulled up the resident's pants. The CNA then removed her contaminated gloves and washed her hands.</p> <p>Note: Resident #3 had been receiving prophylactic antibiotic treatment for chronic UTI's.</p> <p>On 7/9/14 at 5:30 PM, the DNS was interviewed related to the above concern. The DNS stated the CNA should have removed her gloves and washed her hands after providing peri-care for the bowel movement and before providing additional peri-care to the resident's front peri-area. The DNS stated the facility had just provided in-service training for staff on proper handwashing to include: washing hands before applying gloves, after providing peri-care in the front/back, and before dressing residents after providing peri-care. No further information was provided to resolve this concern.</p> <p>2. On 7/8/14 at 2:15 PM, the Infection Control Nurse (ICN) was interviewed regarding infection control policies and procedures. When asked if the facility monitored and tracked staff illness and infections, the ICN stated, "No. I believe that also is [SDC's name]."</p> <p>On 7/9/14 at approximately 3:00 PM, the SDC</p>	F 441			

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F 441	Continued From page 45 was asked if she had a tracking system for employee illnesses and she stated, "No," and she did not always get the information as to why staff were calling off.  On 7/9/14 at 5:45 PM, the Administrator and DON were informed of the issues. No further information was provided.	F 441			

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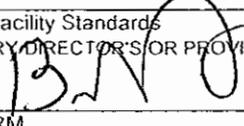
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001330</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/11/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KARCHER ESTATES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>
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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 State licensure and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Sherri Case, BSW, LSW, QIPD, Team Coordinator Lauren Hoard, RN, BSN Susan Gollobit, RN Amy Jensen, RN, BSN</p>	C 000		
C 125	<p>02.100,03,c,ix Treated with Respect/Dignity</p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F241 as it relates to dignity.</p>	C 125	Refer to Plan Of Correction F 241	
C 325	<p>02.107,08 FOOD SANITATION</p> <p>08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Refer to F371 regarding non cleanable surface</p>	C 325	Refer to Plan Of Correction F 371	

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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>9-25-14</b>
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**KARCHER ESTATES, LLC** **1127 CALDWELL BOULEVARD**  
**NAMPA, ID 83651**

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C 325	Continued From page 1 and ice scoop storage.	C 325		
C 342	02.108,04,b,ii Toxics Stored Under Lock and Key  ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F323 regarding cleaning chemical in an unlocked room.	C 342	Refer to Plan Of Correction F 323	
C 644	02.150,01,a,i Handwashing Techniques  a. Methods of maintaining sanitary conditions in the facility such as:  i. Handwashing techniques. This Rule is not met as evidenced by: Please refer to F441 as it relates to handwashing.	C 644	Refer to Plan Of Correction F 441	
C 664	02.150,02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Doctors Quality Assurance/Infection Control Meeting Minutes, it was determined the facility did not ensure the Pharmacist attended the Infection Control Committee. This had the potential to affect all residents, staff and visitors in the facility. Findings included:  On 7/9/14 at 2:15 PM, the Infection Control Nurse	C 664	-No specific residents were identified as being affected by this deficient practice. All residents had the potential to be affected by the pharmacist not attending the infection control meeting. The pharmacist was notified by the administrator and informed he needed to attend the infection control meeting at least quarterly.  -The pharmacist agreed to attend the infection control meeting at least quarterly.	

Bureau of Facility Standards

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C 664 Continued From page 2  
was interviewed. When asked if the Pharmacist attended the Infection Control meetings, she stated, "No. We have been trying to get him to attend, but he doesn't."  
  
Review of the 5/13/14, 6/10/14, and 7/8/14 Doctors Quality Assurance/Infection Control Meeting Minutes attendance sheets documented the Pharmacist signature was not on any of the attendance records.  
  
On 7/9/14 at 5:45 PM, the Administrator and DON were informed of the issues. No other information was provided.

C 664 -The administrator will monitor the attendees of the infection control meeting to make sure all required participants attend the same meeting at least once per quarter. The required members include: the medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services and maintenance services. The monitoring will occur quarterly for three quarters.  
  
*Completion date 8/15/2014*

C 670 02.150,03,a Aseptic/Isolation Techniques  
a. Applied aseptic or isolation techniques by staff.  
This Rule is not met as evidenced by:  
Refer to F441 regarding infection control program and hand washing.

C 670  
  
Refer to Plan Of Correction F 441

C 778 02.200,03,a PATIENT/RESIDENT CARE  
03. Patient/Resident Care.  
a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be:  
This Rule is not met as evidenced by:  
Refer to F 279 as it related to initial care plans.

C 778  
  
Refer to Plan Of Correction F 279

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

C 782

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C 782	Continued From page 3  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	Refer to Plan Of Correction F 280	
C 784	02.200.03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F-309 as it relates to care.	C 784	Refer to Plan Of Correction F 309	
C 787	02.200.03,b,iii Fluid/Nutritional Intake  iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please refer to citatins F325 as it relates to nutritional intake and F327 as it relates to sufficient hydration.	C 787	Refer to Plan of Correction F 325 & F 327	
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 F328 as it relates to oxygen therapy.	C 788	Refer to Plan Of Correction F 328	

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C 790	Continued From page 4	C 790		
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 the prevention of accidents, for example side rail assessment.	C 790	Refer to Plan of Correction F 323	
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 the treatment of UTI's.	C 795	Refer to Plan Of Correction F 315	
C 796	02.200,03,b,xii Rehabilitative Nursing Standards  xii. Rehabilitative nursing current with acceptable professional practices to assist the patient/resident in promoting or maintaining his physical functioning. This Rule is not met as evidenced by: Please refer to F318 as it relates to Restorative Nursing Program.	C 796	Refer to Plan Of Correction F 318	
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders  04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following:	C 798		

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C 798	Continued From page 5  a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F333 regarding medication errors.	C 798	Refer to Plan Of Correction F 333	



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

July 30, 2014

Brent Schneider, Administrator  
Karcher Estates  
1127 Caldwell Boulevard  
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Schneider:

On **July 11, 2014**, a Complaint Investigation survey was conducted at Karcher Estates. Judy Atkinson, R.N., Susan Gollobit, R.N., Amy Barkley, R.N., and Sherri Case, L.S.W., Q.M.R.P., conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006056**

**ALLEGATION #1:**

The complainant stated all of the night shift nurses pre-pour medications.

FILE COPY

**FINDINGS:**

During the investigation the facility's two (2) medication carts were observed on night shift, and the medication pass for night shift was observed.

On July 8, 2014 at 4:45 AM, the surveyors entered the building. The facility's two (2) medication carts were checked for poured medications. None were found. During the 6:30 AM medication pass the Licensed Nurse was observed to dispense all medication at the time they were being given.

Brent Schneider, Administrator

July 30, 2014

Page 2 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the medication carts are always left unlocked on night shift.

FINDINGS:

During the investigation the surveyor entered the building on July 8, 2014 at 4:45 AM. The facility had two (2) medication carts. Both carts were locked at this time. During the early morning medication pass the night shift Licensed Nurse was observed to leave the medication cart open.

The facility was cited at F431 for non-compliance related to the medication cart left unlocked during the medication pass.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated the nurse "borrowed" medications from other residents when a resident ran out. The complainant stated it was all the night shift nurses, to every nurse.

FINDINGS:

On June 8, 2014, during the investigation, the night shift nurse was observed administering medications to residents. The nurse did not have 2 medications available for 2 different residents. For both medications the nurse went to the Pyxis dispensing machine and also checked the medication storage room. On the same day, a day shift nurse was observed to be out of a medication for a resident. This nurse also went to the Pyxis dispensing area and checked the medication storage room. Neither of the nurses were observed to obtain medications from other residents to dispense to the resident that was out of a medication.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Brent Schneider, Administrator

July 30, 2014

Page 3 of 3

The complainant stated a nurse slept on night shift.

FINDINGS:

On June 8, 2014 during the investigation, the surveyors entered the building at 4:45 AM. The night shift nurse was awake and working on charts. Two (2) CNA's were working on the floor and providing cares for residents.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott, R.N.". The signature is written in a cursive style with a large initial "D" and "S".

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

DS/aj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

July 30, 2014

Brent Schneider, Administrator  
Karcher Estates  
1127 Caldwell Boulevard  
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Schneider:

On **July 11, 2014**, a Complaint Investigation survey was conducted at Karcher Estates. Judy Atkinson, R.N., Susan Gollobit, R.N., Amy Barkley, R.N., and Sherri Case, L.S.W., Q.M.R.P., conducted the complaint investigation. This complaint was investigated during the Annual Recertification and Licensure survey on July 7, 2014 to July 11, 2014.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006084**

FILE COPY

ALLEGATION #1:

The complainant stated the family elected to place the identified resident on hospice, with a specific hospice agency on May 24, 2013, and the facility failed to honor the request of the resident and family at the time of the request.

FINDINGS:

The following documents were reviewed:

- The medical records for the identified resident along with two additional residents receiving hospice care;
- Grievances from January 2014 to February 2014 and May 2013 to June 2013;

Brent Schneider, Administrator  
July 30, 2014  
Page 2 of 2

- Physicians Progress Notes for May 24, 2013;
- Hospice Records from May 24, 2013 to June 2013; and,
- Interdisciplinary Notes from May 22, 2013 to May 29, 2013.

The Physician's Progress note dated May 24, 2013 documented, "(###) had been showing significant decline, her cognition decreased, she was disoriented, she is hypoxic. I will not be surprised if she passes away in the next few weeks if natural course progresses's (sic)." The Physician documented the resident had failure to thrive and a referral was sent to the identified hospice agency.

The Interdisciplinary note dated May 24, 2013 documented the following:

- 1730 (###) documented, the resident "Returned from Physician's office (###) order to refer to (###) regarding failure to thrive. Hospice notified by Unit Manger their n (###) will be in to set up their program."
- 1815 (###) documented, "Hospice (###) arrived reviewed chart, started intake paperwork and assessed patient..."

The hospice log in sheet was reviewed and identified the resident was seen by the hospice agency on May 24, 2013.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



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

DS/lj



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FAX 208-364-1886

July 30, 2014

Brent Schneider, Administrator  
Karcher Estates  
1127 Caldwell Boulevard  
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Schneider:

On **July 11, 2014**, a Complaint Investigation survey was conducted at Karcher Estates. Judy Atkinson, R.N., Susan Gollobit, R.N., Amy Barkley, R.N., and Sherri Case, L.S.W., Q.M.R.P., conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006292**

**ALLEGATION #1:**

The complainant stated an identified resident was not given sufficient time to eat his meals.

**FINDINGS:**

Grievances from December 1, 2014 through July 7, 2014 were reviewed.  
Interviews with family members and residents were completed.  
Resident Council Meeting minutes were reviewed from April 2014 through June 2014.  
Observations of meals were completed.  
The identified resident's record was reviewed.

The facility was cited in the 2567 Federal Report at F 325 for not providing a pleasant dining experience and allowing a resident adequate time to eat his meal.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the facility did not know how an identified resident sustained two bruises on his buttock.

FINDINGS:

Incident and accident reports were reviewed for the past 6 months.  
Investigations were reviewed.  
Family and residents were interviewed.

Review of the identified resident's closed medical record documented the resident had bruises to his left buttock of unknown origin on November 28, 2013.

An investigation, dated December 2, 2013 documented the facility had interviewed the staff working with the resident the night the bruises were discovered. The facility was unable to determine what caused the bruises, but determined they may have been caused by the type of wheel chair the resident used. The facility changed the type of wheel chair as a precautionary measure.

Residents at the group meeting, two family members and four residents stated the staff treated them with respect and had never been abusive.

Investigations reviewed documented investigations of unknown injuries and allegations of abuse.

The complaint was substantiated as it was determined the resident did have an unknown injury, however, the facility was in compliance as they had investigated the allegation and implemented precautionary measures.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated the resident had been referred to hospice services but his medical

condition did not meet the requirements for the services.

FINDINGS:

Records for the identified resident and two other residents receiving hospice services were reviewed. The residents currently receiving hospice services had been assessed by the hospice agency and qualified for services. The medical record for the identified resident included an informed consent, which was signed by the resident's family member, and included an assessment by the hospice agency, which documented he qualified for hospice services.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the resident's nails were never clean or clipped and he was not shaved daily.

FINDINGS:

Observations of residents were completed from July 7, 2014 through July 10, 2014 for all shifts. Residents were observed upon rising in the morning to have their face washed, hair combed, shaved and teeth brushed. All residents were observed to be clean, shaven and well groomed with their nails clipped. Eight residents' medical records were reviewed and documented the residents were groomed on a regular basis. Resident's attending the council meeting did not express concerns regarding bathing or grooming. Grievances reviewed did not include any concerns regarding bathing or grooming.

During an observation of a resident currently receiving hospice services the nurse evaluated the resident's toenails and stated he was going to let the podiatrist cut the nail. The nurse stated he cuts the resident's fingernails and toenails if needed, but because the resident's big toenail was lifting he was going to have the podiatrist cut the nail.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated the identified resident was too hot and covered with blankets.

FINDINGS:

Grievances reviewed from December 2013 through July 8, 2014 did not contain any concerns regarding the temperature of the resident rooms. Ten residents met with the surveyors and stated the room temperature was hot or cold off and on but did not occur frequently. The residents stated the temperature of the facility had improved in the past year. Four residents were interviewed and two family members interviewed did not voice any complaints regarding the temperature of their room or common areas in the facility.

The building was a comfortable temperature during the survey from July 7, 2014 through July 11, 2014.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant stated call lights were disconnected preventing residents from requesting help and were not toileted or offered a bedside commode.

FINDINGS:

Grievances reviewed from December 2013 through July 8, 2014, did not have concerns regarding call lights being disconnected. Ten residents attended the meeting with the surveyors, but did not voice concern regarding the call lights being disconnected. The residents stated sometimes staff were busy during meal times but they would toilet the residents. The residents did not voice any concerns regarding being offered a bedpan or bedside commode.

During observations from July 7, 2014 through July 10, 2014 staff were observed to answer call lights within twelve minutes. Resident's rooms were observed to always have working call lights. Commodes were observed in residents' rooms and were offered to the residents. Residents were encouraged to go to the toilet but were allowed to use a bedpan if they requested.

The Director of Nursing stated the facility encouraged the residents to go to the toilet but they were allowed to use a bedside commode or bedpan if they requested.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Brent Schneider, Administrator  
July 30, 2014  
Page 5 of 5

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott, R.N.". The signature is written in a cursive style with a large initial "D" and "S".

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

DS/lj