



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 2427

July 31, 2013

Debra J. Mills, Administrator
Avamere Transitional Care & Rehabilitation - Boise
1001 South Hilton Street
Boise, ID 83705-1925

Provider #: 135077

Dear Ms. Mills:

On **July 19, 2013**, a Recertification and State Licensure survey was conducted at Avamere Transitional Care & Rehabilitation - Boise by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete Date to signify when you allege that each tag will be back in compliance. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.**

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After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, 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 13, 2013**. Failure to submit an acceptable PoC by **August 13, 2013**, may result in the imposition of civil monetary penalties by **September 3, 2013**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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

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effective date of the remedy when determining your target date for achieving compliance.

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

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

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

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

Imposition of a CMP, related to the serious nature of the findings cited at F309.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 19, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, 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.

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

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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 13, 2013**. If your request for informal dispute resolution is received after **August 13, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626.

Sincerely,



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

LT/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135077	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/19/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</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 the resident assessment accurately reflected the resident's status. This was true for 1 of 13 (#5) sampled residents. The assessment inaccurately documented the resident's fall status. Findings include:</p> <p>Resident #5 was admitted to the facility on 1/30/13 with multiple diagnoses including respiratory failure and muscular wasting and disuse atrophy, not elsewhere classified.</p> <p>The resident's Quarterly MDS dated 5/9/13 documented the resident did not have a fall since her prior MDS assessment dated 2/13/13.</p> <p>The resident's Resident Event Report Worksheet signed and dated on 4/16/13, documented the resident had a fall without injury on that day.</p> <p>The MDS coordinator was interviewed on 7/17/13 at 2:40 PM regarding the fall issue. She acknowledged the MDS should have documented the fall and stated, "I can't believe it...I'll have to make a modification correction."</p> <p>On 7/18/13 at 1:30 PM, the Administrator, DON, and Regional Director of Operations were informed of the issue. No further information was provided by the facility.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Arnold Rosling, RN, BSN, QMRP Karla Gerleve, RN Debbie Bernamonti, RN</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BLE = Bilateral Lower Extremity cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing D/C = Discontinue D/T = Due To FWW= Front Wheeled Walker HX = History IDT = Interdisciplinary Team IT = Ischial Tuberosity L = Left LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NP = Nurse Practitioner OT = Occupational Therapy P/U = Pressure Ulcer PRN = As Needed PT = Physical Therapy Q = Every R = Right RNA = Restorative Nurse Aide R/T = Related To</p>	F 000	<p>The Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Avamere Transitional Care & Rehab - Boise does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p style="text-align: center;">RECEIVED AUG 12 2013 FACILITY STANDARDS</p>	8-15-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 8/8/13

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 TBI = Tramatic Brain Injury T/X = Treatment W/C = Wheelchair	F 000	F-156	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156	I. Identified Resident Resident # 7 received and acknowledged an addendum to the admission packet that addressed a resident's right to self-administer medications if deemed appropriate by the IDT Members and the right to share a room with a spouse if desired. Resident # 14 no longer resides in the facility. II. Other Residents An audit was done to identify other residents residing in the facility that were admitted after 3/31/13. Those residents have also been provided the addendum informing them of their right to self-administer medications if deemed appropriate by the IDT Members and the right to share a room with a spouse if desired. III. Systemic Change Facility's Admission Coordinator (AC) was educated regarding the addendum of the two resident rights and need to inform residents of these rights at the time of admission to the facility. Education provided by facility's Administrator. IV. Monitoring The Administrator is responsible to oversee that residents are fully informed of their rights at the time of admission. The administrator or designee will audit three to five admission records a week for the next three months to validate the record reflects appropriate education of resident's rights. The findings of these audits will be presented to	8-15-13

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F 156	<p>Continued From page 2 under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and</p>	F 156	<p>the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and further recommendations.</p>		

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F 156	<p>Continued From page 3</p> <p>applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's admission agreement and staff interview, it was determined the facility did not ensure residents were fully informed of their rights at the time of admission. This was true for 2 of 13 sampled residents (#7 & #14) and any resident admitted to the facility after 4/1/13, when a new parent company admissions packet was introduced. Findings include:</p> <p>The facility's admission agreement was reviewed on 7/16/13 as part of the standard survey process. The agreement did not include language informing residents of the right to share a room with his or her spouse and the right to self administer medications if the interdisciplinary team determined the practice was safe.</p> <p>On 7/16/13 at 2:10 PM, after a review of the admission agreement, the Admissions Coordinator said she found the self administration right in the nursing assessment, but it was not in the admissions agreement. She also commented on the spousal roommate right and stated, "We couldn't find it, we've always offered it"</p> <p>On 7/16/13 at 3:50 PM, the Administrator gave the surveyor an addendum created in response to the surveyor inquiry, which included the two rights listed above to be included in the admission</p>	F 156		

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F 156	Continued From page 4 agreement going forward.	F 156			
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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 §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 staff interview and record review, the facility failed to ensure a resident's care plan addressed current cancer treatment at a tumor center. This was true for 1 of 13 (# 4) sampled residents. Not having a care plan for such a need, potentially could harm residents because staff would not have directions on how to provide for this need. Findings include: Resident #4 was admitted to the facility on</p>	F 279	<p>F-279</p> <p>I. Identified residents</p> <p>Resident # 4's Care Plan has been reviewed and revised to reflect the resident's current status as it relates to Cancer Treatment at the Tumor Center</p> <p>II. Other Residents</p> <p>Other residents receiving outside services have been identified through chart review. Those residents care plans have been reviewed and revised as necessary to reflect outside services.</p> <p>III. Systemic Changes</p> <p>Facility's IDT Members have been re-educated on necessity of care plan reflecting services provided outside the facility. Education provided by facility's Staff Development Coordinator (SDC).</p> <p>IV. Monitoring</p> <p>The facility's Administrator) is responsible to oversee that residents' Care Plans accurately reflect external services resident is receiving. DNS or Designee will audit charts of residents with physician orders for external services. Audits will be conducted monthly for three to five residents for three months. Results of audits will be documented and presented to facility's QAPI Committee for analysis and further recommendations.</p>	8-15-13	

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F 279	Continued From page 5 11/23/12 with diagnoses of depressant disorder and breast cancer. The residents's 3/21/13 physicians progress notes documented the resident was receiving active treatment at a local tumor center. A comprehensive care plan for the resident's visits to the tumor center and the treatments she was receiving could not be located in the medical record. The DON was interviewed on 7/17/13 at 1:15 p.m. and indicated the resident was receiving treatments to include chemotherapy outside the facility. The DON was not aware there was no care plan and was not able to locate one in the medical record.	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	F-280 I. Identified residents Residents # 5 has been reassessed and care plan reviewed and revised as appropriate related to toileting needs. Resident # 1's care plan has been reviewed and revised to accurately reflect resident's indwelling catheter status. II. Other Residents Other residents who have sustained a fall in last three months have been identified. Those residents' care plans have been reviewed to validate post fall interventions are reflected. Current residents with physician orders for indwelling catheters have been identified through physician orders. The care plans for identified residents have been reviewed and revised as needed to accurately reflect the type of indwelling catheter.	8-15-13	

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F 280	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to revise care plans for 2 of 13 sampled residents (#5 & #1). The care plans did not reflect revisions for a resident's toileting needs and appropriate catheter care when the type of catheter was changed. This had the potential to result in harm if the residents did not receive appropriate care due to lack of direction in the care plan. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 1/30/13 with multiple diagnoses including respiratory failure and muscular wasting and disuse atrophy, not elsewhere classified.</p> <p>Resident #5's Resident Event Report Worksheet documented a fall on 5/21/13 with a IDT (Interdisciplinary Team) Review note which documented, "Upon investigation, pt's [patient's] call light was within reach but was not on." It also documented an approach for the resident, "Patient offered toileting Q [every] 2 hrs while awake." (Note: During record review, this approach was not found on the care plan.)</p> <p>On 7/18/13 at 8:35 AM the Staff Development Coordinator and MDS Coordinator were interviewed regarding the care plan issue. The MDS Coordinator stated, "It should be on the toileting care plan." She then looked through the care plan and stated, "It's not there, sorry."</p> <p>On 7/18/13 at 1:30 PM, the Administrator, DON,</p>	F 280	<p>III. Systemic Changes</p> <p>Facility's Licensed Nursing Staff have been re-educated on accuracy of care plans as it relates to Fall Interventions and Indwelling Catheters. Education provided by the facility's SDC.</p> <p>IV. Monitoring</p> <p>The Administrators responsible to oversee that the care plans for residents with indwelling catheters accurately reflect the type of catheter in use and that Care Plans are updated with new Fall Interventions. The DNS or designee will perform a monthly audit for three month of residents with indwelling catheters. In addition, will audit two to three care plans a week for residents who sustained a fall to validate the Care Plan is reflective of Post Fall Interventions. Results of audit will be presented to facility's QAPI Committee for tracking and trending and further recommendations.</p>	8-15-13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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F 280	<p>Continued From page 7</p> <p>and Regional Director of Operations were informed of the care plan issue. No further documentation was provided by the facility.</p> <p>2. Resident #1 was readmitted to the facility on 3/2/13 with diagnoses of unspecified retention of urine, mononeuritis of unspecified site, pneumonitis due to inhalation of food.</p> <p>The 6/8/13 quarterly MDS assessment documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact with a BIMS of 13, - required extensive assistance for transfer, dressing, personal hygiene and bathing, - had a catheter. <p>The 3/31/13 care plan documented the resident had a catheter. On 7/4/13 the problem was changed from a foley catheter to supra-pubic catheter. The interventions for the "foley catheter care" were not changed or updated to reflect the changes to where the catheter was placed.</p> <p>The MDS coordinator was interviewed on 7/18/13 at 12:20 p.m. and did not have an answer as to why all the changes were not made. The Coordinator stated, the facility was in transition to new ownership and facility staff had to complete all care plan revisions by hand because the original care plans were not brought forward to the new company's system, and this had created some problems.</p>	F 280		
F 309 SS=G	<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</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>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 staff interview and record review, the facility failed to ensure physicians orders were followed for a resident receiving Coumadin. As a result, resident #14 was harmed when the facility failed to hold ordered Coumadin and she was emergently transferred to the hospital where she died.</p> <p>The failure to follow physician's orders affected 1 of 15 (#14) sampled residents. Findings include:</p> <p>Resident #14 was admitted to the facility on 6/19/13 with diagnoses of left total knee replacement, after care following joint replacement, muscular wasting and disuse atrophy and bipolar disorder.</p> <p>The resident was admitted with a physician's order for "Coumadin 5 mg by mouth one time a day for prophylactic." The physician ordered a PT/INR [Prothrombin Time and International Normalized Ratio] to be done on 6/21/13. The results were 55.0/4.6 [Normal = 12-13 seconds/2 to 3.] The Nurse Practitioner ordered, on 6/21/13, [Note: No time on the order], the facility to hold the Coumadin 5 mg for two days and then start Coumadin 4 mg on 6/23/13.</p> <p>The DON was interviewed on 7/18/13 at 10 a.m. and the following information was obtained. The facility had converted to computer documentation</p>	F 309	<p>F-309</p> <p>I. Identified Residents</p> <p>Resident # 14 was discharged from the facility.</p> <p>II. Other Residents</p> <p>Other residents with physician orders for Coumadin Therapy have been identified. Those residents' physician orders were verified and an audit was done to validate medications matched physicians orders.</p> <p>III. Systemic Changes</p> <p>Facility's Licensed Nursing Staff have been re-educated regarding validation of physician's orders for Coumadin. Education provided by the facility's SDC.</p> <p>IV. Monitoring</p> <p>The facility's Administrator is responsible to oversee that residents receive the correct Coumadin Dose per MD Orders. The DNS or designee will audit three charts a week for three months to validate that the current orders are accurately reflected on the resident's Electronic Medication Record. The findings of these audits will be presented to the facility's QAPI Committee monthly for three months for further recommendations.</p>	8-15-13

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F 309	<p>Continued From page 9</p> <p>for medications on 6/10/13. The medication hold information on the MAR had to be typed into the computer by nursing staff. LN #2 entered the medication hold order and failed to input the information correctly, as a result the Coumadin was not held. LN #2 input the new order for the Coumadin 4 mg to restart in two days (6/23/13). The "Significant Event Investigation Conclusions & Plan for Prevention" submitted to the Bureau of Facility Standards on July 8, 2013 and the June 2013 MAR documented, Coumadin was routinely administered at 4:00 p.m. daily at the facility. Coumadin 5 mg continued to be administered on 6/21/13 and 6/22/13. On 6/23/13 the resident received both Coumadin 5 mg and Coumadin 4 mg. On 6/24, 25 and 26/13 the resident received 4 mg of Coumadin.</p> <p>On 6/27/13 at 5:20 a.m. a nurse documented, "Pt [Patient] noted by CNA to be incont[inent] of [large] amount of liquid wine tinged stool. Asked this nurse for help. Pt noted [with] copious amount of wine colored loose stool, Hemacult (+) for blood, 911 called and en Route."</p> <p>On 7/18/13 at 10:00 a.m. the DON was interviewed about the resident receiving the medications without following the physician's order. The facility had investigated the error and implemented some corrective actions. The "Corrective Action Plan Time Line" submitted to Certification Bureau on July 22, 2013 documented:</p> <p>"1. Patients on anticoagulants have been reviewed to evaluate their most recent INR and validate their current physician orders. Physicians will be contacted as needed if there are any identified concerns or discrepancies.</p> <p>2. Physician's orders will be reviewed and compared with EMAR [Electronic Medication Administration Record] to validate accurate</p>	F 309		

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F 309	<p>Continued From page 10 medication administration.</p> <p>3. LN will be re-educated on management of known and potential medication errors including investigation, reporting via medication error report and notification of physician and responsible party.</p> <p>4. Nurses have been re-educated and return demonstration / competency validated for management of EMAR system.</p> <p>5. Abnormal lab results will be communicated between nurses during change of shift report. New physician orders will be communicated / reviewed during change of shift.</p> <p>6. LN will be educated on potential drug interactions of anticoagulants and other medications.</p> <p>7. Facility routine / standing orders for Coumadin management will be reviewed with facility LN.</p> <p>8. New physician orders will be validated by second LN within 24 hours after entry into the EMAR system by comparing handwritten or verbal order page / print out to EMAR order." The Administrator and DON, in an interview on 7/17/2013 at 3:30 p.m., stated the facility management company had taken over the facility on April 1, 2013. The policies from the previous company continued to be in place for 90 days. The policy for "Coumadin Dosing" dated 10/31/06, did not have information on what to do for an Electronic Medication Administration Record [EMAR]. During the survey the current EMAR policy was requested from the DON on 7/18/13 at 10:00 a.m. and was not provided. The facility failed to develop a policy and a comprehensive procedure/process for documenting and making changes in the EMAR.</p>	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	<p>Continued From page 11</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide oral care for 1 of 13 (# 13) sampled residents. Poor oral care could potentially harm a resident by creating a medium for bacterial growth and can lead to oral infections.</p> <p>Resident #13 was admitted to the facility on 5/6/13 with diagnoses of pressure ulcer stage IV, Contracture of joint and multiple sites, unspecified infantile cerebral palsy and unspecified intellectual disabilities.</p> <p>On 7/15/13 at 10:30 a.m. during the initial tour of the facility, the resident was found in his bed in his room. The resident appeared to need some oral care. The resident had a whitish/yellow thick buildup of material on his tongue and palate. The resident's lips had a thin crusty appearance and appeared dry.</p> <p>The DON was interviewed on 7/15/13 at 11:00 a.m. about the resident and she stated, the resident required total care for ADLs, and was receiving nutrition via a feeding tube. Further observations on 7/17/13 at 1:50 p.m. and 2:30 p.m. revealed the resident appeared to breathe mostly with his mouth open. The resident responded when someone entered the room by</p>	F 312	<p>F-312</p> <p>I. Identified residents</p> <p>Resident # 13 has been assessed, care plan updated and staff educated regarding resident's current oral care needs.</p> <p>II. Other Residents</p> <p>Other residents with NPO Status were identified. The Care Plans for those residents were reviewed and updated as necessary to accurately reflect resident's oral care needs.</p> <p>III. Systemic Changes</p> <p>Nursing staff have been re-educated on providing more frequent oral care needs for residents with NPO Status. This training included return demonstration. Education has been provided by the facility's SDC.</p> <p>IV. Monitoring</p> <p>The Administrator is responsible to oversee that residents who are NPO receive adequate oral care as needed. DNS or designee will monitor through random rounds three times a week for three months. The findings of these rounds will be presented to the facility's QAPI Committee for review and further recommendations.</p>	8-15-13
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F 312	Continued From page 12 opening his mouth wide and making sounds. On 7/15/13 at 11:00 a.m. the DON was informed of the observation. The resident was observed several times later in the survey to have good oral hygiene care.	F 312	F-314 I. Identified residents Resident # 2 has been reassessed, care plan and physician orders reviewed and updated as deemed appropriate based on resident's current needs related to pressure ulcer care.	8-15-13
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure a resident having pressure sores received necessary treatment and services to prevent new sores from developing. This affected 1 of 13 (#2) sampled residents reviewed for pressure ulcers. Resident #2 was harmed when he experienced a reoccurring Stage II pressure ulcer to his right ischial tuberosity and a Stage II pressure ulcer to his left 4th ring finger. Findings included: Resident #2 was admitted to the facility on 1/31/11 with diagnosis of TBI (traumatic brain injury), dysphagia, quadriplegia, and Diabetes Mellitus (DM). Resident #2 also had an implanted Baclofen pump that was refilled on 5/28/13.	F 314	II. Other Residents Other residents with current pressure ulcers and those identified with resolved pressure areas in last ninety days have been identified.. Those residents have been reassessed by facility's Wound Team to validate appropriate care and services are in place and reflected in the resident's plan of care. III. Systemic Changes Facility's Nursing Staff have been re-educated regarding implementation of physician orders and maintaining care plans for residents with pressure ulcers and/or recently resolved pressure areas. Education was provided by the facility's SDC. IV. Monitoring The Administrator is responsible to oversee those residents with pressure ulcers receive the necessary care and services related to the treatment of pressure ulcers. The DNS or designee will monitor through chart review and observation of three residents a week with a current pressure ulcer and one resident with recently resolved area to validate that the resident is receiving appropriate care and services to	

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F 314	<p>Continued From page 13</p> <p>Resident #2's 3/22/13 Annual MDS documented in part: -BIMS Score of 9, moderately impaired -Total assistance with bed mobility, transfer, locomotion on and off the unit, dressing, eating, toilet use, and bathing -Extensive assistance for personal hygiene -Functional limitations on both sides of his upper and lower extremity -Always incontinent of bowel and bladder -Received Scheduled pain medication -Had 1 stage 2 pressure ulcer -Had a pressure reducing device for chair and bed, was on a turning/repositioning program, -The annual MDS triggered a CAA for pressure ulcer and was checked for care plan, indicating pressure ulcer would be care planned</p> <p>Resident #2's 6/22/13 Quarterly MDS documented in part: -The same information as the above Annual MDS but with a BIMS Score of 11, moderately impaired and -Had a 1 Stage 2 pressure ulcer</p> <p>Resident #2's 6/22/13 "Braden Scale for Predicting Pressure Sore Risk", total score was 15, low risk.</p> <p>A) Resident #2 developed a Stage II pressure ulcer to his left 4th ring finger as follows:</p> <p>Resident #2's "Occupational Therapy Progress Report" documented in part: -2/5/13 "New skin issue with left hand focus of Tx [treatment] was orthotic modification with decrease pressure to wound area..." -2/13/13 "Fitted with orthotic for decreased</p>	F 314	<p>prevent new pressure ulcers. Findings of these audits will be presented to facility's QAPI Committee for three months for trending and further recommendations.</p>	

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F 314	<p>Continued From page 14 pressure on finger per NRS [nursing] request and wound team"</p> <p>Resident #2's Weekly Pressure Ulcer BWAT (Bates Wound Assessment Tool) Report documented weekly entries from 2/7/13 to 6/17/13 and was signed by wound care team licensed nurses. It documented in part: - "2/7/13-Left 4th ring finger, anterior DIP [distal interphalangeal] joint, Stage II, .5x.8x.1, continue with PolyMem Ag QOD (every other day). - "2/11/13-Left 4th ring finger, anterior DIP joint, Stage II, .7x.6x.1, ulcer remains stable, PT eveled [evaluated] and tx with soft brace to left hand, continue current tx per PT." - "2/25/13-pt verbalizes less pain to ulcer when brace applied cont [continue] to monitor + [and] tx ulcer" - "5/27/13-Left 4th ring finger DIP Joint, intact, skin is now intact, continue current tx to protect skin integrity" - "6/3/13-Finger remains intact. Pt conts [continues] to wear finger/palm protector for pressure reduction" - "6/17/13- monitor d/c'd [discontinued] on 6/15/13 area remains intact [with] pink scar tissue"</p> <p>Resident #2's "Resident Progress Notes" documented in part: - "3/7/13 Left ring finger Stg 2 [Stage II] improving" - "5/28/13 Left ring finger now intact will continue with current dressing for protection" - "6/15/13 Left 4th finger has been monitored x 14 days and remains intact. order to d/c on 6/15/13"</p> <p>The facility's care plans were difficult to follow. On 7/16/13 at 2:30 pm, the surveyor asked the MDS Coordinator to explain Resident #2's care plan and how information was discontinued or added</p>	F 314		

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F 314	<p>Continued From page 15</p> <p>to it. The MDS Coordinator stated, "We can't put anything in the computer care plan right now. We are going through computer changes. We normally get a "3 part" from staff and the 3 part counts as an add on to the care plan." The MDS Coordinator said that often the 3 part was not accurate or complete. She said she tried to update the care plan by writing items in and crossing items out, but agreed the care plan was difficult to follow and understand.</p> <p>Note: The "3 part" was a care plan update form that consisted of an original and two duplicates. It was placed on a "Care Plan Update Posting Sheet" and documented problems, goals, and approaches.</p> <p>Resident #2's "Care Plan Update Posting Sheet" documented in part: -2/5/13-"Problem: Left 4th finger ant [anterior] DIP joint superficial skin loss, Goal: Heal [without] complication, Approach: monitor [and] tx as ordered" -2/7/13-"Problem: Stg II P/U [pressure ulcer] left 4th finger-anterior DIP joint, Goal: Resolve without complication, Approach: Tx/ monitor as ordered" -2/8/13-"Problem: #7 Skin integrity, Goal: no pressure areas on left hand/fingers, Approach: apply left hand orthotic when awake, remove Q shift for hygiene, remove e [sic] night for cleaning, ..." -6/1/13-"Problem: R IT Stg II P/U, Goal: Heal [without] complications, Approach: Monitor [and] tx as ordered" -6/15/13-"L [left] 4th finger, Goal: skin intact area resolved, Approach:" (No approaches were identified)"</p> <p>Resident #2's 12/27/12 Care Plan identified the</p>	F 314		

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F 314	<p>Continued From page 16</p> <p>following problems and approaches in part: Problem: "Physical Mobility, Impaired" with approaches listed as follows: -"L neuroflex splint when out of bed" (this information was written in ink and not dated) -"Dependent with turning & repositioning Q 2 hours" -"Gentle PROM [passive range of motion] to bilateral UE [upper extremity] before donning splints on both hands. Wear splints at night up to 12 hours." Note: The care plan documented evidence Resident #2 had hand splints in place before the pressure ulcer on his left 4th ring finger developed on 2/7/13.</p> <p>"Skin Integrity, Impaired: Potential" with approaches listed as follows: -"Report any red or open areas" -"SAR [Skin at Risk] checks Q Week D/T High Risk for Skin Breakdown" -"R palm protector in hand when OOB [out of bed], remove Q shift for hygiene and wash in sink at night and leave for dry" (this information was written in ink and dated 2/8/13)</p> <p>Resident #2's July 2013 Order Summary Report (Physician Recapitulation) documented in part: -04/09/2013 "Left hand orthotic to be placed when awake, off at HS [hour of sleep] and washed two times a day" -04/09/2013 "Resting hand splints to both hands on @ HS for up to 12 HRS every evening shift" -04/09/2013 "Right hand palm protector to be placed when awake, off at HS and washed two times daily" -04/08/2013 "Remove both hand splints/orthotic/palm protector QS [every shift] for hand hygiene then replace every shift"</p>	F 314		

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F 314	<p>Continued From page 17</p> <p>On 7/16/13 at 1:35 pm, the wound team was asked about the wound Resident #2 previously had on his left 4th ring finger. Wound Nurse #7 stated, "It was from pressure." The Wound Nurse #7 said Resident #2 had a hand splint on his left hand before the pressure ulcer occurred. She said the OT made changes to the splint after the pressure ulcer was discovered. Wound Nurse #7 said the wound on Resident #2's left 4th ring finger had healed on 6/15/13.</p> <p>Note: The facility failed to identify that the hand splint was causing a pressure ulcer until it had progressed to a Stage II.</p> <p>B) Resident #2 developed a reoccurring Stage II pressure ulcer to his right ischial tuberosity (IT) and it was documented as follows:</p> <p>Resident #2's "Weekly Pressure Ulcer BWAT Report" documented in part: -"6/1/13 ischial tuberosity R, Stage II, 0.9x0.7, Base is firm with 100% granulation. Edges well defined and adhered and regular. Ulcer presents over pink scar tissue. Multiple preventative in place. See progress note 6/1/13" -"6/9/13 ischial tuberosity R, Stage II, 0.9x0.7, Base firm 100% pink shiny tissue. Edges regular and adhered. Continue current treatment" -"6/17/13 ischial tuberosity R, 0.5x0.3, Ulcer remains stable and decreased in size. Epithelized tissue to margins. Surrounding skin pink and blanching" -"6/21/13 ischial tuberosity R, intact, Continue to monitor area has remained newly intact"</p>	F 314		
	Resident #2's 12/27/12 Care Plan documented in part "Physical Mobility, Impaired" with approaches			

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F 314	<p>Continued From page 18 listed as follows:</p> <ul style="list-style-type: none"> - "Dependent with turning & repositioning Q 2 hours" - "Bariatric long bed D/T [due to] height" - "Evaluate for appropriate seating & or device" - "High Profile ROHO Cushion to wheelchair" <p>Toileting Deficit" with approaches listed as follows:</p> <ul style="list-style-type: none"> - "Check attends Q2 HRS, change PRN, Peri-care after each incontinence" - "Provide incontinence protection: Large attends briefs" <p>"Skin Integrity, Impaired: Potential" with approaches listed as follows:</p> <ul style="list-style-type: none"> - "Report any red or open areas" - "Peri care with PH balanced cleanser after each incontinent episodes" - "Minimize skin exposure to incontinence by using a moisture barrier" - "SAR checks Q Week D/T High Risk for Skin Breakdown" - "Bariatric Bed" <p>Resident #2's July 2013 Order Summary Report (Physician Recapitulation) documented in part:</p> <ul style="list-style-type: none"> - Apply barrier cream QS and PRN every shift and PRN - Bariatric bed in place to help maintain skin integrity - Foam W/C cushion to be used for pressure redistribution <p>Note: Resident #2's care plan documented "High Profile ROHO Cushion to wheelchair"</p>	F 314		
	<p>On 7/16/13 at 12:10 pm, CNA#4 and CNA#8 were observed providing cares for Resident #2. When Resident #2 was rolled to his right side for</p>			

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F 314	<p>Continued From page 19</p> <p>peri-care, the surveyor discovered a small wound on his right buttock. The surveyor asked CNA# 4 if that was an open area? CNA#4 replied, "I haven't seen it that bad lately" and "I will tell the nurse."</p> <p>On 7/16/13 at 1:35 pm, the surveyor met with the wound team regarding Resident #2. The surveyor asked about Resident #2's wound on his right ischial tuberosity. Wound Nurse #7 stated, "that [right ischial tuberosity] is healed and intact, and monitoring was discontinued on 7/2/13." The surveyor informed the Wound Team of the observation of the wound on the resident's buttocks, during resident cares, at 12:10 pm, earlier in the day. Wound Nurse #7 said they were not aware of a present wound on Resident #2's buttocks. The wound team said they would look at the wound and perform an assessment right away. Wound Nurse #6 said, "He's had an issue on his IT before and he has scar tissue in that area." At 1:50 pm the same day, the surveyor observed the wound team as they assessed Resident #2's wound on his right ischial tuberosity. Wound Nurse #6 stated, "That's the same area as before, see the previous scar tissue? That's in the same spot." The surveyor asked if she would call that a Stage II pressure ulcer? Wound Nurse #6 said, "Yes, it's 0.7x1.5 cm and is less than 0.1 cm in depth." Resident #2's broda chair was observed up against the wall at the foot of his bed. The broda chair had a thin vinyl pad on the straps of the seat of the chair.</p> <p>Note: Resident #2 had a broda chair with a thin vinyl pad with a strapping system for the seat. The Physicians Orders documented a foam wheelchair cushion for pressure redistribution was to be used, and the Care Plan documented a</p>	F 314		

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F 314	<p>Continued From page 20</p> <p>High Profile ROHO cushion was to be provided to the wheelchair.</p> <p>Resident #2's "Interdisciplinary Progress Notes" dated 7/17/13 documented in part: "IDT review for event on 7/16/13. Pt [patient] noted to have a stage II p/u to right IT. Pt is dependent on others for all cares and incontinent of bowel and bladder. Resident had denuded skin to same area starting 5/20/13 with partial thickness skin loss. On 6/1/13 wound team notified via SAR to decline to area. Upon assessment, area presented as stage II p/u and was reclassified as such - MD notified and new appropriate treatment was initiated. Resident was care planned for limited seating, last up/first down, and Q 2 hour repositioning was continued as previously care planned. Wound team assumed treatment and monitoring of pressure area and it was noted to be intact on 6/21/13. On 6/26/13 new orders were initiated for Mepilex boarder dressing to protect fragile/friable newly intact scar tissue. Area remained intact and on 7/2/13 treatment/daily monitoring by LN was discontinued. From that time forward daily skin checks by CNA's during ADLs were completed as care planned and were negative for skin impairment to right IT. Last LN skin check was completed 7/15/13 and was negative for right IT as well. Resident currently using Broda 758 specialty w/c with corresponding seat pad and back pad. Seat pad is attached to w/c seat with adjustable straps. Wound team staff member recreated seating shortly with-in .5 hr of event notification and was able to determine that there was enough play in attachment strap that the cushion was non stationary and easily misplaced, allowing for the right IT to become pinched between the specially designed seat straps. Also</p>	F 314		

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F 314	<p>Continued From page 21</p> <p>noted at time of event, that terrycloth seat and back covers were not in place. Straps have been readjusted/tightened and cushion was verified to be stationary. Strap length to be fixated at appropriate length to assure they won't loosen again. Will pursue the possibility of pressure mapping to eval current seating system. Last up/first down seating restrictions reinstated. Treatment initiated and wound team following daily. Terrycloth covers have been replaced to seat and back cushions."</p> <p>Resident #2's "Interdisciplinary Progress Notes" documented as follows: -7/16/13 (1:50 pm), "Wound tx notified of open area to right IT. Upon assessment noted Stg II PU to R IT 0.7x1.5 [less than] 0.1 cm. Wound bed pink, regular edges, peri-wound with recently intact scar tissue red and blanching. Scant serous drainage, NP [nurse practitioner] notified tx orders received and initiated. Patient with paraplegia and dependent for cares and mobility, DM and TBI" Note: On 7/16/13 at 12:10 pm, The surveyor discovered a open wound on Resident #2's right ischial tuberosity while staff were observed performing cares for the resident. The surveyor informed the wound team on 7/16/13 at 1:35 pm of the wound, which they were not aware of.</p> <p>-7/9/13 (1:56 pm), "F/U wound and nutrition. Stg II p/u to right IT remains stable and intact..." -6/25/13 (no time documented), "Right IT with 100% epithelialization. Will continue with protective dressing at this time." -6/11/13 (2:40 pm), "IT wound improving with decreased measurements. Resident continues with limited seating and is to be last up first down for meals".. -6/1/13 (no time documented), "Nursing request</p>	F 314		

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F 314	<p>Continued From page 22</p> <p>to asses right inner buttock denuded skin r/t [related to] decline. Upon assessment noted denuded skin now presents as Stg II p/u 0.9x0.7x [less than] .1. Edges well defined and adhered. Base is firm ulcer present over pink scar tissue that is anatomically marked R IT [ischial tuberosity]"</p> <p>Resident #2's "Resident Progress Notes" documented as follows: -5/20/13, 1:00 pm-"Wound tx notified via SAR of denuded skin to right buttock. Upon assessment red blanchable area of superficial skin loss 0.7x0.5cm edges irregular and adhered. Nursing initiated order to cleans with NS and apply lantiseptic with each incontinence episode. Nursing to continue to tx" -5/20/13, 10:45-"CNA reported to this nurse that patient had an old area to inner right buttocks that opened back up upon assessment area was noted to be 0.2x0.1cm with small amt [amount] of bloody drainage, denuded skin was cleansed with NS [normal saline] and antiseptic applied"</p> <p>Note: Resident #2 had a broda chair with a thin vinyl pad over the seat straps and no terrycloth covers were observed. The Physicians Orders documented a foam wheelchair cushion for pressure redistribution was to be used, and the Care Plan documented a High Profile ROHO cushion was to be provided to the wheelchair.</p> <p>Note: The facility failed to provide the physicians ordered foam wheelchair cushion for pressure redistribution, and failed to ensure Resident #2's broda chair seat straps were properly attached, causing a Stage II pressure ulcer to reoccur to the resident's right ischial tuberosity. Additionally, the facility failed to identify or have any type of</p>	F 314		

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F 314	Continued From page 23 documentation for the Stage II pressure ulcer until the surveyor brought it to their attention. Resident #2 had also received a Stage II pressure ulcer to his left 4th ring finger. On 7/18/13 at 1:30 pm, the Administrator and DNS were informed of the reoccurring Stage II right ischial tuberosity pressure ulcer and the acquired Stage II pressure ulcer on the left 4th ring finger for Resident #2. No information or documentation was provided that resolved the issue.	F 314			
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 range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and medical record documentation, the facility failed to ensure 3 of 13 (#1, 4, and 8) sampled residents received range of motion to prevent their contractures from getting worse. The residents were admitted to the facility with contractures but there was no program in place to prevent them from deteriorating. This had the potential for harm due to lack of range of motion may cause functional deterioration in a residents ability to perform ADL activities. Findings include:	F 318	F-318 I. Identified residents Residents # 1, 4, and 8 have been re-assessed to determine their current needs as it relates to Range of Motion Programs. The care plans for those residents have been reviewed and revised as appropriate. II. Other Residents Other residents with impaired range of motion have been identified through an audit of their most recent MDS. Those residents have been reviewed for range of motion programs. Residents needing a program have been assessed and care plan updated to reflect their range of motion program. III. Systemic Changes The facility's nursing staff have been re-educated regarding providing necessary care and services to maintain a resident's range of motion status by the facility's Staff Development Coordinator.	8-15-13	

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F 318	<p>Continued From page 24</p> <p>1. Resident #1 was readmitted to the facility on 3/2/13 with diagnoses of unspecified retention of urine, mononeuritis of unspecified site, and pneumonitis due to inhalation of food.</p> <p>The 6/8/13 quarterly MDS documented the resident:</p> <ul style="list-style-type: none"> - was cognitively intact with a BIMS of 13, - needed extensive assistance for transfers, dressing, personal hygiene and bathing, - had range of motion [ROM] limitations for both upper and lower extremities. <p>The 3/31/13 care plan for "Comfort - Altered Pain" related to "bilateral lower extremities contractures" and "bilateral upper extremities contractures." All of the interventions for the resident were for the facility to assess and treat pain but there was no plan to provide ROM to prevent further contractures from occurring.</p> <p>On 7/17/13 at 11:00 a.m. the DON was interviewed about failure to have a program for ROM for the resident. She indicated the facility had provided adaptive eating utensils but he was not receiving formal ROM from staff. No further information was provided.</p> <p>2. Resident #8 was admitted to the facility on 1/30/13 with diagnoses of senile dementia, uncomplicated and depressive disorder not else where classified.</p> <p>The 5/29/13 quarterly MDS documented the resident:</p> <ul style="list-style-type: none"> - had severe cognitive impairment with BIMS = 3, - required extensive assistance for transfers, dressing, eating, personal hygiene and bathing, - had ROM limitations to his lower extremities. 	F 318	<p>IV. Monitoring</p> <p>The Administrator is responsible to oversee that residents admitted with contractures receive the appropriate care and services. The DNS or designee will monitor through chart reviews of three residents a week for three months to validate that residents with limited range of motion receives appropriate treatment. The findings of these reviews will be presented to the facility's QAPI Committee monthly for analysis and further recommendations.</p>	

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F 318	<p>Continued From page 25</p> <p>The 3/29/13 care plan documented a problem of "physical mobility - impaired" related to decrease ROM. The facility developed interventions of:</p> <ul style="list-style-type: none"> - "ROM Program: Requires at least 15 minutes of RNA time [each day] 6 - 7 X week to physically assist or verbally cue the resident." - "Avoid causing pain, monitor for signs and symptoms of pain: verbalization, facial grimacing, resistance to motion. Report to charge nurse if noted." - "[Passive]ROM for the following joints: bilateral lower extremity, bilateral/gastroc[nemious] stretches." <p>The above approaches had lines drawn through them and noted, "DC'd" without a date.</p> <p>On 7/17/13 at 11:00 a.m. the DON was asked when and why the ROM was discontinued. On 7/17/13 at 2:00 p.m. the DON responded the RNA program was discontinued on 6/5/13 and the CNA's were to be doing ROM and stretching during cares. There was no documentation to show the CNA's were doing this and no documentation on what level of contractures the resident had. No further information was provided.</p> <p>3. Resident #4 was readmitted to facility on 11/23/12 with diagnoses of osteoporosis, anemia, restless leg syndrome, urge incontinence, history of urinary tract infections, depressive disorder, persistent mental disorder, and metastatic carcinoma of breast to brain.</p>	F 318		
	<p>The 4/10/13 quarterly MDS documented the resident:</p> <ul style="list-style-type: none"> - had moderate cognitive impairment BIMS=9, 			

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F 318	<p>Continued From page 26</p> <ul style="list-style-type: none"> - required assistance with transfers, dressing, personal hygiene and bathing, - had limited ROM of the upper and lower extremities. <p>The comprehensive care plan dated 1/21/13, documented a problem of, "physical mobility, impaired related to bilateral hip/knee flexors." The approaches were:</p> <ul style="list-style-type: none"> - "Exercise group for upper & lower strengthening & [active] ROM program: Requires at least 15 minutes of nursing assistant time each day to physically assist or verbally cue the resident." <p>The resident was in the Restorative Nurse Aide [RNA] program. The nursing goals were:</p> <ul style="list-style-type: none"> - "Exercise group for upper & lower strengthening & [active] ROM program: Requires at least 15 minutes of nursing assistant time each day to physically assist or verbally cue the resident." - "Avoid causing pain, monitor for signs and symptoms of pain: verbalization, facial grimacing, resistance to motion. Report to charge nurse." - "Encourage resident to perform all motions slowly and smoothly." - "6 - 7 x/week." <p>The RNA documentation was reviewed for June and July 2013. The documentation showed: The resident in June 2013 had 30 opportunities for group exercise but did not attend 15. The resident in July 2013 had 15 opportunities for group exercises but did not attend 10 of them.</p> <p>The resident indicated during interview on 7/15/13 that she preferred to stay in bed until 9:30 or 10:00 a.m. The facility had failed to develop an alternate plan for ROM of the residents upper and lower extremities.</p>	F 318		

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F 318 F 323 SS=G	Continued From page 27 The DON was interviewed about the resident not attending exercise group on 7/18/13 at 9:45 a.m. No further information was obtained. 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, resident interview, and staff interview, it was determined the facility failed to provide adequate supervision to prevent falls. This was true of 1 of 9 residents (#7) sampled for falls. Resident #7 was harmed when she fell and received a right ankle fracture requiring surgical intervention. In addition, peri-wash, sunscreen & sani-wipes were observed in an unlocked linen closet, and deodorant, shampoo, lotion, peri-wash and hand sanitizer were found in an unlocked cupboard in an unlocked storage room. This had the potential of harm to the cognitively impaired residents who resided in the facility and who may have wandered into these areas using the items for other than their specific purpose. Findings included:	F 318 F 323	F-323 I. Identified residents The linen closet and cupboard identified during survey have been fit for a lock for safe storage of care items. Resident # 7 has been re-assessed and care plan reviewed for appropriate interventions related to fall prevention. II. Other Residents Facility rounds have been conducted to identify other storage areas for care items that were unlocked. Measures have been put into place to secure these areas to prevent access by cognitively impaired residents. Residents sustaining two or more falls in the last three months have been identified and reviewed to validate that appropriate care and services are in place for fall prevention. III. Systemic Changes The facilities IDT Members have been re-educated on implementation of appropriate interventions for fall prevention.	8-15-13
	1. Resident #7 was admitted to the facility on 8/28/12 and readmitted to the facility on 5/16/13			

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705	
(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 323	<p>Continued From page 28</p> <p>with diagnosis aftercare for a right ankle fracture, difficulty walking, muscular wasting, edema, neurogenic bladder with a indwelling foley catheter. The resident experienced a fall on 5/10/13 in the facility and was admitted to the hospital on 5/12/13 for a right ankle fracture.</p> <p>Resident #7's 2/28/13 Quarterly MDS documented in part: -BIMS Score of 15, cognitively intact -Extensive assistance of one person for transfers, bathing and toileting -Limited assistance of one person for walking in the corridor and dressing -Independent for locomotion on and off the unit -Supervision and set up for personal hygiene -Functional limitation impairment on one side, lower extremity -Occasional pain and received PRN pain medication</p> <p>Resident #7's 5/23/13 significant Change MDS, documented in part: -BIMS Score 15, cognitively intact -Total dependent of one person for transfer and toileting -Walk in Corridor did not occur -Limited assistance of one person for locomotion on the unit and hygiene -Extensive assistance of one person for locomotion off the unit and dressing -Extensive assistance of two persons for bathing -Functional limitation impairment on both sides, lower extremity -Occasional pain and received PRN pain medication</p> <p>Resident #7's 3/20/13 Care Plan documented in part:</p>	F 323	<p>In addition, the facility's nursing staff were re-educated on the proper storage of care items to prevent access by cognitively impaired residents.</p> <p>Education was provided by the facility's SDC.</p> <p>IV. Monitoring</p> <p>The facility's Administrator is responsible to oversee that the environment remains free of accident hazards and each resident receives adequate supervision to prevent avoidable falls. The Administrator or designee will conduct rounds three times a week to monitor for potential safety hazards. In addition, the DNS or designee will conduct three chart reviews a week to validate that appropriate interventions are in place for fall prevention. These audits will be conducted for three months and findings of these audits will be presented to the facility's QAPI Committee for trending and further recommendations.</p>	

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

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F 323	<p>Continued From page 29</p> <p>"Potential for trauma related to fall risk, history of falls, unsteady gait : Will be free from falls with injury"</p> <p>Approaches included:</p> <p>- "9/11/2012 PT [patient] has long history of getting out of bed or chair down to the floor and then standing. This was her prior level of function and continues to do so despite attempts to educate or redirect."</p> <p>- "8/28/2012 Anticipate needs with: offer fluids with each care contact, personal items within reach, sharp edged items away from bed, nonstationary items away from bed, eliminate room clutter, non skid socks."</p> <p>- "1/29/2013 Falling Star Program."</p> <p>"Self Care Deficit: ADL's related to history of falls and R ankle fx [right ankle fracture]"</p> <p>"Will be able to transfer self to and from w/c independently, will ambulate 150 ft [feet] to 250 ft with supervision using FWW [front wheeled walker], Will retrieve clothing from closet independently."</p> <p>Approaches included:</p> <p>"5/14/13 Right mobility bar to assist with bed mobility."</p> <p>"5/14/13 Transfer with mechanical lift NWB R LE [non weight bearing right lower extremity]."</p> <p>"5/16/13 WBAT [weight bearing as tolerated]"</p> <p>Note: Resident #7 received a right ankle fracture from a fall in the facility on 5/10/13. She was hospitalized and returned to the facility on 5/16/13. Resident #7 was non-weight bearing status when she returned to the facility. The update to the care plan on 5/28/13 documented the resident required a mechanical lift for transfers, but there was also an approach on the care plan dated 5/16/13 that documented the resident was weight bearing as tolerated. The</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>resident's care plans were difficult to follow and had multiple cross outs. It was difficult to determine when and what items were added or discontinued from the care plan. However, the care plans did not include any interventions about increasing the supervision for Resident #7 and the facility did not provide documented evidence of increased monitoring or supervision for Resident #7. The facility failed to provide documented evidence Resident #7 was monitored daily for falls and lack of falls, as directed by the facility's "Falling Stars Policy". It could not be determined that the Falling Stars Program was effective for Resident #7.</p> <p>NOTE: Federal guidance at F323 indicated, "...'Supervision/Adequate Supervision' refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is defined by the type and frequency of supervision, based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident..."</p> <p>There were 12 "Resident Event Report Worksheets" for Resident #7 from her admission on 8/28/2012 until her fall with an ankle fracture on 5/10/13. They were summarized in part as follows: -9/19/12 at 6:30 am-Resident #7 got out of bed and ambulated to her closet with a FWW. She retrieved her clothes from the closet and walked back to her bed, lost her balance and fell, leaving her FWW at the closet. The PI (Performance Improvement) recommendations were to continue PT and OT.</p>	F 323		

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F 323	<p>Continued From page 31</p> <p>-12/5/12 at 6:15 pm-Resident #7 stood up to close the blinds in her room and fell to her knees while holding on to a stationary chair. The PI recommendations were to encourage resident to request assistance and to modify the pull string to the blinds.</p> <p>-12/8/12 at 9:40 am-Resident #7 was assisted with her shower in the shower room. Resident #7 stood up so that her buttocks could be washed. When the CNA tried to assist Resident #7 back into the shower chair, the shower chair moved and Resident #7 was assisted to the floor by the CNA. The shower chair was found to have a broken lock on the left rear wheel. The PI recommendations were to educate staff, repair the shower chair, and maintenance to check all other shower chairs.</p> <p>-12/12/12 at 3:00 pm-Resident #7 was attempting to empty her catheter bag into the toilet in the bathroom when she lost her balance. She went down slowly to the floor. The PI recommendations were to refer to PT and OT.</p> <p>-1/28/13 at 2:50 pm- Resident #7 fell in her room and was found sitting on the floor. Resident stated she was attempting to push her wheelchair out of her way to go to bed. The PI recommendations were to add Resident #7 to the "Falling Stars Program".</p> <p>-2/8/13 at 3:30 pm- Resident #7 said she got out of her wheelchair and crawled under her bed to get the alarm clock. PI recommendations were were none, and Resident #7 had been educated to call for assistance when retrieving items off the floor.</p> <p>-3/7/13 at 2:15 am- Resident #7 said she was trying to put her pants on by herself and sat down on the floor. Resident #7 was found on the floor with her back against the head of her bed. PI recommendations were to have the Nurse</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>Practitioner review and discontinue Ambien and increase the Trazadone.</p> <p>Note: Resident started Ambien on 3/4/13 and was discontinued on approximately 3/7/13, and Trazadone was increased from 50 mg to 100 mg at that time per Progress notes dated 3/7/13.</p> <p>-3/11/13 at 9:20 pm- Resident #7 utilized her call light but stood up and was reaching to lower her window blinds when she lost her balance and fell. PI recommendations were to x-ray the right ankle, perform a UA, and check the cord on the blinds. The x-ray revealed there was no fracture to Resident #7's right ankle. Resident #7 received an ankle strain and began PT.</p> <p>-4/30/13 at 3:30 pm- Resident #7 stood up from the wheelchair and was attempting to get clothes out of her closet. She lost her balance and lowered herself to the floor. The call light was not on. PI recommendations were not listed but the report indicated that therapy services would continue for increased strengthening and "resident continues to attempt to maintain independence despite education to request assistance."</p> <p>-5/4/13 at 13:15 pm- Resident #7 was sitting in her wheelchair in the lobby. She stood up and tried to get her her bag with belongings from the back of her wheelchair. She fell to the floor on her knees. PI recommendations were to continue with therapy for strengthening.</p> <p>Interdisciplinary Team follow up notes stated in part: "Resident with hx of falls r/t not requesting assistance d/t desire to maintain independence."</p> <p>-5/10/13 at 4:15 pm- Resident #7 wheeled herself out of the dining room to her bathroom in her room. She turned on the call light and tried to transfer herself onto the toilet. Resident #7 was found with her back up against the wall facing the toilet. PI recommendations were to x-ray the</p>	F 323		

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F 323	<p>Continued From page 33</p> <p>ankle and for PT and OT. Resident #7 received a right ankle fracture resulting in a ORIF [open reduction internal fixation] of the right ankle.</p> <p>Resident #7's 5/15/2013 History and Physical stated in part:</p> <p>"1. Right ankle fracture with surgical reduction and fixation 5/13/13."</p> <p>"2. Longstanding moderate paresis of both legs of unclear etiology, worse involving the left leg for approximately 20 years. Etiology is unclear."</p> <p>On 7/15/13 at 2:15 pm, Resident #7 was observed sitting in a wheelchair in her room, next to her bed. She had a black, knee high cast type boot on her right leg, and a clear AFO (ankle foot orthotic) brace on her left leg. The surveyor asked the resident what had happened to her legs. Resident # 7 said she had turned the call light on in the bathroom for assistance but it took a while for the staff to help her. She had attempted to get onto the toilet independently when she fell. She said she had broken her right ankle and stated, "And that was my good leg, my left leg is practically paralyzed."</p> <p>On 7/16/13 at 9:15 am, the Physical Therapist #10 was asked if Resident #7 experienced a functional decline due to her right ankle fracture. The Physical therapist replied, "Of course." The Physical Therapist said Resident #7 was independent and transferred on her own before her ankle fracture, although the staff encouraged her to get assistance to transfer. After her fall, Resident #7 was placed on non weight bearing status and required a hooyer lift for tranfers.</p> <p>On 7/16/13 at 9:45 am, the DNS reviewed Resident #7's falls and provided the time line for</p>	F 323		

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F 323	<p>Continued From page 34</p> <p>the falls mentioned above. She was asked about the Falling Star Program. The DNS said the Falling Star Program included a star magnet placed outside the resident's door. When staff walk by that room, they looked in the room to see if the resident needed assistance.</p> <p>Note: On 1/28/13, Resident #7 was placed on the "Falling Stars Program", and had 6 additional falls after that time.</p> <p>Although Resident #7 attempted to remain independent, she had a history of LE weakness and was a high fall risk. She had a history of falls. The facility failed to increase supervision for Resident #7 and Resident #7 experienced a fall resulting in a right ankle fracture. Resident #7 required surgical intervention and experienced a functional decline. Resident #7 required a mechanical lift for transfers and was no longer able to ambulate in the corridor with assistance. She also required total assistance with toileting and limited assistance with hygiene where as before her fall she only required limited assistance with toileting and set up assistance for hygiene.</p> <p>On 7/18/13 at 1:30 pm, the Administrator and DNS were informed of the fall with a fracture concern with Resident #7. No other information or documentation was provided which resolved the issue.</p> <p>2. During the environmental tour conducted on 7/16/13 at 8:45 a.m., the clean linen closet on the 200 hallway was not secured. Inside the closet, which would be accessible to residents, the following chemicals were found on the shelf:</p> <ul style="list-style-type: none"> - 2 bottles of antiseptic peri-wash which had an active ingredient of Benzethonium Chloride 0.2%, - 1 tube of sunscreen with active ingredients of: 	F 323		

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F 323	Continued From page 35 Octinoxate, 7.50%; Homosalate, 5.0%; Octisalate, 5.0 % and Benzophenone -3, 3.0%, - 1 container of PDI Sani-wipes with active ingredients of n-alkyl dimethyl ethylbenzyl ammonium chloride, and n-alkyl dimethyl benzyl ammonium chloride. The products were collected and the staff development coordinator, who was at the nursing station, was given the items to secure. 3. During the environmental tour conducted on 7/16/13 at 9:10 a.m., the storage room on the 300 hallway had a wooden cupboard which had a sign which read "keep locked all times." The cupboard was checked and it was not locked. Inside the cupboard were: - 14 bottles of liquid deodorant, - 2 bottles of shampoo, - 2 bottles of lotion, - 3 bottles of peri-cleaner, and - 3 bottles of alcohol hand sanitizer [4 ounces]. The surveyors informed RN#1 at 9:15 a.m., who then locked the cupboard.	F 323			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F-371 I & II. Identified residents and Other Residents. A splash guard has been placed beside the hand washing sink in the Nutritional Services Department to prevent potential contamination from water during sink use. This corrected measure impacts identified residents' # 1 - 12 and other residents receiving meals from the Nutritional Services Department.	8-15-13	

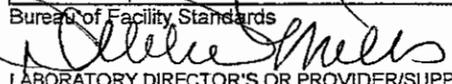
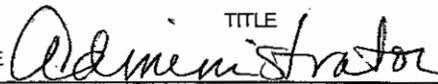
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F 371	<p>Continued From page 36</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store food under sanitary conditions. This affected 12 of 13 (#s 1-12) sampled residents and had the potential to affect all residents who ate in the facility. Findings included:</p> <p>On 7/15/13 at 10:10 am, the surveyor met Cook #3 in the kitchen for the initial tour of the kitchen. The surveyor asked Cook #3 where the handwashing sink was located. Cook #3 directed the surveyor to the hand washing sink. Upon approaching the handwashing sink, the surveyor observed a prepared sheet cake sitting next to the handwashing sink. The sheet cake was approximately 3 inches way from the handwashing sink, in proximity where potentially contaminated water could splash onto the cake. Immediately, the surveyor informed Cook #3 about the issue with the cake being next to the handwashing sink where potentially contaminated water could splash onto it. Cook #3 removed the cake and placed it away from the handwashing sink, on the opposite end of the counter. The surveyor did not observe the cake was compromised by being within 3 inches of the handwashing sink.</p> <p>At 10:45 on 7/15/13, the surveyor informed the Dietary Manager about the observation of the sheet cake sitting next to the handwashing sink.</p> <p>On 7/18/2013 at 1:30 pm, the Administrator and</p>	F 371	<p>III. Systemic Changes</p> <p>Facility's Nutritional Services Director and staff have been re-educated on prevention of contamination from water during skin use of food items. Education provided by facility's Consultant Registered Dietician.</p> <p>IV. Monitoring</p> <p>The facility's Administer is responsible to oversee that food is stored under sanitary conditions. The Administrator or designee will conduct rounds in Nutritional Services Department three times a week for three months. The findings of these rounds will be presented to the facility's QAPI Committee for tracking and trending and further recommendations.</p>	

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F 371	Continued From page 37 DNS were informed of the sheet cake sitting next to the handwashing sink, in proximity where potentially contaminated water could splash onto it. There was no information or documentation provided that resolved the issue.	F 371			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 1 of 13 (#4) sampled resident's medical records contained information to make it complete and accurate. The lack of medical record documentation could put residents at potential harm because the information missing from the medical records, especially chemotherapy information, would be important in establishing treatment plans for any side effects the resident may experience. Findings include: Resident #4 was admitted to facility on 11/23/12 with diagnoses of persistent mental disorder and	F 514	F-514 I. Identified residents Resident # 4's medical record has been updated to include information regarding resident's cancer treatment. II. Other Residents No other residents currently receiving cancer treatment reside in the facility. III. Systemic Changes The facility's Health Information Manager and IDT Members have been re-educated regarding complete and accurate medical record as it pertains to cancer treatment. Education provided by facility's SDC. IV. Monitoring The facility's Administrator is responsible to oversee that residents' medical records are complete related to chemotherapy information. The Health Information Manager or designee will audit three clinical records a week for complete and accurate reflection of the resident's status. The findings of these reviews will be presented to facility's QAPI Committee monthly for three months for trending and further recommendations.	8-15-13	

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F 514	<p>Continued From page 38</p> <p>metastatic carcinoma of breast to brain.</p> <p>Upon reviewing the Comprehensive care plan dated 01/15/13, the facility identified:</p> <p>Problem 13: "Infection; Potential for/actual" as evidenced by "related to Herceptin Infusion." Review of Care area assessment, under Activities of daily living, documented Resident #4 received monthly chemotherapy. None of this information could be found in the medical record. Further review of patient chart revealed one entry dated 07/05/12, "returned from [local hospital] outpatient with no orders." The medical record lacked documentation from local Tumor Institute for treatment or a plan of care.</p> <p>On 7/17/13 at 1:15 p.m. the medical records person was interviewed and stated that she would request the information. She further indicated she was not always aware when the resident went to the tumor institute for treatments. On 7/19/13 at 11:00 a.m. the tumor institute documentation was provided to the surveyors.</p>	F 514			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - B		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705		
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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Arnold Rosling, RN, BSN, QMRP Karla Gerleve, RN Debbie Bemamonti, RN	C 000	RECEIVED AUG 12 2013 FACILITY STANDARDS	
C 117	02.100,03,c,i Fully Informed of Rights i. Is fully informed, as evidenced by the patient's/resident's written acknowledgement, prior to or at the time of admission and during his stay, of these rights and of all rules, regulations and minimum standards governing patient/resident conduct and responsibilities. Should the patient/resident be medically or legally unable to understand these rights, the patient's/resident's guardian or responsible person (not an employee of the facility) has been informed on the patient's/resident's behalf. This Rule is not met as evidenced by: Refer to F156 regarding right to share a room with a spouse was not found in admission documents.	C 117	C 117 02.100, 03, c, i Refer to POC for F-156	8-15-13
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The	C 325	C 325 02.107, 08 Refer to POC for F-371	8-15-13

Bureau of Facility Standards

 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
 TITLE 
 (X6) DATE **8/8/13**

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001250	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2013
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NAME OF PROVIDER OR SUPPLIER AVAMERE TRANSITIONAL CARE & REHAB - B	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH HILTON STREET BOISE, ID 83705
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C 325	Continued From page 1 acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please see F371 due to unsanitary condition	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 as it relates to toxic chemicals available to residents.	C 342	C 342 02.108,04,b,ii. Refer to POC for F-323	8-15-13
C 720	02.153,03,a ORAL CARE AND HYGIENE 03. Oral Care and Hygiene. The facility shall ensure that patients/residents receive care in the facility which promotes a healthy mouth through: a. Regular oral care. This Rule is not met as evidenced by: Refer to F312 as it relates to oral hygiene.	C 720	C 720 02.153,03,a. Refer to POC for F-312	8-15-13
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:	C 778	C 778 02.200,03,a. Refer to POC for F-279	8-15-13

Bureau of Facility Standards

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C 778	Continued From page 2 This Rule is not met as evidenced by: Refer to F279 as it relates to initial care plan.	C 778			
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 regarding not revising toileting and catheter care plans.	C 782	C 782 02.200,03,a,iv. Refer to POC for F-280	8-15-13	
C 786	02.200,03,b,ii Body Alignment, Exercise, Range of Motion ii. Good body alignment and adequate exercises and range of motion; This Rule is not met as evidenced by: Refer to F318 as it relates to providing range of motion.	C 786	C 786 02.200,03,b,ii. Refer to POC for F-318	8-15-13	
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: Refer to F309 as it relates to following physician orders.	C 788	C 788 02.200,03,b,v. Refer to POC for 309 F 309 <i>Received phone approval from Debra Mills on 8/27/13 at 4:00pm to add F 309. BMD BERRY</i>	8-15-13	
C 789	02.200,03,b,v-Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited	C-789	C 789 02.200,03,b,v. Refer to POC for F-314	8-15-13	

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C 789	Continued From page 3 to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F314 for roccuring and unavoidable Stage II pressure ulcers.	C 789		
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 for falls with fracture.	C 790	C790 02.200,03,b,vi. Refer to POC for F-323	8-15-13
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to records missing from the residents medical record.	C 881	C 881 02.203,02 Refer to POC for F-514	8-15-13