IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
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FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 1529

August 6, 2014

Kelly Spiers, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Spiers:

On **July 25, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Teton Post Acute Care & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

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 19, 2014**. Failure to submit an acceptable PoC by **August 19, 2014**, may result in the imposition of civil monetary penalties by **September 8, 2014**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:

  a. Specify by job title who will do the monitoring.
     * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
     * The monitoring cannot be completed by the individual(s) whose work is under review.

  b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
     * A plan for "random" audits will not be accepted.
     * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.

  c. Start date of the audits;

- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 29, 2014 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 29, 2014**. A change in the seriousness of the deficiencies on **August 29, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 29, 2014** includes the following:

Denial of payment for new admissions effective **October 25, 2014**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 25, 2015**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 25, 2014** and continue uutil substantial

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

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

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

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

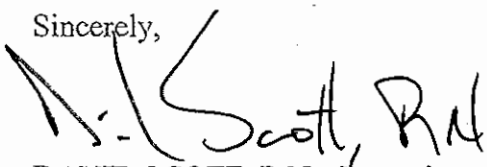
- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **August 19, 2014**. If your request for informal dispute resolution is received after **August 19, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

DS/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135138		C 07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON POST ACUTE CARE & REHABILITATION	3111 CHANNING WAY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator, Brad Perry, BSW, LSW, Judy Atkinson, RN, Linda Kelly, RN and Linda Hukill-Neil, RN. The survey team entered the facility on July 21, 2014, and exited on July 25, 2014. Survey Definitions: ADL = Activities of Daily Living ADM = Administrator BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed RDCO = Regional Director of Clinical Operations	F 000	RECEIVED OCT 23 2014 FACILITY STANDARDS	
F 156 SS=D	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	F 156	***F156*** • ***How corrective action accomplished for the identified residents?*** Resident#10 was discharged from the facility 6/11/14. • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. Admissions agreements will be reviewed by the Administrator or designee to validate they have been completed and signed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	10-22-14

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

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F 156	Continued From page 1 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 under Medicare or by the facility's per diem rate. 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; 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	F 156	• ***Address what measures will be put in place to ensure deficient practice will not recur.*** Administrator and or designee will re-educate the admission staff to fully inform residents of their rights prior to or upon admission. Residents, guardians, advocates, or family members will sign the resident rights document after they have been reviewed. • ***How will the plan be monitored to ensure the solutions are sustained?*** The Admission Director and or designee will start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month. These audits will include that resident rights have been explained to residents, guardians, advocates, or family members on or before admission, and the agreement have been signed.	

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F 156	Continued From page 2 toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. 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. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure 1 of 11 residents (R #10) sampled for resident rights was fully informed of his rights prior to or upon admission to the facility. This deficiency created the potential for more than minimal harm when	F 156	Findings will be brought to CQI for further review and educational opportunities. • *The ED is responsible for compliance* *Compliance date is ~~10/28/14~~* 11/3/14 Chg per facility request 11/4/14 DL	

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F 156	Continued From page 3 the resident did not have information about exercising his rights in the facility. Findings included: Resident #10 was admitted to the facility on 5/7/14, and readmitted on 6/2/14, with diagnoses which included hepatic encephalopathy, diabetes mellitus, peripheral neuropathy, left ankle fracture, and lower extremity weakness. Review of the resident's clinical record on 7/23/14 revealed there were no signed admission agreement documents in the resident's record. On 7/25/14 at 9:35 a.m., when asked to provide the admission agreement documents signed by the resident or the resident's responsible party, the Administrator indicated he would provide the documentation. By 12 noon, however, the facility still had not provided any signed admission agreement documents for the resident and was again asked to provide them. On 7/28/14 at 2:00 p.m., during a follow-up telephone call with the Administrator, the Administrator said the resident "did not sign any admit paperwork." The facility did not provide any other information or documentation which resolved this issue.	F 156		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone	F 164	*F164* • ***How corrective action accomplished for the identified residents?*** Resident #12 primary care physician was re-educated on 7/23/14 about resident rights and patient confidentiality by the Director of Nursing. The LN #4 and LN #5 who cared for residents #12, 13, and 14 have been re-educated to cover the medication record by the Director of Nursing on 7/29/14	

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F 164	Continued From page 4 communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, it was determined the facility failed to maintain residents' privacy during cares and confidentiality of their personal information for 4 of 5 random residents (#s 12, 13, 14, & 15). These failures created the potential for a negative affect on residents' psychosocial well-being related to the need for privacy and confidentiality. Findings included: 1. On 7/22/14 at 12:05 p.m., Resident #12 was observed seated near the end of the long table in the dining room. Several other residents were at the same table; 2 of them were on the opposite	F 164	The LN #5 nurse that cared for resident #15 has been re-educated on 7/29/14 to keep the blinds closed when performing personal care by the Director of Nursing. • ***How you will identify other residents with the potential of being affected by the same practice?*** Resident and or family members will be interviewed to validate privacy has been maintained during physician visits when receiving care by their physician in the facility. Primary care physicians for residents are being educated to validate they understand patient confidentiality by signing and returning a letter of notification of the education. Licensed nurse have been observed to have resident information on the medication carts covered and confidential. Residents have been observed to have had their blinds closed during personal care.	

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F 164	Continued From page 5 side and 1 was on the same side, 2 places down from the resident. From about 12:07 to 12:12 p.m., Resident 12's physician was observed as she assessed the resident in the dining room. The physician pulled up the resident's right sleeve to just below the elbow, the left sleeve above the wrist, and the left pant leg to about mid-calf. The physician asked the resident several questions as she briefly touched the resident's left ankle and palpated the resident's left radial pulse. Then, the physician left the dining room and went to the Nurses' Station where several of the staff began talking to her about other residents and Resident #12. At about 12:15 p.m., the DNS was informed of the aforementioned dining room assessment observation. The DNS, stated, "That sounds about right. We'll have a conversation with her [the doctor]." On 7/23/14 at 11:30 a.m., Resident #12 was asked what she thought about the aforementioned assessment in the dining room. The resident stated, "I would have preferred she didn't do it in the dining room. I would have liked more privacy." When asked if the physician had asked if she could do the assessment in the dining room, the resident stated, "No!" 2. During medication pass the following were observed: a. On 7/23/14 at 10:45 AM, LN #4 was observed to leave Resident #12's MAR on top of the medication cart in the 200 Hall in full view when she walked away and entered a residents room. When LN #4 was asked about leaving the MAR open she stated "I did."	F 164	• ***Address what measures will be put in place to ensure deficient practice will not recur.*** Notification will be sent by the Health Information Manager and or designee to resident's primary care physicians in writing to provide re-education of patient confidentiality. This will be returned to the center signed by the physician. Nursing staff will be re-educated by the Direct of Nursing and or designee on how to keep resident information confidential while passing medications. Staff including Therapists, Nurses' Aides, Registered Nurses, Housekeeping, and Dietary will be re-educated by the Director of Nursing and or designee to keep the residents blinds closed during personal care and maintain resident privacy. • ***How will the plan be monitored to ensure the solutions are sustained?*** The Health Information Manager or designee will complete audits that will begin on 8/25/14 for signed notification of the physician re-education will be completed weekly X4 weeks, until they are all returned.	

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F 164	Continued From page 6 b. On 7/23/14 at 4:52 PM, LN #4 was observed to leave Resident #13"s MAR on top of the medication cart in the 200 Hall in full view and entered a residents room. When LN #4 was asked about leaving the MAR open she stated, "The medication nurse called in sick and I haven't done this [medication pass] here before." and, c. On 7/24/14 at 8:04 AM, LN #5 was observed to leave Resident #14's MAR on top of the medication cart in the 300 Hall in full view and entered a resident's room. When LN #5 was asked about leaving the MAR open she stated, "In general I have it upside down and flipped, no it is not ok." 3. On 7/24/14 at 8:45 AM, the surveyor observed LN #5 flush Resident #15's Gastric tube however LN #5 failed to close the window blinds which were in full view of the facility entrance. On 7/25/14 at 12:00 PM, the Administrator and DNS were informed of the observations. No other information or documentation was received from the facility regarding the issue.	F 164	Director of Nursing or designee will start audits and on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month, to validate that medication administration records are being covered, blinds are being closed during personal care. The Administrator or designee will start audits and resident/family interviews on 9/29/14 to be completed 3 days a week X4 weeks, and 2 days a week X4 weeks, and 1 day a week X1 month, to validate that resident privacy is maintained with physician visits and when receiving personal care. All findings will be brought to CQI monthly for further review and educational opportunities.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226	• *The ED is responsible for compliance* *Compliance date is ~~10/28/14~~* 11/3/14 Chg per facility request 11/4/14 *F226* • *How corrective action accomplished for the identified residents?* No residents were identified.	

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F 226	Continued From page 7 Based on review of the facility's abuse policies and procedures, staff personnel files, and staff interview, it was determined the facility failed to obtain reference checks prior to employment for 5 of 5 sampled staff members (A, B, C, D, and E). This practice created the potential to place residents at risk for and subject to abuse, neglect, and/or misappropriation of property. Findings included: The facility's abuse policy dated November 2012, documented the following: "Policy Statement: This Nursing Center (Center) complies with federal and state requirements to screen, train, prevent, identify, investigate, protect and report abuse, neglect, mistreatment, and misappropriation of property. Procedure: An employee screening processes has been developed so that employees are not knowingly hired who: 1. Have been found guilty of abusing, neglecting or mistreating residents by a court of law. OR 2. Have had a finding entered into the state nurse registry concerning abuse, neglect, mistreatment of resident or misappropriation of their property..." In addition, the facility's screening policy documented: "The Center conducts reference checks from previous and current employer for prospective employees. Reference checks shall be documented utilizing the Employee Reference Check Guide." The facility had reference check documentation from 2 previous employers for each of the 5 new employees. However, all prospective employee reference checks were completed after the employees were hired and listed as follows:	F 226	• ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. New hire packets have been improved to include reference checks forms to be completed prior to employment. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** The Regional Vice President will re-educate the facility Administrator on the abuse and neglect policy. The facility administrator will re-educate the Dietary Manager, Staff Development Coordinator, Director of Nursing, Business Office manager, and Admission Director that performs the employee reference checks has been re-educated on the abuse and neglect policy.	

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F 226	Continued From page 8 *Staff A was hired and worked on 5/6/2014 and reference checks were dated 5/6 and 5/8/2014 (Day of hire and 2 days after hire). *Staff B was hired and worked on 5/15/2014 and reference checks were dated 5/19 and 5/21/2014 (4 days and 6 days after hire). *Staff C was hired and worked on 5/16/2014 and reference checks were both dated 5/19/2014 (3 days after hire). *Staff D was hired and worked on 4/18/2014 and reference checks were dated 5/7 and 5/8/2014 (9 days and 20 days after hire). *Staff E was hired and worked on 3/7/2014 and reference checks were dated 5/14 and 5/19/2014 (38 and 43 days after hire). On 7/24/2014 at 10:30 AM, the Administrator was interviewed regarding the screening process for their prospective employees. The Administrator acknowledged reference checks were dated after the employees were hired and had worked with residents. On 7/25/2014 at 12:00 PM, the Administrator, the DNS, and the Regional Director of Clinical Operations were informed of the issue. No additional information was provided to address the concern.	F 226	• ***How will the plan be monitored to ensure the solutions are sustained?*** Administrator or designee will begin audits on 8/25/14 and will be completed 3 days a week X4 weeks, 2 days weekly X4 weeks, and 1 day a week X1 month, to validate that reference checks are completed before an employee is hired. All findings will be brought to CQI monthly for further review and educational opportunities. ***The ED is responsible for compliance*** ***Compliance date is ~~10/28/14~~*** 11/3/14 Chg per facility request 11/4/14 VR	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241	***F241*** • ***How corrective action accomplished for the identified residents?*** CNA #1 has been re-educated about resident dignity on 7/25/14 by the Director of Nursing.	

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F 241	Continued From page 9 by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a staff member did not stand while she fed 1 of 6 sample residents (#6) reviewed and observed for dignity. Failure to promote the resident's independence and dignity in dining created the potential for a decline in the resident's abilities with activities of daily living and a negative on effect on the resident's psychosocial well-being. Findings included: Resident #6 was admitted to the facility on 5/28/14 with multiple diagnoses which included muscle weakness and dementia. The resident was readmitted on 6/16/2014 after suprapubic catheter placement. The resident's significant change MDS assessment, dated 7/22/14, documentation included: * Adequate hearing and vision; * Short and long-term memory problems; * Sometimes understood others and understood by others; * Moderately impaired cognition; * Supervision and set-up for eating; and, * No functional limitation in range of motion in the upper extremities. The resident's nutrition hydration status care plan, dated 6/28/14, included the following approaches, "Encourage to feed self [equal to or more than] 50% [percent] of meals" and "Assistance Needed[:] Set Up [and] Cueing." On 7/23/14 at 6:15 p.m., during the dinner meal service in the dining room, CNA #1 was observed as she stood next to Resident #6 and fed him a	F 241	• ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility that need assistance with eating are at risk for the failed practice. Staff have been observed sitting while they are assisting with residents with breakfast, lunch, and dinner. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** Staff will be re-educated on resident rights and dignity by the Director of Nursing and or designee. • ***How will the plan be monitored to ensure the solutions are sustained?*** Director of Nursing or designee will begin audits starting on 8/25/14 to be completed 3 days a week X4 weeks, 2 days weekly X4 weeks, and 1 day a week X1 month, to validate that residents are being treated with dignity during breakfast lunch and dinner.	

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F 241	Continued From page 10 spoonful of mechanical soft chicken pot pie then handed the spoon to the resident and cued him to eat. At 6:18 p.m., when informed of the observation, the CNA asked, "Is that bad?" The CNA was informed it was a dignity issue. She then stated, "I was gonna get a chair after I gave him a bite." On 7/25/14 at 12:00 p.m., the Administrator, DNS, and RDCO were informed of the issue. No other information was received from the facility which resolved the issue.	F 241	All findings will be brought to CQI monthly for further review and educational opportunities. • *The ED is responsible for compliance* *Compliance date is ~~10/24/14~~* 11/3/14 chg per facility request 11/4/14	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, it was determined the facility did not ensure call lights were accessible for 2 of 9 sample residents (#s 2 and 5). Inability to access call lights placed the residents at risk to have unmet needs and a negative effect on their psychosocial well-being. Findings included: 1. On 7/21/14 at about 1:30 p.m., during the initial tour of the facility, Resident #5's call light was observed clipped to a raised siderail on the resident's right side. When asked how she	F 246	*F246* • *How corrective action accomplished for the identified residents?* Resident #2 discharged from the center on 7/11/2014. Resident #5 has had their call light placed back into their reach by the Health Information Manager on 7/21/14. • *How you will identify other residents with the potential of being affected by the same practice?* Residents in the facility are at risk for the failed practice. Staff will be re-educated to validate they understand that call lights are to be in reach of each resident.	

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F 246	Continued From page 11 summoned staff if she needed help or wanted something, the resident said she used the call light. The resident made several unsuccessful attempts to reach the call light then stated, "It's usually here (pointed to the middle of the lower bar on the siderail) but it slips down and I can't reach it. It slips down a lot." The resident stated, "I holler if I need something and I can't reach it (call light)." At about 1:33 p.m., the surveyor activated the resident's call light and the Medical Records Manager (MRM) answered it in less than a minute. The resident told and showed the MRM that she could not reach the call light where it was. The MRM unclipped the call light from the siderail and clipped it to the resident's gown. The resident was able to reach the call light after that. 2. Resident #2 was admitted originally on 2/10/2014 with multiple diagnoses including a right below the knee amputation, diabetes, and peripheral vascular disease and readmitted on 4/14/2014 after a left below the knee amputation. On 7/22/2014 at 8:25 AM, Resident #2 was observed in his bed. His call light was not readily seen. When Resident # 2 was asked about his call light he stated, "They usually clip it on my sheet or my gown, but it is not there." The resident tried to find the call light. He looked under his covers and felt around with his hands, but could not locate it. At 8:30 AM, LN #3 entered the resident's room. Resident #2 told her that he could not find his call light. LN #3 followed the cord from the wall and	F 246	Residents have call lights have been observed to be in place and within their reach. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** The Director of Nursing and or designee will re-educated staff that call lights are in the reach of each resident. • ***How will the plan be monitored to ensure the solutions are sustained?*** The Director of Nursing or designee will begin audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1day a week X1 month, to validate that call lights are in residents reach. The Activity Director or designee will interview resident council monthly x3 months about call light placement.	

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F 246	Continued From page 12 located the call light on the floor, behind the oxygen concentrator that was on the left side of the resident. LN #3 was interviewed and was asked if the call light was out of the resident's reach. She acknowledged that the resident could not have reached his call light. LN #3 clipped the call light on the resident's bed sheet and made sure it was now accessible for him. On 7/25/2014 at 12:00 PM, the Administrator, DNS, and RDCO were informed of the issue. No other information or documentation was received from the facility regarding the issue.	F 246	All findings will be brought to CQI monthly for further review and educational opportunities. • *The ED is responsible for compliance* *Compliance date is ~~10/28/14~~* 11/3/14 Chg per facility request 11/4/14	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to coordinate care between the facility and a dialysis center and to ensure an order was in place for a walking boot. This was true for 2 of 11 sampled residents (#3 and #10). These failures created the potential for the residents to experience complications and/or compromised medical status. Findings included: 1. Resident #3 was admitted to the facility on	F 309	*F309* • *How corrective action accomplished for the identified residents?* Re-education was provided by the Director of Nursing to the Licensed Nurses that they complete the dialysis communication and transfer forms before the resident #3 went to dialysis on 7/29/14. Resident #3 is going to dialysis with completed dialysis communication and transfer forms. Resident #10 has been discharged from the center on 6/11/14.	

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F 309	Continued From page 13 5/16/14 and readmitted on 7/11/14 with multiple diagnoses which included dislocation of right shoulder, end stage renal disease, anxiety, altered mental state, obesity and depressive disorder. The resident's Dialysis Care Plan, dated 7/12/14, documented the resident received dialysis on Mondays, Wednesdays and Fridays at a local dialysis center. A box was checked which documented the facility would "coordinate medication regime with the dialysis center - send a copy of the current MAR and or Dialysis Transfer Sheet with resident to Dialysis." The Dialysis Transfer Form included three sections with the top and middle sections to be filled out by the facility, and the bottom portion to be filled out by the local dialysis center. Record review of the seven Dialysis Transfer Forms for 7/1/14 through survey, 7/23/14, documented the facility filled out the top portion of the dialysis form. However, the middle section which documented, "Information/Current Resident Status the dialysis center may need to be aware of:" was left blank except for the box marked "Yes" which indicated the MAR was attached. The facility did not fill out the following: "Med changes since last dialysis run, Labs since last dialysis run, Copy of lab report attached [box for yes or no to be checked], Any changes in medical or mental status, and Completed by/Date." The Dialysis Center Report section was filled out, signed and dated. The Dialysis Transfer Form, dated 7/23/14, documented the facility only wrote in Resident's #3 name and left the top and middle portions of	F 309	• ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility that receive dialysis are at risk for the failed practice. Residents receiving dialysis have had communication forms completed prior to dialysis. Residents in the facility that have physician ordered devices are at risk for the failed practice. Residents with physician ordered devices have had their physician orders reviewed to validate orders are complete. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** Nursing staff will be re-educated to validate dialysis communication and transfer forms are completed correctly by the Director of Nursing and or designee.	

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F 309	Continued From page 14 the form blank. The facility did not fill in the following: "Nursing Center Name, Address, Phone number, Resident's Attending Physician, Phone #, Date/Time of Appointment, Copies attached: Physician Orders/Other: [Attach a Blank Physician Order and Blank Progress Note to this form], Information/Current Resident Status the dialysis center may need to be aware of: Med changes since last dialysis run, MAR attached [box for yes or no to be checked], Labs since last dialysis run, Copy of Lab report attached [box for yes or no to be checked], Any changes in medical or mental status, and Completed by/Date." The Dialysis Center Report section was filled out, signed and dated. On 7/24/14 at 9:35 AM, the DNS was interviewed about the missing information on the Dialysis Transfer Form. The DNS stated, "We have done an in-service [on dialysis services] but they still aren't following it correctly and they should be signing the form." On 7/24/14 at 6:10 PM, the Regional Vice President, ADM, RDCO and DNS were made aware of the dialysis communication concerns. No further information was provided by the facility. 2. Resident #10 was admitted to the facility on 5/7/14, discharged 5/9/14, then readmitted 6/2/14 with multiple diagnoses which included left ankle fracture, lower extremity weakness and hepatic encephalopathy. The resident's hospital Discharge Summary, dated 5/31/14, documentation included, "X-rays	F 309	Nursing staff will be re-educated that physician ordered devices and walking boots have completed physician orders by the Director of Nursing and or designee. • ***How will the plan be monitored to ensure the solutions are sustained?*** The Director of Nursing or designee will complete audits starting on 8/25/14 to be completed 3 days a week X4 weeks, 2 times weekly X4 weeks, and 1 day a week X1 months, to validate that dialysis communication and transfer forms are completed correctly. The Director of Nursing or designee will complete audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 times weekly X4 weeks, and 1 day a week X1 month. To validate that physician ordered devices have physician orders and are completed correctly.	

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F 309	Continued From page 15 were taken of his ankle and fracture noted. Walking boot applied." The resident's Nursing Admission Evaluation Form, dated 6/2/14, and a Progress Note (PN), dated 6/2/14 at 2:10 p.m., both documented a walking boot on the left lower extremity. The resident's Nursing Facility Admission Orders and a Physician Order Sheet, both dated 6/2/14, as well as a June 2014 Physician Order Sheet (recapitulation), however, did not contain any orders for the walking boot. In addition, none of the subsequent orders included a walking boot. On 7/25/14 at 9:35 a.m., the DNS and Administrator were asked to provide an order for the resident's walking boot. The DNS reviewed the resident's clinical record then stated, "I don't see them here." The DNS said she would continue to look and get back with the surveyor. During a follow-up telephone call on 7/28/14 at 3:50 p.m., the DNS said did not find an order for the resident's walking boot.	F 309	All findings will be brought to CQI monthly for further review and educational opportunities. • *The ED is responsible for compliance* *Compliance date is ~~10/28/14~~* 11/3/14 chg per facility request 11/4/14 TR	
F 314 SS=D	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.	F 314	*F314* • *How corrective action accomplished for the identified residents?* Resident #2 discharged from the facility on 7/11/14.	

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F 314	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and policy review, it was determined the facility failed to ensure 1 of 3 residents (#2) reviewed for pressure ulcers (PU) did not develop an avoidable PU on the back. Failure to thoroughly assess, monitor, track, and care plan a PU on the resident's back that developed 10 days after admission, created the potential for more than minimal harm if the PU worsened or became infected. In addition, the facility's policy regarding PU did not include staging of PUs. Findings included: Resident #2 was admitted to the facility on 2/10/14 with multiple diagnoses which included severe peripheral vascular disease (PVD), right below the knee amputation (BKA), and diabetes mellitus. The resident was readmitted on 4/14/14 after a left BKA. The resident was placed on Comfort Care in early July 2014. The resident's Event Investigation Report (EIR), dated 2/20/14, documented: * A 1 by 2 centimeter "superficial" skin injury found at 11:00 p.m.; and, * A back body diagram noted the skin injury at waist level along the spinal column. An Event Investigation Questionnaire attached to the EIR, documented" * "Bed sore on lower back;" * The resident was alert and oriented and said "it hurt;" * "How was the event avoidable? NA [not applicable];" * "Why did the event occur? No offloading over	F 314	• ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. All residents in the center have had skin assessments completed to evaluate for pressure ulcers and wound documentation reviewed for accuracy. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** Nursing staff will be re-educated by the Director of Nursing and or designee on skin assessments and documentation and complete a competency test. The test will cover completing an accurate skin assessment and documentation. It also includes the evaluation for pressure ulcers, monitoring, tracking and care planning of any new issues, and the correct staging of the ulcer.	

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F 314	Continued From page 17 bony prominence;" * "What was done to protect the resident immediately after the event? Update care plan Turn Q [every] 2 [hours]." An Event Investigation Final Summary, also attached to the 2/20/14 EIR, documented: * "Summary of conclusion..." - CNA notified nurse that Resident has a redness area on the lower back (around bony prominence)...Pressure ulcer seen on lower back..." * The DNS' final summary - "An open area measuring 1 cm x 2 cm x 0.1 was found on resident's lower back. Area treated [with] first aid, family and physician notified. Will [change] dressing every other day. Will update plan of care to reposition Q 2 [hours]. Well treat until healed. Resident [with] confusion at times. Poor perfusion and poor skin integrity...on a specialty mattress. Area noted upon admit. Wound care consult ordered." On 7/23/14 at 3:55 p.m., the DNS was asked about the 2/20/14 EIR. When asked if the "lower back" PU was same or different from the coccyx/sacral PU, the DNS indicated they were one in the same and that staff had incorrectly documented the anatomical location. The resident's 2/10/14 admission/stay clinical records, with all documentation regarding the resident's skin, was requested. The facility provided the resident's 2/10/14 clinical records on 7/24/14. The resident's Admission Body Assessment, dated 2/10/14, included front and back body diagrams. The back body diagram documented a dressing over the coccyx/sacral area and an "old	F 314	• ***How will the plan be monitored to ensure the solutions are sustained?*** The Director of Nursing and or designee will begin audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 times weekly X4 weeks, and 1 day a week X1 month, to validate that skin assessments are completed correctly and residents have been evaluated for pressure ulcers, including monitoring, tracking and care planning. All findings will be brought to CQI monthly for further review and educational opportunities. • ***The ED is responsible for compliance*** ***Compliance date is*** ~~10/28/14~~ 11/3/14 chg per facility request 11/4/14 TR	

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F 314	Continued From page 18 scar" at the mid-thoracic level along the spinal column. A line was drawn from "old scar" to a circle with a dot in it on the right side of the mid-thoracic spinal column. The specific location of the scar (such as T1 (first thoracic vertebrae) or T5 (fifth thoracic vertebrae), etcetera) was not noted. No other skin issues on the resident's back were documented. The resident's skin integrity care plan," dated 2/10/14 and updated 4/14/14, documented, "History of pressure ulcers (Site) coccyx..." Approaches included, "Turn and reposition regularly[,] Weekly skin assessments per schedule and PRN [as needed][,] Pressure reducing mattress[,] Pressure reducing chair device[,] Provide skin care frequently (daily bath, shower 2x [times] a week)." And, on 2/20/14 was added, "Hydrocolloid [change every] 3 D [days]." (Note: The care plan did not include the PU found on the resident's back on 2/20/14.) The resident's admission MDS assessment, dated 2/17/14, documentation included: * Impaired cognition, with a BIMS score of 8; * Able to understand others and usually understood by others; * Extensive assistance by 2 or more people for bed mobility and transfers; * Extensive assistance by 1 person for dressing and toileting; * Total assistance by 1 person for bathing; * At risk for PU; and, * One unhealed stage II PU on admit. The 2/22/14 PU CAA documented the resident was admitted to the facility "with a pressure ulcer on his coccyx..."	F 314		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19 Progress Notes (PNs), dated 2/10 - 4/14/14, contained the following documentation regarding the "lower back" PU: * 2/20/14 untimed - "CNA notified nurse that Resident complaing [sic] of lower back pain...pressure ulcer found on lower back (around bony prominence area). Cleaned...already on air mattress...future prevention Q 2 hrs turns. Resident c/o [complaint of] of tenderness and pain but denies to have pain medicine..." * 2/26/14 untimed - "...did not want to [change] dssg to lower back..." * 2/26/14 at 10:30 p.m. - "...New orders noted for dressing [change] to back bony prominence area..." * 2/27/14 untimed - "...Applied Dssg to pressure area on lower back..." (Note: The lower back PU was not mentioned after the untimed entry on 2/27/14. Also, refer to F514, regarding incomplete documentation.) The resident's February 2014 MAR contained instructions regarding the coccyx/sacral PU wound care, dated 2/16 and 2/21/14, and the left foot and BKA wound care, both dated 2/21/14. It also documented, "2/26 Change hydrocolloid drsg [every other day] and prn to back ulcer..." with the word "ERROR" and a line drawn through the spaces for documentation. There were no other instructions regarding the "back ulcer." And, no other documentation regarding the "back ulcer" or "lower back" PU was provided. On 7/24/14 at 5:00 p.m., the DNS was interviewed with the Administrator and 2 other surveyors present. The DNS was asked for evidence that the resident's "lower back" PU was staged, monitored, tracked, and care planned. The DNS said the skin problem on the resident's	F 314		

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F 314	Continued From page 20 back was superficial and "more like friction than pressure." She said the area must have been healed by 2/26/14 when an outside wound care team saw the resident and did not note any skin issues on the resident's back. The DNS said there were no other documents regarding the area on the resident's back and that the facility was in the process of revising their skin care program. The DNS offered to have the nurse who found the back skin problem available the next morning. On 7/25/14 at 8:15 a.m., LN #12, a registered nurse (RN), was interviewed with the DNS, Administrator, and 2 other surveyors present. The LN said she was still in orientation on 2/20/14 and the other nurse on duty that day no longer worked at the facility. The LN said she saw the resident's back on 2/20/14. She stated, "It was not lower, like on coccyx, it was middle back and off to the left." The LN pointed to the mid-thoracic level on her own back and said, "bony area." The LN said the area was open then stated, "But thinking back it was more like friction." The LN was asked about her education, experience and knowledge regarding skin/wound/PU assessments. The LN said she received some training in nursing school but none since and that she had "little opportunity to assess skin" when she worked the night shift for several months at a local hospital. The DNS said the resident was seen by the aforementioned outside wound care team earlier on 2/20/14. When asked if the back PU was communicated to the outside wound care team, the DNS stated, "Phone calls were made back and forth but it wasn't documented." The DNS said the resident had a history of non-compliance and had removed dressings because they made him hot. She said the PU on	F 314		

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F 314	Continued From page 21 the resident's back was "very superficial and it may have already resolved by 2/25/14" when staff changed the coccyx dressing. The DNS acknowledged that the PU on the resident's back was different from the coccyx/sacral PU and that the back PU had not been staged, tracked or care planned. The facility's pressure ulcer policies were requested. Late morning on 7/25/14, the DNS provided a Skin Integrity policy. The DNS indicated "no" when she was asked if there were any other policies specific to PU. This Skin Integrity policy instructions included the documentation of new skin impairments (included pressure ulcers) with the measurements of size, color, odor, exudate, and associated pain, responsible party and physician notification, obtain treatment orders if needed and document on the TAR after implementation, and to document on a Wound Evaluation and Documentation Form and Nurses Notes. However, the policy did not address staging of PUs. Guidance at F314, Pressure Sores, stated: * Assessment and Treatment of Pressure Ulcer(s) - "It is important that each existing pressure ulcer be identified, whether present on admission or developed after admission...When assessing the ulcer itself, it is important to: ...* Determine the ulcer's stage; * Describe and monitor the ulcer's characteristics;..." * Pressure Points and Tissue Tolerance - "Tissue closest to the bone may be the first tissue to undergo necrosis [death of a cell or cells]. Pressure ulcers are usually located over a bony prominences..."	F 314		

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F 314	Continued From page 22 * Stages of Pressure Ulcers - "The staging system is one method of summarizing certain characteristics of pressure ulcers, including the extent of tissue damage..."Stage II" - Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough..." The facility failed to thoroughly assess, monitor, and identify the location of a new open superficial skin breakdown over a bony prominence on Resident #2's back when the area was not staged, tracked, and different anatomical locations were documented. In addition, the facility's PU policy did not address staging of PUs. The facility did not provide any other information which resolved the issue.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the environment was as free from accident hazards as possible. This was true for 3 of 6 sampled residents (#'s 1, 3, & 6) and for any	F 323	*F323* • ***How corrective action accomplished for the identified residents?*** Transportation director was re-educated on the facility transportation safety policy by the administrator on 6/17/14. Resident #3 has been observed being transported in the facility van with the seatbelts secure.	

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F 323	Continued From page 23 independently mobile resident or visitor in the 300 Unit hallway. This deficient practice had the potential for more than minimal harm if residents were not provided the care needed to prevent falls (Resident #3), potential entrapment in side rails (Resident #1) and appropriate diet texture and consistency of liquids (Resident #6). Additionally, this deficient practice presented potential harm to any resident or visitor who could have ingested or come in contact with hazardous materials or sharp objects. Findings included: 1. Resident #3 was admitted to the facility on 5/16/14 with multiple diagnoses which included dislocation of right shoulder, end stage renal disease, anxiety, altered mental state, obesity and depressive disorder. The Admission MDS Assessment, dated 5/28/14, documented Resident #3 was cognitively intact with a BIMS score of 15 and had one fall since admission or prior assessment. The resident's fall risk care plan, dated 5/17/14, documented the resident was at risk for falls related to weakness. Under the gait balance problem a box beside wheelchair was marked. An approach plan documented the box was marked beside "use wheelchair properly." An Event Investigation Report dated, 6/17/14 at 10:30 AM, included a Fall Scene Investigation Report which documented the resident "was riding in [the] van and slid out onto [the] floor." The Fall Huddle section documented, "Resident slid from power w/c [wheelchair] to floor of van." The Root Cause section documented the resident was "not wearing [a] seat belt" and the initial	F 323	Staff training was immediately provided on 6/17/14 by the Staff Development Coordinator in regards to the event involving resident #3 hoyer transfer. Residents #3 has been observed being transferred with hoyer lift safely. CNA#6 was re-educated on 7/22/14 by the Director of Nursing on what a mechanical soft diet is. Resident #6 is receiving the correct dietary textures for mechanical soft diet. Resident #6 is receiving the correct thickness of fluids in the dining room. Staff distributes fluids to all residents' in the dining area. Resident #1 has had their side rail assessment updated and assessed for safety on 7/25/14.	

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F 323	Continued From page 24 intervention to prevent future falls documented, "Ensure seat belt is secure before transfers." The Summary of Investigation for the Facility Vehicle Incident for the reported date of 6/17/14, documented in the Conclusion section, "The team did determine that the facility failed to validate the resident was wearing her seat belt." A Progress Note, dated 6/17/14 at 11:45 AM, documented, "Bus driver stated that Res[ident] slid out of her w/c [wheelchair] in transit, came back to facility for help." On 7/22/14 at 12:10 PM, Resident #3 was interviewed by the surveyor regarding the van accident. The resident said she didn't think the bus driver saw a lady who was in the crosswalk and said, "Watch out for that lady." Resident #3 stated, "I think that is when I fell out of my power chair...I slid out of the power chair with a thud." She then stated, "The van driver left me where I was until we got back to the facility, which was across the street...I had a bump on my head and a cut on my hand but I wasn't really hurt." On 7/23/14 at 11:40 AM, the van driver was interviewed by the surveyor, with the Administrator present, regarding Resident #3's fall on 6/17/14 in the van. She stated, "I forgot to check to see if the seat belt from the van was on her and didn't check the power chair seat belt." The Administrator then stated, "She needed to ensure the seat belt was fastened to the van and didn't ensure the power chair seat belt was fastened, which she should have done." The facility's policy and procedure for General Automobile Practices documented, "#5.	F 323	Storage room on the 300 hall was secured on 7/22/14 by the Maintenance Director. • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents who ride in the facility van are at risk for the failed practice. Transportation director was re-educated on the facility transportation safety policy by the Administrator. Residents riding in the facility van have been observed to be secured with a seatbelt as observed by the Administrator. Residents in the facility that use a hoyer lift for transferring are at risk. Residents using the hoyer lift have been observed to be transferred properly and with the appropriate hoyer sling by the Director of Nursing.	

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F 323	Continued From page 25 Individuals driving or riding in any vehicle must abide by safety laws including wearing seat belts at all times while the automobile is in motion...#9 c. Do not set an automobile in motion until passengers are safely seated with the lap and shoulder restraints secured and all doors are shut. If the passenger is in a wheelchair, secure the wheelchair as well." A second Event Investigation Report, dated 6/17/14 at 11:45 AM, documented Resident #3 fell as a result of an "accident during Hoyer transfer" and documented a bruise to the left inner thigh. The resident was sent to a local hospital at 12:30 PM. The Fall Scene Investigation Report, dated 6/17/14 at 11:45 AM, documented the factor observed at the time of the fall was due to "equipment malfunction, Hoyer." The report documented the fall occurred in the resident's room when the resident was assisted by staff during Hoyer transfer. The Root Cause section documented, "Resident started moving in Hoyer while being transferred, leaned out side of sheet, was eased to the floor" and the initial intervention to prevent future falls documented, "Use full Hoyer sheet instead of sheet that goes between legs." The Summary of Investigation for Neglect with a reported date of 6/17/14, documented in the Conclusion section, "...the facility used proper Hoyer transfer procedure. A new Hoyer sling will be used to avoid pressure to the residents groin area, due to the current injury...staff will be reeducated on safe Hoyer transferring training techniques." A Progress Note, dated 6/17/14 at 12:00 PM, documented, "Phone call to 911, Res[ident]	F 323	Residents in the facility that have altered diets are at risks for the failed practice. Residents with altered diets have been reviewed for safety and care directives are in place. Residents in the facility that have side rails are at risk for the failed practice. Residents with side rails have had their safety assessments have been reviewed for safety. Residents in the facility have the potential to enter the unsecured storage room. Maintenance will review all storage rooms to validate they are secure. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** The facility transportation director will be re-educated by the Administrator to validate residents are secured in the facility van correctly.	

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F 323	Continued From page 26 eased to floor from Hoyer and is c/o [complaining of] pain. Paramedics here to take res to ER (Emergency Room). A second Progress Note, dated 6/17/14 at 12:00 PM, documented, "This nurse was called to [resident's room] to assist with a Res that had fallen, when I entered the room the Res was lying on the floor in the supine position next to her bed...Res transported to...ER." A handwritten witness statement by CNA #10, dated 6/17/14, documented, "As I started to lift her up [Resident #3] began to yell saying that the sling was digging in to her crotch. [CNA #9] and I assured her that she would be ok and in bed soon...once chair was removed, pt [patient] became restless and continued to say "hurry hurry!" As she yelled she began to lean to her right side in which [Resident #3] managed to slip her top part of her body out of sling. I then was able to cradle [Resident #3's] head and shoulders to the floor while CNA #9 went for help. CNA #6...suggested that the Hoyer lift be lowered all the way. CNA #6 lowered the Hoyer while CNA #9 held on to [Resident #3's] legs which had gotten twisted in the whole process. Resident was complaining of left leg and left hip pain. Resident was then lowered in which she was laying on Hoyer legs." An Investigator's Interview/Statement of Event by CNA #6, dated 6/17/14, documented in the Description of Event/Injury, "...saw the CNA's trying to clean [resident] her leg was up in the Hoyer lift. I said push the bottom and lower her." In a statement about what CNA #6 saw, she documented, "I saw [resident's] leg up in the air, the girls were trying to clean her."	F 323	Nursing staff will be re-educated by the Director of Nursing or designee on how to use the hoyer correctly, and use the appropriate sling for the resident. Nursing staff will also be re-educated by the Director of Nursing and or designee to validate staff are aware they should stop a transfer and assess the resident if they state they are in pain. Facility staff have been re-educated by the Dietician and or designee on how to identify what altered diets are and how to identify residents who have an alerted diet. Facility staff have been re-educated by the Director of Nursing and or designee that the appropriate fluids need to be passed to residents at meals times. Nursing staff have re-educated by the Director of Nursing and or designee on how to complete a side rail safety assessment.	

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F 323	Continued From page 27 A Care Directive for Resident #3 documented in the Transfer section with a date of 6/17/14, to check for proper Hoyer sheet size On 7/23/14 at 12:20 PM, the DNS was interviewed by the surveyor regarding the Hoyer event and stated Resident #3 went to the ER after the accident to be evaluated because the resident complained she hurt everywhere. She stated, "Before the resident went to the ER, we noticed a bruise on her left inner thigh and the ER conclusion was the resident had a contusion and hematoma. It is resolving but the resident still has a bruise." When asked if residents normally get a bruise or hematoma with Hoyer transfers, the DNS stated, "No, we changed the type of Hoyer sheet to a full sheet and did an in-service on Hoyer transfer." On 7/24/14 at 6:10 PM, the Administrator, DNS and RDCO were made aware of the concerns with falls. No further information was provided by the facility. 2. Resident #6 was originally admitted on 5/28/2014 with multiple diagnoses including untreated myocardial infarction, atrial fibrillation, muscle weakness, dementia, and clostridium difficile and readmitted on 6/16/2014 after a suprapubic catheter placement. The Resident's 6/19/2014 Bedside Swallow Evaluation documented the following: *Regular texture: Resident was unable to because of partial dentition with signs and symptoms (s/s) of dysphagia. *Mechanical soft texture: Resident displayed mild issues with prolonged mastication time but no s/s	F 323	Facility staff will be re-educated by the Administrator to validate all storage rooms are locked. Nursing staff have been re-educated by the Director of Nursing or designee to complete care directive updates and update the twenty four hour report log to validate changes in a residents care are communicated. • ***How will the plan be monitored to ensure the solutions are sustained?*** The Administrator or designee will complete audits and interviews starting on 9/29/14 that will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month. To validate that residents are secured in the facility van correctly.	

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F 323	Continued From page 28 of aspiration. *Puree texture: Within functional limits. *Thin Liquids in a Cup: Resident displayed profound issues of dysphagia. Resident exhibited a delayed cough response following thin liquid trials. *Nectar liquids: Within functional limits. *Behaviors Impacting Safety: Reduced attention to task. *Recommendations: Solids: Mechanical soft textures/chopped textures, Mechanical Soft/Ground textures, Moist Puree Consistencies. Liquids: Nectar thick liquids. Resident #6's current Nutrition Care Plan documented as follows: "...6/19/14 D/C [discontinue] Reg [regular], Reg Diet, Begin with Reg, Mech [mechanical] soft, nectar thick liquid..." The resident's July 2014 Physician Order recapitulation documented: "DIET: Regular, TEXTURE: Mech [mechanical] Soft (NECTAR THICK LIQUIDS)...Order date 6/19/2014." On 7/22/2014 at 12:40 PM, Resident #6 was observed in the main dining room having lunch. The resident had a plate with a hamburger, leaves of lettuce, a slice of tomato and a bowl of potato chips. CNA #6 placed the slice of tomato on the resident's hamburger and cut the hamburger into sections. The resident's meal card listed his diet: "Diet: Regular/Texture:Mechanical Soft - Thickened water (nectar)." At 12:50 PM, OT #7 was interviewed regarding the potato chips and his mechanical soft diet. The	F 323	The Director of Nursing and or designee will complete audits starting on 9/29/14 that will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month. To validate that hoyer transfers are completed safely. And the appropriate sling for the residents is used. The Dietician and or designee will complete audits starting on 8/25/14 that will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month. To validate that residents are receiving the correct textured diet and fluids during meals. Director of Nursing and or designees will complete audits starting on 8/25/14 that will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month. To validate that side rail assessments are complete and safe for the resident.	

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F 323	Continued From page 29 OT stated, "No, I don't think potato chips would be considered mechanical soft. [Resident's name] was supposed to have mashed potatoes and he asked [CNA #6's name] for the potato chips, which she provided." At 12:52 PM, the Dietary Consultant was asked about the lettuce and tomato being considered mechanically soft. The Dietician stated, "Sliced tomatoes need to have no skin on them to be considered mechanical soft and the lettuce needed to be shredded to be okay." On 7/22/2014 at 1:10 PM, the surveyor interviewed Resident #6's spouse and she stated, "He had a speech evaluation and it was determined he was choking on things. His teeth are in very poor shape. They are putting thickener in his drinks and the food is softer also. He doesn't mind at all and it has been helpful." On 7/23/2014 at 6:12 PM, Resident #6 was observed in the main dining room at dinnertime with a glass of water directly in front of him and a pitcher of water with ice cubes accessible to the resident. The Dietary Consultant stated, "There is no thickener in the water glass. I think it belonged to someone else. He could have reached the glass and the pitcher." On 7/25/14 at 12:00 PM, the Administrator, DNS and RDCO were made aware of the issue. No further information was provided by the facility. 3. Resident #1 was amitted to the facility on 3/19/14 with multiple diagnosis including, Altered	F 323	Director of Nursing or designees will complete audits starting on 8/25/14 that will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month. To validate that care directive side rail assessment are complete and safe for the resident. Administrator and or designee will complete audits starting on 8/25/14 that will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month. To validate that storage rooms are locked. All findings will be brought to CQI monthly for further review and educational opportunities. • *The ED is responsible for compliance* *Compliance date is ~~10/28/14~~* 11/3/14 chg per facility request 11/4/14 TR	

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F 323	Continued From page 30 Mental Status, encephalapathy and below the knee amputation. On 7/22/14 at 8:12 AM, and at numerous other times during the survey, the resident's bed was observed with a 1/2 side rail to the left side of the bed in the upright position. Upon review of the resident's medical records, no documented assessment was found to show the resident was safe with the side rail. On 7/24/14 at 1:01 PM, the DNS was interviewed regarding no safety assessment for the 1/2 side rail, on the device evaluation form. She stated "Yes, it is not there, we document when [something] is unsafe not safe." On 7/24/14 at 6:10 PM, the Administrator and the DNS were informed of the finding. No other information or documentation was provided by the facility. 4. On 7/22/14 at 9:32 a.m., the 300 Hall Storage Room door was observed closed and the door knob locked. However, the door opened with a light push and the following hazardous items were found inside the unsecured storage room: * A 1 quart plastic container of carpet and flooring adhesive - "May be skin and eye irritant" and "Caution! ...Avoid contact with skin or eyes...;" * A 5.5 fluid ounce tube of Tub Seal Latex - "Caution: Contains ethylene glycol and petroleum distillates. Do not take internally. If ingested, may cause slight discomfort...;" * A 32 fluid ounce spray bottle of Mold Armour Mildew Stain Remover Plus Blocker - "Caution:	F 323		

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F 323	Continued From page 31 Avoid contact with eyes. Do not take internally...;" * A 1 pint can of Multi-Purpose Remover - "Danger: Harmful or fatal if swallowed. Vapor harmful. Flammable;" and, * A single handle 6 inch long serrated saw blade. On 7/22/14 at 9:45 a.m., the DNS accompanied 2 surveyors to the 300 Hall Storage Room. Again, the door was closed and the knob was locked; however, the door opened when the DNS pushed on it. The DNS acknowledged the hazardous items in the unsecured room. The DNS said the door was not securely locked and that she would immediately notify maintenance. The DNS left and returned moments later with the Regional Vice President (RVP) and Maintenance Supervisor with her. The RVP stated, "I noticed it on rounds this morning." He said he had "pulled hard on the door" and he "thought it was closed."	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it	F 328	***F328*** • ***How corrective action accomplished for the identified residents?*** Resident #3 has had their CPAP orders reviewed for completeness, accuracy, and to validate the resident is receiving as ordered on 8/13/14 • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility that have respiratory care needs are at risk for the failed practice. Residents with respiratory care orders have been reviewed for accuracy and completion.	

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F 328	Continued From page 32 was determined the facility failed to obtain orders on admission for a resident who regularly used CPAP (continuous positive airway pressure). This was true for one of four residents (#3) sampled for respiratory care. This failure created the potential for the resident to experience increased sleepiness and lethargy during the day. Resident #3 was admitted to the facility on 5/16/14 and readmitted on 7/11/14 with multiple diagnoses which included dislocation of right shoulder, end stage renal disease, anxiety, altered mental state, obesity and depressive disorder. The resident was hospitalized from 7/8/14 through 7/11/14 for a right shoulder replacement. A Progress Note showed a late entry on 5/17/14 at 2:00 PM for 5/16/14 which documented, "Res[ident] has a CPAP which was assembled and 02 (oxygen) brought in, air concentrator...CPAP set up. Family in and obtained...face mask for CPAP." Record review did not include documentation an order for CPAP had been obtained from the resident's physician. On 5/27/14 at 11:10 AM, a Progress Note documented, "Resident returns from appt [appointment] with sleep institute WO [without] new orders given, only to continue CPAP at 15 cm [centimeters] H20 [water] nightly and to return for a follow up in 2 months." The order did not include how many liters of oxygen were needed. A Physician's Progress Note, dated 5/27/14, documented Resident #3 had been using the "CPAP with pressure @ 15 cm H20 and her AHI	F 328	• ***Address what measures will be put in place to ensure deficient practice will not recur.*** Nursing staff will be re-educated by the Director of Nursing and or designee to validate that respiratory care needs have orders that are complete and accurate. • ***How will the plan be monitored to ensure the solutions are sustained?*** The Director of Nursing or designee will complete audits starting 8/25/14 that will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1day a week X1 month, to validate that respiratory care orders are correct. All findings will be brought to CQI monthly for further review and educational opportunities. • ***The ED is responsible for compliance*** ***Compliance date is ~~10/28/14~~*** Chg per facility Request 11/3/14 11/4/14 DR	

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F 328	Continued From page 33 [Apnea-Hypopnea Index - used to assess the severity of sleep apnea] average is 5.3/hr, great improvement from 22.2/hr...will follow-up in 2 months." On 5/27/14 a Physician's Order documented, "Continue CPAP @ 15 cm H20 nightly." NOTE: The physician's order for CPAP was obtained 11 days after the resident was admitted. A care plan for the problem of alteration of respiratory status was initiated on 5/27/14. The approach documented, "Use CPAP as ordered" but did not include the CPAP parameters included in the order or how many liters of oxygen were needed. On 7/11/14 a Physician Order Sheet contained readmission orders from the resident's hospitalization which documented the following order: "CPAP/BiPAP [bi-level Positive Airway Pressure] @ [at] _____cm with _____liters of 02 @ HS [hour of sleep] off in AM." However, none of the blanks had been filled in. On 7/24/14 at 4:20 PM, the surveyor interviewed the DNS regarding the CPAP concerns and why an order was not obtained until 5/27/14. The DNS stated, "We should have obtained an order for CPAP with parameters when she [Resident #3] was admitted, however, respiratory distress was not noted." On 7/24/14 at 6:10 PM, the Regional Vice President, Administrator, DNS, and RDCO were made aware of the concerns regarding Resident #3's CPAP. No further information was provided by the facility.	F 328		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to consider the risk identified in the black box warning for antipsychotic medications. This was true for 1 of 9 sampled residents (#1). This created the potential for harm if residents or their representatives did not have adequate risk versus benefit information prior to starting an antipsychotic medication which could lead to	F 329	*F329* • ***How corrective action accomplished for the identified residents?*** Resident #1 has a consent signed and educated to the black box warning of the medications they take on 8/7/14. • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility that take medications that have Black Box warnings have been informed of the risk of death and other side effects and new consents signed. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** Nursing staff will be re-educated by the Director of Nursing and or designee to educate patients about all medications with a black box warning, and the new consent form by the Director of Nursing.	

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F 329	Continued From page 35 adverse reactions and health decline. Findings included: 1. Resident #1 was admitted to the facility on 3/19/14 with multiple diagnoses including, Altered Mental Status and Bipolar Disorder. The resident's physician order dated 4/23/14 documented "Abilify 10 MG , 1 PO [by mouth] QD [every day]. Dx [diagnosis] Bipolar. The May, June and July 2014 MAR documented the resident had received the medication as ordered. The resident's informed Consent For Medication form was signed by the resident on 3/19/14 and contained potential risks and benefits, however the document did not contain a warning of increased risk of death in the elderly for antipsychotics. On 7/24/14 at 1:01 PM, the DNS was interviewed regarding the consent form. She stated, "Our consent does not have risk of death at this time, but we are rolling out a new policy with this risk." On 7/24/14 at 6:10 PM the Administrator and the DNS were informed of this issue. The facility provided no further documentation.	F 329	• ***How will the plan be monitored to ensure the solutions are sustained?*** The Director of Nursing and or designee will complete audits starting on 8/25/14 that will be completed 3 days a week X4 weeks, and 2 days a week X4 weeks, and 1 day a week X1 month, to validate that residents who take medications that have black box warnings have consents signed and are educated about the risks. All findings will be brought to CQI monthly for further review and education. • ***The ED is responsible for compliance*** ***Compliance date is ~~10/28/14~~ 11/3/4***	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by:	F 332	***F332*** Chg per facility request 11/4/14 DE • ***How corrective action accomplished for the identified residents?*** LN#4 received re-education about the medication error that could occur if contra indicated medications were given together. Resident #16 discharged from the facility on 7/24/14.	

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F 332	Continued From page 36 Based on observation, record review, and staff interview it was determined the facility failed to ensure 2 random residents (#s 12 and 16) were free from medication errors. This failure created the potential for less than optimum benefit from prescribed medications when the medications were not administered as ordered. The facility's medication error rate was 7.14%. Findings include: 1. Resident #12's physician orders dated 3/10/14, documented, "Ferrous Sulfate 325 MG (65 MG Iron) (1) tablet, delayed release (enteric coated) oral" and "Carafate 1 gram (1 tab[let]) before meals and HS [hours of sleep] oral". On 7/23/14 at 10:45 PM, LN #4 was observed administering Ferrous Sulfate and Carafate together. The resident's medication dispensing card warning documented not to give Iron with Carafate. The card warning documented to wait at least 1 hour. When LN #4 was stopped from giving the medication at the same time, shown the warning and asked about giving the two medications at the same time, she stated, "Oh I didn't know." 2. Resident #16's physician orders dated 5/6/14, documented, "Myrbetriq F/C 25 MG (1) Tablet, extended release 24 HR (hours) oral." One time daily starting 5/6/14. On 7/24/14 10:50 AM, LN #11 was observed administering medication to the resident, however LN #11 said the Myrbetriq was not available at the time of the medication pass nor was it available in the PYXIS dispensing machine. LN #11 stated the medication would not be given that day,	F 332	• ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. All residents in the center have had their medications assessed to ensure medications are not contraindicated by the pharmacy. Residents have had their medication records reviewed to validate the medications ordered are in the center. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** Nursing staff will be re-educated to follow manufacture medication administration guidelines by the Director of Nursing and or designee. Nursing staff re-educated on the policy for medication shortages and unavailable medications by the Director of Nursing and or designee.	

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F 332	Continued From page 37 although it was ordered the day before and should be in that night, "it would be available for tomorrow's morning medication pass." On 7/24/14 at 2:27 PM, the DNS was interviewed and stated, "We have taught the nurses not to miss more than 3 scheduled doses. If a dose is missed they must document on the back of the MAR, the date, the time and why the medication was missed. If needed they can get a dose with a local pharmacy within 4 hours or they can order the medication through our contracted pharmacy and it will come in with the nightly shipment." On 7/24/14 at 6:10 PM, the Administrator and DNS were informed of the issues. No further information was provided.	F 332	• ***How will the plan be monitored to ensure the solutions are sustained?*** The Director of Nurse will start audits on 8/25/14 that will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1day a week X1 month. To validate that manufacture medication administration guidelines are being followed. The Director of Nursing or designee will start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1day a week X1 month. To validate that medication shortage and unavailable medications are being handled per policy. All findings will be brought to CQI monthly for further review and educational opportunities.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this	F 353	• ***The ED is responsible for compliance*** ***Compliance date is ~~10/28/14~~*** 11/3/14 Chg per facility ***F353*** • ***How corrective action accomplished for the identified residents?*** Resident #11 has discharged from the facility on 6/10/14	

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F 353	Continued From page 38 section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on a resident group interview, record review, ombudsman, resident, family and staff interviews, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of all residents. This affected 1 of 11 sampled residents (#11), 1 random resident (#12), and 3 of 3 residents who attended the group interview. And, it had the potential to affect all other residents who lived in the facility who required staff assistance with their ADLs. This failure created the potential for psychosocial and physical harm to the residents in the facility. Findings included 1. Documentation: a. On 7/21/14 the facility grievance file was requested. Upon review, a Concern/Comment form for Resident #11 dated 6/6/14, documented the following: *Under the Nature of Concern section, "Resident has leaking colostomy bags that were to be changed while PT [Physical Therapy] was waiting for resident. Nurse took over two hours to change bag. Was told he was not a "priority resident." *Under the Action section of the form, "Res[ident] and family wanting to go out of facility for day. RN was working [with] another p[atien]t. Resident wait time 30 min[utes] to 1 [hour]...Nurse did have resident wait for a period of time, but both nurses stated that the [colostomy] bag was not overflowing or leaking upon assessment."	F 353	Resident #12 has had her call light audit times under review and call light is being answered timely. • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. Call light audits have been completed and call lights are being answered timely. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** Facility staff will be re-educated about call light response time by the Director of Nursing and or designee. • ***How will the plan be monitored to ensure the solutions are sustained?*** The Director of Nursing will start audits on 8/25/14 and will begin completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month, to validate that call light response times are timely.	

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F 353	Continued From page 39 *Under the findings section, "Colostomy bag was not overflowing, bed linens were clean and dry...Family was satisfied [with] resident's care. Staff education r/t [related to] call light response..." Note: A "Summary of Investigation Abuse" investigation was attached to the Concern/Comment form. The investigation findings documented in the conclusion section that neglect did not occur in this situation. b. Resident #11's Progress note on 6/6/14 at 12:00 PM, documented by an LN, "PT [Staff Name] Alerted RN that Resident's [Resident Name] colostomy bag x [times] 2 needed [changed]. RN aknowledged [sic] PT's request. RN to Resident's room ASAP/Available [at] 1245 [12:45 PM] 1300 [1:00 PM] to address needs of Resident. Resident family made aware of delay [and] reason R/T more critical needs of other Residents [at] that time. Resident/family verbalized understanding." 2. Resident Interviews: a. On 7/21/14 at about 1:45 p.m., during the initial tour of the facility, Resident #12 was asked how staff responded when she wanted something or needed help. The resident stated, "Sometimes good, sometimes bad when my legs are swelled up and my [call] light is on." The resident said she had had to wait 20-30 minutes sometimes and she had told staff about it, "But it doesn't change." b. On 7/23/14 at 2:30 PM during the resident Group Interview, 3 out of 3 residents complained call light response times was an issue. They said 25 to 30 percent of the time, they waited 20 minutes or more. They said the problem occurred	F 353	The Administrator or designee will start audits on 9/22/14 and will begin completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month, to validate that interview with families, residents, and therapists have been completed about call light response times and issues have been addressed. The Administrator or designee will start audits on 9/29/14 which will be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1day a week X1 month, to validate that grievances/concerns are being reviewed for concerns regarding call light responses. Resident council meeting minutes to be reviewed starting 8/25/14 monthly X3 months to validate residents are satisfied with call light response times.	

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F 353	Continued From page 40 mostly during the evening and night shifts. One of the residents stated, "It's a growing problem." 3. Family Interview: On 7/24/14 at 1:30 PM, during a family interview, the family member was asked about the resident's needs, he/she said the resident was not checked on often enough by staff. When asked to clarify he/she said the staff was nice enough, but felt the resident only got attention when the family came in to visit. 4. Ombudsman Interview: On 7/21/14 at 1:30 PM, the local Ombudsman was interviewed about concerns. The Ombudsman said during onsite visits she had complaints by residents regarding slow call light response times. 5. Staff Interview: On 7/24/14 at 8:52 AM, the DNS was interviewed regarding Resident #11's Concern/Comment form and progress notes from 6/6/14. When asked why there was a delay in the resident's colostomy bag change, the DNS said the nurse at the time had to work with another critical resident and had to prioritize the care needs. When asked about the progress note, she agreed the resident had to wait at least 45 minutes and possibly up to an hour to be assisted with his care needs and the family was delayed in taking the resident out of the facility at the time. On 7/25/14 at 12:00 PM, the Administrator, DNS, and Regional Director of Clinical Operations were informed of the staffing issue. No further	F 353	All findings will be brought to CQI monthly for further review and educational opportunities. • ***The ED is responsible for compliance*** ***Compliance date is ~~10/28/14~~*** 11/3/14 Chg per facility request 11/4/14 JR	

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F 353	Continued From page 41 information was provided by the facility.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food contact and non-food contact surfaces were free of debris and grime accumulation and failed to ensure food was prepared and served under sanitary conditions. This affected 1 of 9 sample residents (#s 1-9) and had the potential to affect all residents who dined in the facility. This failure created the potential for cross contamination of food and exposed residents to potential disease causing pathogens. Findings included: 1. On 7/21/15 1:15 to 1:45 PM, during the initial tour of the kitchen, with the Registered Dietician (RD) in attendance, the following was observed: *There was an accumulation of light brown greasy substance with food debris in the bottom of a drawer full of utensils which included various scoops, a potato masher, a spatula, and other food preparation utensils. The substance was in direct contact with several of the items in the	F 371	*F371* • ***How corrective action accomplished for the identified residents?*** The greasy drawer was washed and cleaned on 7/21/14. The dirty bowls were washed and cleaned on 7/21/14. Dietary Aide #2 was provided re-education about facial hair in the kitchen by the Regional Dietician on 7/23/14. • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. Bowls and drawers in the kitchen have been inspected and are clean. Dietary Aid #2 is free of facial hair. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** Dietary staff will be re-educated to about keeping drawers and bowls clean by the Dietician and or designee.	

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F 371	Continued From page 42 drawer. The RD said, "Something we need to clean, I think." The RD then took the whole drawer with the utensils and placed them in the dirty dish area to be cleaned. *On a wire shelf on trays were cleaned plastic bowls and mugs. 3 of 7 bowls inspected contained several rice sized pieces of food debris inside the bowls. The RD stated, "I think it's cereal...oatmeal or something." 2 of 8 plastic mugs inspected contained dried streaks of a brown powdery substance inside of them. The RD stated, "It's going to be dried hot chocolate or...other beverage." The 2009 FDA Food Code, Chapter 4, Part 4-6, Cleaning of Equipment and Utensils, Subpart 601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils indicated, "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. On 7/23/14 from 5:40 PM to 5:50 PM, Dietary Aide #2 (DA) was observed entering the kitchen without a facial restraint to cover his chin hair goatee beard, which was approximately 1 inch in length. DA #2 was in the kitchen for 2 minutes before coming out into the main dining room. He went into the kitchen two more times and was observed at 5:50 PM inside the kitchen in the food preparation area dishing up 3 cups of ice cream. At 5:53 PM the Regional Dietician was asked about the lack of facial hair restraint and	F 371	Dietary staff will be re-educated about hair restraints in the kitchen by the Dietician and or designee. • ***How will the plan be monitored to ensure the solutions are sustained?*** Dietician will start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1 month, to validate that bowls and drawers are clean. The Dietician will start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1day a week X1 month, to validate that hair restraints are being used in the kitchen area. All findings will be brought to CQI monthly for further review and educational opportunities. • ***The ED is responsible for compliance*** ***Compliance date is ~~10/28/14~~*** 11/3/14 Chg per facility request 11/4/14	

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F 371	Continued From page 43 she stated, "I wasn't even paying attention to it. He needs to put one on." She then spoke to DA #2 and a few minutes later he was observed with a facial hair restraint. The 2009 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles." On 7/23/14 at 7:00 PM, the Administrator and DNS were informed of the issues. No further information was provided by the facility.	F 371	*F431* • ***How corrective action accomplished for the identified residents?*** LN#13 was re-educated about medication administration standards by the Director of Nursing. • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. Medication carts have been observed randomly to validate they are locked and keys are not left on the cart.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 431	Continued From page 44 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were stored in locked areas and not accessible to residents. This was true for 1 of 2 medication carts when the keys were left on top of the unattended cart in the 200 Hall. This created the potential for more than minimal harm for all independently mobile residents if they ingested the accessible medications. Findings included:	F 431	• ***Address what measures will be put in place to ensure deficient practice will not recur.*** Nursing staff will be re-educated about medication administration standards by the Director of Nursing and or designee. • ***How will the plan be monitored to ensure the solutions are sustained?*** Director of Nursing and or designee to start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X2 weeks, and 1 days a week X1 month, to validate that Medication carts are being locked and keys are not left out and accessible. All findings will be brought to CQI monthly for further review and educational opportunities. • ***The ED is responsible for compliance*** ***Compliance date is*** ~~10/28/14~~ 11/3/14 Change per facility request 11/4/14	

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F 431	Continued From page 45 On 7/23/14 at 12:07 PM, LN #13 was observed during medication pass. LN #13 left the keys to the medication cart on top of the cart and walked away for several minutes when she went into a resident's room and closed the door. On 7/23/14 at 12:15 PM, LN #13 was interviewed and stated, "Oh, I locked the cart." On 7/25/14 at 12:00 PM, the Administrator and the DNS were informed of the surveyor's findings.The facility offered no further information.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	***F441*** • ***How corrective action accomplished for the identified residents?*** CNA #14 was provided re-education verbally on 7/22/14 on proper hand washing by the Director of Nursing. No ill effects noted to the resident. CNA #14 is no longer employed at the facility as of 7/25/14. • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. Staff has been randomly observed to be following proper hand washing procedure.	

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F 441	Continued From page 46 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview, it was determined the facility failed to follow standard infection control practices to reduce the spread of infections and prevent cross-contamination for 1 of 9 (#3) sampled residents. This failed practice created the potential to spread infection from one resident to another. Findings included: Resident #3 was admitted to the facility on 5/16/14 and readmitted on 7/11/14 with multiple diagnoses which included dislocation of right shoulder, end stage renal disease, anxiety, altered mental state, obesity and depressive disorder. The resident's most recent Admission MDS Assessment, dated 7/17/14, documented the resident was cognitively intact with a BIMS Score of 15 and needed total assistance of 2 or more persons in the following areas: Bed Mobility, Transfer, Toilet Use, and Bathing.	F 441	• ***Address what measures will be put in place to ensure deficient practice will not recur.*** Nursing staff will be re-educated on proper hand washing procedure by the Staff Development Coordinator and or designee. • ***How will the plan be monitored to ensure the solutions are sustained?*** The Staff Development Coordinator and or the designee will start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X2 weeks, 1 day a week X1 month, to validate proper hand washing protocols is being followed.	

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F 441	Continued From page 47 On 7/22/14 at 8:55 AM, two CNA's, one of which was CNA#14, entered the resident's room to help get the resident out of bed for physical therapy. Another CNA entered the room and offered to help. All three CNA's were observed to wash their hands and to put on gloves. The DNS was present and closed the resident's window blinds. The three CNA's rolled the resident on her left side to place an adult brief on the resident. While the resident was in that position, a bandage was observed to be partially unattached on the resident's coccyx. The resident requested the DNS place a new bandage over the area. At this time, CNA#14 was observed to remove her gloves and dispose of them in the trash can. The CNA did not wash her hands and left the resident's room. On 7/22/14 at 9:15 AM, CNA #14 was interviewed by the surveyor, with the DNS present, regarding not washing her hands before leaving the resident's room. CNA#14 stated, "I had barely put on my gloves and didn't think I needed to wash them." When asked if this was the proper procedure, CNA#14 stated, "I know I should have washed my hands before leaving the room." The DNS nodded in agreement. The facility provided their Hand Hygiene Policy which documented hand hygiene, "After removing gloves or aprons." On 7/24/14 at 6:10 PM, the Regional Vice President, Administrator, DNS, and RDCO were made aware of the infection control concerns regarding handwashing. No further information was provided by the facility.	F 441	All findings will be brought to CQI monthly for further review and educational opportunities. The Staff Development Coordinator is responsible for infection control and will share information and validate policies are followed. • ***The ED is responsible for compliance*** ***Compliance date is ~~10/28/14~~*** 11/3/14 Chg per facility request 11/4/14 DS	
F 514	483.75(l)(1) RES	F 514		

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F 514 SS=E	Continued From page 48 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 record review and staff interview, it was determined the facility failed to maintain clinical records for each resident in accordance with accepted professional standards and practices to ensure the records were complete and accurate. This was true for 3 of 11 sample residents (#s 2, 3, and 10). This deficient practice created the potential for medical decisions to be based on incomplete or inaccurate information which increased the risk for complications due to inappropriate care or interventions. Findings included: 1. Resident #2 was admitted on 2/10/2014 with multiple diagnoses, which included Peripheral Vascular Disease, status post right below the knee amputation, diabetes, hypertension, transcerebral ischemia and anemia. The resident was readmitted on 4/14/2014 after a left below the knee amputation.	F 514	*F514* • ***How corrective action accomplished for the identified residents?*** Resident #2 discharged from the center on 7/11/14. Resident #10 discharged from the center on 6/10/14. Resident #3 CPAP orders have been reviewed for accuracy on 8/12/14. Resident #3 inventory list has been reviewed, signed, and dated by the patient on 8/12/14. • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. Residents in the facility with orders for oxygen have had their orders reviewed for accuracy.	

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F 514	Continued From page 49 a. The resident's 4/14/2014 admission Physician's Orders documented oxygen to be prn at 2 lpm (liters per minute) to 4 lpm and adjust to maintain sats (saturation) >88%. The resident's current Care Plan documented an alteration in respiratory function related to oxygen use and the goal as being oxygen saturation to remain greater than 90%. Resident #2's July 2014 Treatments-Respiratory Evaluation documented from 7/1/2014 to 7/22/2014 the resident's oxygen saturation per shift, oxygen liters per minute, and the staff members' initials that recorded the monitoring. The resident's oxygen was not monitored on 7/13, 7/17, and 7/18 on night shift, and 7/14 for any shift. Resident #2's July 2014 Physician's Orders Recapitulation does not reflect the oxygen order and there was no order for the oxygen to be discontinued. On 7/24/2014 at 5:00 PM, the DNS along with the Administrator was asked about the oxygen being dropped on the July 2014 Physician recapitulation. The DNS stated, "It's never been dropped, but through the recapping process it didn't get transcribed to the May recaps when readmitted with oxygen in April. It should have been transcribed over." b. On the Event Investigation Final Summary dated 2/17/2014 regarding a family-reported left foot injury for Resident #2, the LN documented the resident with a left below the knee amputation and a wound to the right lower extremity. The	F 514	Resident's with leg amputations have had their medical records reviewed for accuracy of the amputation. Residents in the facility have had their progress notes, treatment records, and other clinical information for all disciplines reviewed. To validate entries are timed, dated, resident names are included, and accuracy. Resident personal inventory sheets have been reviewed to validate accuracy and that they are signed and dated. Residents that have a CPAP have had their ordered medication and treatments records reviewed. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** Staff will be re-educated to validate clinical records for all disciplines are accurate and complete by the Director of Nursing and or designee.	

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F 514	Continued From page 50 resident had a right below the knee amputation prior to being admitted on 2/10/2014. The resident's ADL (activities of daily living) CAA dated 2/22/2014 documented "Antonio requires two person extensive assistance with all transfers and bed mobility r/t [related to] L [left] BKA [below the knee amputation] and history of right side weakness r/t history of CVA." On 7/24/2014 at 5:00 PM, the DNS along with the Administrator was asked about the discrepancies in documentation on whether Resident #2 had a right or left BKA when originally admitted. The DNS stated, "I can't argue with that." c. Progress Notes (PNs), dated 2/10 - 4/14/14, included untimed entries for documentaion on 2/20/14, 2/26/14, and 2/27/14. On 7/25/2014 at 12:00 PM, the Administrator, DNS, and RDCO were informed of the issue. No other information or documentation was received from the facility to resolve the issue. 2. Resident #10 was admitted to the facility on 5/7/14 and readmitted on 6/2/14 with multiple diagnoses which included hepatic encephalopathy, diabetes mellitus, ankle fracture, and lower extremity weakness. The following documents were found in the resident's closed clinical records: * A "TREATMENTS" form which was not dated and did not include the date range; * Two "WOUND/SKIN EVALUATION AND DOCUMENTATION FORMs" both of which did not include the resident's name; * Two Medication records which did not include	F 514	Staff will re-educated by the Director of Nursing or designee that inventory sheets are completed, accurate, and signed by the resident/guardian. • ***How will the plan be monitored to ensure the solutions are sustained?*** The Director of Nursing and or designee will start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1month, to validate oxygen orders are accurate. The Director of Nursing or designee will start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1month, to validate residents with amputations have accurate medical recorders of the amputation location.	

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F 514	Continued From page 51 the date range; and, * Two Personal Belonging Inventory lists, one for each admission/stay, and neither of which were dated or signed. Instructions at the top of Personal Belonging Inventory list were, "Upon admission complete form, listing quantity. Additional space is provided for other items as necessary...Update as necessary..." On 7/25/14 at 12:00 p.m., the DNS acknowledged that documentation for the resident was not consistently completed. She acknowledged the resident's name was missing on the aforementioned wound/skin forms and the date was missing on the aforementioned treament form. 3. Resident #3 was admitted to the facility on 5/16/14 and readmitted on 7/11/14 with multiple diagnoses which included dislocation of right shoulder, end stage renal disease, anxiety, altered mental state, obesity and depressive disorder. The resident was hospitalized from 7/8/14 through 7/11/14 for a right shoulder replacement. a. Review of the resident's medical record documented a Personal Belonging Inventory list without a facility signature or date the items were inventoried. The instructions documented, "Upon admission complete form, listing quantity." b. Resident #3's medical record included an original order for CPAP, written on 5/27/14, which documented, "Continue CPAP @ 15 cm H20 nightly." On 7/11/14 a Physician Order Sheet contained readmission orders from the resident's	F 514	The Director of Nursing or designee will start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1month, to validate that progress notes, treatment records are dated and timed, and accurate for all disciplines. The Administrator or designee will start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1 day a week X1month, to validate that admission agreements are signed, dated, complete, and accurate. The Director of Nursing or designee will start audits on 8/25/14 to be completed 3 days a week X4 weeks, 2 days a week X4 weeks, and 1day a week X1 month, to validate that CPAP orders are complete and accurate.	

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F 514	Continued From page 52 hospitalization which documented the following order: "CPAP/BiPAP [bi-level Positive Airway Pressure] @ [at] _____cm with _____liters of 02 @ HS [hour of sleep] off in AM." However, none of the blanks had been filled in. The July 2014 Treatments - Respiratory Therapy/Oxygen sheet documented the resident had an order for CPAP/BiPAP with an order date of 7/11/14. However, the parameters of cm (centimeters) and number of liters of 02 were not filled in on the treatment sheet. On 7/24/14 at 5:50 the DNS was interviewed by the surveyor regarding the missing information on Resident #3's Personal Belonging Inventory Sheet, the 7/11/14 readmission orders, and the missing parameters on the Respiratory Therapy/Oxygen Treatment Sheet. The DNS acknowledged the information was incomplete. On 7/24/14 at 6:10 PM, the Regional Vice President, Administrator, DNS, and RDCO were made aware of the concerns regarding the missing CPAP information and the problem regarding the accuracy of records and missing dates. No further information was provided by the facility.	F 514	All findings will be brought to CQI monthly for further review and education opportunities. • *The ED is responsible for compliance* *Compliance date is ~~10/28/14~~* 11/3/14 Chg per facility request 11/4/14	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001775		C 07/25/2014

NAME OF PROVIDER OR SUPPLIER: TETON POST ACUTE CARE & REHABILITATIO

STREET ADDRESS, CITY, STATE, ZIP CODE: 3111 CHANNING WAY, IDAHO FALLS, ID 83404

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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: Rebecca Thomas, RN, Team Coordinator, Brad Perry, BSW, LSW, Judy Atkinson, RN, Linda Kelly, RN and Linda Hukill-Neil, RN	C 000	RECEIVED OCT 23 2014 FACILITY STANDARDS	
C 111	02.100,02,f Provide for Sufficient/Qualified Staff f. The administrator shall be responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility, i.e., food services, housekeeping, maintenance, nursing, laundry, etc. This REQUIREMENT is not met as evidenced by: Refer to F353 regarding sufficient staffing to meet resident needs.	C 111	*C111* Refer to the plan of correction on the 2567 for F353.	
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	C 117	C117 Refer to the plan of correction on the 2567 for F156.	

eau of Facility Standards
ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10-22-14

Bureau of Facility Standards

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C 117	Continued From page 1 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 as it pertained to written acknowledgement residents were informed of their rights and all rules and regulations.	C 117	*C124* Refer to the plan of correction on the 2567 for F164.	
C 124	02.100,03,c,viii Confidentiality of Records viii. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care facility, or as required by law or third-party payment contract; This Rule is not met as evidenced by: Please refer to F164 as related to Clinical Record Privacy	C 124	*C125* Refer to the plan of correction on the 2567 for F241. Refer to the plan of correction on the 2567 for F164.	
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F241 as it related to dignity while dining. Please refer to F164 as it related to privacy during care/examination.	C 125		

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C 147	Continued From page 2	C 147		
C 147	02.100,05,g Prohibited Uses of Chemical Restraints g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please refer to F329 as related to Adverse Consequences, drugs.	C 147	*C147* Refer to the plan of correction on the 2567 for F329 *C159* • ***How corrective action accomplished for the identified residents?*** Resident #11 has discharged from the facility. • ***How you will identify other residents with the potential of being affected by the same practice?*** Residents in the facility are at risk for the failed practice. Resident belonging lists are completed before discharge, for residents in the facility. • ***Address what measures will be put in place to ensure deficient practice will not recur.*** Nursing staff will be re-educated to validate inventory sheets are being completed and signed by resident/guardian before the resident discharges, by the Director of Nursing and or designee.	
C 159	02.100,09 RECORD OF PTNT/RSDNT PERSONAL VALUABLES 09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request. This Rule is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure an accounting of personal possessions was completed upon discharge for 1 of 11 sample residents (#11). Findings include: Resident #11 was admitted to the facility on 5/17/14 with multiple diagnoses including difficulty in walking and muscle weakness, and was	C 159		

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C 159	Continued From page 3 discharged on 6/10/14. During review of Resident #11's records, an inventory of personal belongings was found, but was not signed by the responsible party or by a facility staff member upon discharge. No progress notes were found which documented the resident's personal effects were ever returned. On 7/24/14 at 4:40 PM the Administrator was interviewed about the personal belongings form. When asked if he could find where it was signed or where a progress note was made, he stated, "I don't see that they signed anything either...I know they [belongings]went with the resident." No other information was provided.	C 159	• ***How will the plan be monitored to ensure the solutions are sustained?*** Audits will began 8/25/14 to be completed 3 days a week X4 weeks and 2 times weekly X2 weeks by the Director of Nursing or designee to validate that inventory sheet are signed and completed. All findings will be brought to CQI monthly until the issue has been resolved.	
C 191	02.105,05 APPLICABLE IDAHO & FEDERAL LAWS 05. Applicable Idaho and Federal Laws. Applicable Idaho and federal laws shall be observed in relation to employment of any individual. This Rule is not met as evidenced by: Please refer to F226 as it related to not performing reference checks before hiring individuals.	C 191	• ***The ED is responsible for compliance*** ***Compliance date is 10/28/14*** ***C191*** Refer to the plan of correction on the 2567 for F226.	
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)."	C 325	***C325*** Refer to the plan of correction on the 2567 for F371.	

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C 325	Continued From page 4 This Rule is not met as evidenced by: Refer to F371 regarding kitchen sanitation.	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 related to unsecured chemicals and a sharp instrument.	C 342	*C342* Refer to the plan of correction on the 2567 for F323.	
C 393	02.120,04,b Staff Calling System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F246 as it related to residents' call lights.	C 393	*C393* Refer to the plan of correction on the 2567 for F246	
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as:	C 644	*C644* Refer to the plan of correction on the 2567 for F441.	

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C 644	Continued From page 5 i. Handwashing techniques. This Rule is not met as evidenced by: Please refer to F-441 as it relates to Infection Control.	C 644		
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F-309 as it relates to providing necessary care and services for residents to attain or maintain their highest practicable well-being. Please refer to F-328 as it relates to obtaining orders for CPAP upon admission.	C 784	*C784* Refer to the plan of correction on the 2567 for F309. Refer to the plan of correction on the 2567 for F328	
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 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: Refer to F314 as it related to avoidable pressure ulcers.	C 789	*C789* Refer to the plan of correction on the 2567 for F314.	
C 790	02.200,03,b,vi Protection from Injury/Accidents	C 790		

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C 790	Continued From page 6 vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F-323 as it relates to accidents.	C 790		
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please refer to F-514 as it relates to accurate and complete medical records. Please refer to F-514 as it relates to complete, accurate, signed and dated medical records.	C 881	*C790* Refer to the plan of correction on the 2567 for F323. *C881* Refer to the plan of correction on the 2567 for F514.	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
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August 21, 2014

Kelly Spiers, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

FILE COPY

Provider #: 135138

Dear Mr. Spiers:

On July 25, 2014, a Complaint Investigation survey was conducted at Teton Post Acute Care & Rehabilitation. Rebecca Thomas, R.N., Bradley Perry, L.S.W., Judy Atkinson, R.N., Linda Kelly, R.N. and Linda Hukill-Neil, R.N. conducted the complaint investigation.

The complaint was investigated during the annual Recertification and State Licensure survey conducted on July 21 through July 25, 2014.

The following documents were reviewed:

- The facility's grievance and investigation about these issues;
- The facility's Resident Council minutes from May to July 2014;
- The entire medical records of the identified residents;
- Seven other residents were reviewed for Quality of Life and Quality of Care concerns;
- Staffing records for the days in question; and,
- Call light audits for the days in question.

Call light response times and residents' cares were observed.

The following interviews were completed:

- Three residents in a group interview were questioned regarding call light and care response times;
- Five residents were interviewed individually about call light and care response times;
- Two residents' family members were interviewed about call light and care response times;
- Various staff members were interviewed regarding call light and care response times; and,

- The Director of Nursing Services was interviewed regarding call light and care response times.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006521

ALLEGATION:

The complainant stated that on either June 9, 2014 or June 11, 2014, two identified residents did not have their call lights answered in a timely manner and care needs were delayed due to slow response times.

FINDINGS:

One of the identified resident's progress notes, grievance and investigation revealed the resident had to wait 45 minutes to an hour to have a colostomy bag changed.

The complaint was substantiated, and the facility was cited at F353 for failure to maintain sufficient staffing levels to meet the residents' needs.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

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

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

Sincerely,
Lorene Kayser

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

LKK/dmj