



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 2335

August 22, 2013

Rod Jacobson, Administrator
Bear Lake Memorial Skilled Nursing Facility
164 South 5th Street
Montpelier, ID 83254-1557

Provider #: 135070

Dear Mr. Jacobson:

On **August 2, 2013**, a Recertification and State Licensure survey was conducted at Bear Lake Memorial Skilled Nursing Facility by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 4, 2013**. Failure to submit an acceptable PoC by **September 4, 2013**, may result in the imposition of civil monetary penalties by **September 24, 2013**.

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

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

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

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

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 2, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

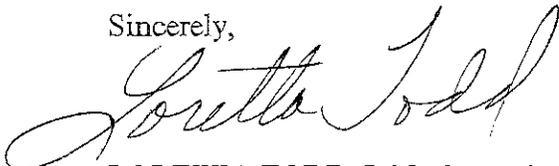
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **September 4, 2013**. If your request for informal dispute resolution is received after **September 4, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

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

LT/dmj
Enclosures

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

PRINTED: 12/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2013
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal Recertification survey of your facility. This survey report includes changes resulting from the Informal Dispute Resolution (IDR) process.</p> <p>The surveyors were:</p> <p>Nina Sanderson LSW BSW, Team Coordinator Linda Kelly RN Lauren Hoard RN BSN</p> <p>Survey definitions:</p> <p>MDS = Minimum Data Set ESRD = End Stage Renal Disease BIMS = Brief Interview of Mental Status PT/ INR =Prothrombin Time and International Normalized Ratio mg = milligrams CNA = Certified Nursing Assistant RN = Registered Nurse LN = Licensed Nurse DNS = Director of Nursing PEG = Percutaneous Endoscopic Gastronomy</p>	F 000	<p style="text-align: center;">RECEIVED JAN - 3 2014 FACILITY STANDARDS</p>	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was</p>	F 241		<p>F-241</p> <ul style="list-style-type: none"> Reviewed regulatory guidance @ Inservice on 08/08/13. Reinforced need to respect resident privacy by knocking on doors before entering the room of resident #2 and the rooms of all other residents.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admin	(X6) DATE 12-31-13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>determined the facility did not ensure a resident's privacy was protected. This was true for 1 of 6 residents (Resident #2) sampled for privacy. The deficient practice had the potential for more than minimal harm when facility staff repeatedly entered Resident #2's private living space without knocking. Findings included:</p> <p>Resident #2 was admitted to the facility on 5/30/13 with multiple diagnoses including ESRD and a right hip fracture.</p> <p>Resident #2's most recent Change of Condition MDS assessment, dated 6/11/13, coded a BIMS of 13, indicating the resident was cognitively intact.</p> <p>On 7/29/13 at 3:00 PM, during the initial tour of the facility, a sign was noted on the door to Resident #2's room, just above the door handle. The sign stated, "Please knock on my door before you enter. My privacy is very important to me."</p> <p>On 7/30/13 between 9:10 AM and 9:20 AM, a resident interview was conducted with Resident #2 in his room. During that time, CNA #6, CNA #7, and CNA #8 entered Resident #2's room without knocking. When asked about his privacy, Resident #2 stated, "Oh, they're always around like that. At least I guess there's plenty of help."</p> <p>On 7/30/13 at 11:05 AM, CNA #6 and CNA #8 were again noted to enter Resident #2's room without knocking.</p> <p>On 7/30/13 at 12:40 PM, RN #1 and RN #9 were observed to enter Resident #2's room together without knocking. When they exited the room a</p>	F 241	<ul style="list-style-type: none"> • All residents have the potential to be effected if their privacy is not protected. • Staff members will be required to read and acknowledge understanding of 'Dignity Policy' particularly pertaining to knocking on doors prior to entering. If non-compliance is observed, Staff member will be re-educated in the need to respect privacy by knocking on resident's doors before entering. • Staff members will be monitored at random times and on different shifts to assure compliance with knocking on doors before entering resident's room. <ol style="list-style-type: none"> a. The DNS, ADNS, or other appointed staff will do the monitoring. 	

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F 241	Continued From page 2 few minutes later, the surveyor asked them about the sign on Resident #2's door. RN #1 stated, "That's for other residents and visitors, so they know to knock before they go in." The surveyor then asked if the sign applied to staff. RN #1 stated, "Yeah, staff are supposed to knock." The surveyor then pointed out RN #1 and RN #9 had not knocked. RN #1 then stated, "I forget. I pop my head in the door and say and say hi as I go in." On 7/31/13 at 4:30 PM, the Administrator, DNS, and MDS nurse were informed of the surveyor's findings. The facility offered no further information.	F 241	<ul style="list-style-type: none"> b. Monitoring will be done daily times one week, weekly times one month, and monthly thereafter. c. Audits will begin on 08-06-13. • Date completion: 09-04-13 	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	<p>F-280</p> <ul style="list-style-type: none"> • The Care Plan (CP) for Resident (Res) #6 was updated on 08-02-13. Instructions for Restorative to provide swallowing exercises removed. (Swallowing exercises performed by Speech Therapist 2 times weekly). The CP for Res. #1 was updated 08-02-13. Her current order is for O2 @ 2L/min. ; the 3L/min was misprinted on her CP. The correct 2L/min order was fixed. 	9/4/13

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to update and/or revise residents' care plans after there were changes in the residents' status. This was true for 2 of 10 sample residents (#s 1 and 6). This failure created the potential for harm if staff were confused about directions for restorative swallowing exercises for Resident #6 and the liter flow rate for Resident #1's oxygen. Findings included: 1. Resident #6 was admitted to the facility on 12/8/08, and readmitted on 9/28/12 and 5/29/13, with multiple diagnoses which included CVA (cerebrovascular accident). Resident #6's significant change MDS assessment, dated 6/11/13, coded, in part: * Severe cognitive impairment, with a BIMS score of 3; and * Holds food in mouth/cheeks or residual food in mouth after meals. The resident's nutrition care plan, dated 6/14/13, interventions included, "Adhere to mechanical soft, thickened liquid diet. May have thin liquids between meals but requires meticulous oral care every morning, after meals and before bed to minimize the risk of aspiration pneumonia...Able to feed himself but requires extensive cueing and encouragement to complete the task...Restorative to perform swallowing exercises...5-6 times per week..." Review of the resident's clinical record revealed	F 280	<ul style="list-style-type: none"> All residents have the potential to be affected if CP's are not updated or revised after changes in a resident's status. CP's will be reviewed @ weekly QA meetings. Future CP's will reflect the date the intervention was implemented. During CP review, it will be determined if interventions are still appropriate or if further revisions need to be made to the CP. CP's will be reviewed per MDS schedule. CP's will be reviewed @ weekly QA meetings. Any changes to identified problems, goals or interventions will be documented on CP review log. <ol style="list-style-type: none"> CP review logs will be monitored by the DNS, ADNS or other appointed licensed nurse (medical review nurse). 		

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F 280	<p>Continued From page 4</p> <p>there was no documentation that swallowing exercises were provided by the restorative nursing program.</p> <p>On 7/31/13 at 3:10 p.m., the DON was asked about the restorative swallowing exercises per Resident #6's care plan. The DON stated the swallowing exercises by restorative were never provided because the restorative aide was not trained to do the exercises. The DON stated, "I should have taken it off."</p> <p>On 8/1/13 at 5:45 p.m., the Administrator was also informed of the issue. No other information or documentation was received from the facility which resolved the issue.</p> <p>2. Resident #1 was admitted to the facility on 10/16/10 with diagnoses of hypertension, diabetes, and bullous disease.</p> <p>The most recent quarterly MDS, dated 6/25/13, documented the resident: * Was cognitively intact with a BIMS of 15, * Required oxygen therapy.</p> <p>The "Nursing Orders" for July 2013 includes an order for oxygen (O2) at 2 LPM via nasal cannula (NC) to keep saturations greater than 90 percent for hypoxia. Note: On 7/31/13 at 10:30 a.m., an interview with the DON confirmed that the "Nursing Orders" are a direct reflection of the Physician's orders.</p> <p>A review of the resident's comprehensive care plan for O2 therapy, dated 1/22/13 and modified</p>	F 280	<p>b. Monitoring will be done weekly times 4 weeks, then monthly.</p> <ul style="list-style-type: none"> Date Completion: 09-04-13 		

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F 280	Continued From page 5 on 7/3/13, revealed four interventions related to oxygenation, which included; * Needs O2 per nasal cannula continuously at 3 liters per minute (LPM). On 7/31/13 at about 12:30 p.m., the DON was informed of the care plan issue. No other information or documentation was received that resolved the issue.	F 280			
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 interview and record review, it was determined the facility did not ensure PT/INR results were obtained per physician's order for residents receiving Coumadin. This was true for 1 of 2 residents (#5) sampled for Coumadin use. The deficient practice had the potential to cause more than minimal harm if the resident experienced bruising, bleeding, or other negative effects from Coumadin use. Findings included: Resident #5 was admitted to the facility on 1/25/13 with multiple diagnoses including atrial fibrillation. Resident #5's facility medication record for July	F 309	F-309 <ul style="list-style-type: none">The PT/INR for Resident #5 was drawn immediately upon discovery of the omission (06-10-13) and has continued to be drawn as ordered.All residents receiving Coumadin or requiring routine labs have the potential to be affected by the deficient practice.A policy for monitoring /tracking lab orders will be implemented and reviewed with Licensed Nursing staff on 08-28-13.A routine lab monitoring /tracking form will be developed. Lab orders will be reviewed every week day.	9/4/13	

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F 309	Continued From page 6 2013 documented the resident received Coumadin 2.5 mg every Monday and Thursday starting 2/25/13, and 5 mg every Friday, Saturday, and Sunday starting 2/23/13. In reviewing Resident #5's record, PT/INR results were noted for 1/21/13, 1/28/13, 2/12/13, 2/19/13, 2/22/13, 2/28/13, and 3/4/13. On 3/4/13, a physician's order for Resident #5 documented, "Next INR on 4/3/13. Then please do once monthly." On 4/3/13, Resident #5's record documented PT/INR results of 20.1 and 1.9, respectively. The next PT/INR results noted in Resident #5's record were dated 6/10/13, with values of 22.0 and 2.0, respectively. [NOTE: These values were within the acceptable range as identified by Resident #5's physician.] Resident #5's record also included PT/INR results dated 7/5/13. On 8/1/13 at 8:45 AM, the DNS was asked about PT/INR results from the blood test scheduled monthly for May, as specified in the physician's orders. The DNS stated, "It wasn't done." On 8/1/13 at 5:45 PM, the Administrator, DNS, and MDS nurse were informed of these findings. The facility offered no further information.	F 309	a. The Administrative Assistant or DNS will monitor. b. Monitoring will be done every day times one month and every week thereafter. c. Audits will begin 08-26-13 • Date Completion: 09-04-13		
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	F 314		9/4/13	

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F 314	<p>Continued From page 7</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, it was determined the facility failed to ensure residents with pressure ulcers received thorough wound assessments. This created the potential for the wound to worsen if treatment decisions were based on incomplete data. This was true for 1 of 2 sample residents (#1) reviewed for pressure ulcers. Findings included:</p> <p>Resident #1 was admitted to the facility on 10/16/10, and readmitted on 1/7/13 with multiple diagnoses including congestive heart failure, diabetes, pemphigoid, renal failure, and a tibial fracture.</p> <p>The resident's significant change MDS assessment, dated 1/14/13, documented in part: * BIMS score of 15, cognitively intact; * Bed mobility, transfer, walk in room and corridor, locomotion on and off unit, did not occur; * Dressing and toilet use, total dependent with 2 person assist; * Bathing extensive assist with 1 person; * Pain intensity of an "8" on a 1-10 pain scale; and, * Had no healed or unhealed pressure ulcers</p> <p>The resident's quarterly MDS assessment, dated 6/25/13, and different from the prior significant change assessment, was coded in part:</p>	F 314	<p>F-314</p> <ul style="list-style-type: none"> Nursing staff was educated in identification of risk factors for the development of pressure ulcers (PU) and for interventions for healing, prevention of infection, preventing new ulcers from forming and documentation requirements at Inservice on 08-28-13. Included in Inservice was education specific to interventions to promote healing of PU and prevention of new PU's from developing for Res #1. All residents determined to be at risk for the development of PU (per Braden Scale) have potential to be affected by the deficient practice. A second wound nurse was added to assist the primary wound nurse. Staff members were provided with specific criteria that must be assessed and documented with every dressing change (for existing wounds) and re-educated in prompt notification to MD when changes occur. 	

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F 314	<p>Continued From page 8</p> <ul style="list-style-type: none"> * Total dependent for bed mobility, transfer; * Dressing extensive assist with 2 person; * Bathing total dependent of 1 person; * Pain intensity of a "3" on a 1-10 pain scale; * Had 1 unstageable pressure ulcer with necrotic tissue and suspected deep tissue injury; * Had 1 stage II pressure ulcer; and, * Received ulcer care. <p>Resident #1's care plan identified the problem "07/3/13 Skin conditions skin integrity, impaired r/t (related to) bullous disease- pemphis vulgaris and limited physical mobility. Has pressure ulcer to left heel (unstageable)." A goal was, "No infections from Bullous disease through 10-3-12</p> <p>Pressure ulcer will heal by 10-3-13."</p> <p>Interventions were documented in part:</p> <ul style="list-style-type: none"> * Assist with repositioning at least every hour throughout the day and every two hours throughout the night. Repositioning kit to bed. * Pressure ulcer risk assessment at least every two weeks per licensed nurse. Current pressure ulcer risk per Braden scale is 13 (moderate). Place sheep skin underneath and between feet to prevent them from touching. Do not place heavy blankets on legs as left foot deviates to the left causing ankle to be at risk for re-injury r/t pressure. Guard extremities well during transfers in mechanical lift. * Apply splint to left leg only when up in wheelchair to dialysis chair. Remove when back in bed. * Inspect skin daily during toileting and other personal cares. Notify nurse of new reddened areas, open/drainng blisters, bruises, rashes or other breaks in the skin. * Nursing to inspect dressings daily per MD order. Report concerns to MD. * Do not use leg strap for catheter tubing. 	F 314	<ul style="list-style-type: none"> • Wounds are reviewed at weekly QA meetings to determine if interventions are appropriate or if further interventions are necessary to prevent PU's from worsening and to prevent the development of new ulcers. <ol style="list-style-type: none"> a. The DNS, wound nurses or other appointed LN will do the monitoring. b. Monitoring will be done weekly times 3 months, then biweekly thereafter. c. Audits will begin 08-27-13 • Date of Completion: 09-04-13 		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 9</p> <p>On 8/1/13 at about 10:00 a.m., when asked about Resident #1's left heel and left inner ankle pressure ulcers, the DON stated a Stage II left heel pressure ulcer was discovered when a left lower extremity cast was removed on 2/28/13 and the inner ankle pressure ulcer developed later. The DON also stated that after the cast was removed a "nonremovable" splint was placed to the left lower extremity. When asked for documentation regarding the pressure ulcer assessments and monitoring, the DON stated she would look into it.</p> <p>On 8/1/13 at 11:30 a.m., LN #1 stated she was the nurse who provided wound care, but she had been off work for personal reasons. When asked who provided the wound care in her absence, the LN indicated the floor nurses did it. When asked about Resident #1's unstageable left heel pressure ulcer and Stage II left medial ankle pressure ulcer, the LN said she would do some research and get back to the surveyors. She added that she was in the process of training other staff in wound care.</p> <p>On 8/1/13 at 4:00 p.m., LN #1 provided a stack of papers almost 2 inches thick regarding Resident #1's pressure ulcers. The LN indicated she had provided all the documentation she could find regarding the pressure ulcers.</p> <p>The documents LN #1 provided revealed the following documentation: * A 2/28/13 Physician's Order - Change LLE dressing daily with 2-3 people. * July 2013 Nursing Orders and July 2013 treatment administration record (TAR) included watch for signs and symptoms of infection,</p>	F 314		

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F 314	<p>Continued From page 10</p> <p>increased pain/tenderness, heat at wound, foul smelling drainage, redness or swelling, body temp, dressing change daily to legs per protocol amlactin to legs, wrap with kerlix and ace, and change LLE [left lower extremity] dressing daily with 2-3 people.</p> <p>* 3/5/13 "Progress Notes" - Braden Scale Assessment score of 11, high risk for pressure ulcer.</p> <p>* July 2013 Medication Administration Record (MAR) included, amlactin lotion, apply topically two times a day, hydrophor ointment, apply topically to affected skin four times a day: skin integrity.</p> <p>NOTE: It was unclear which "affected skin" area the above medication referred to, given that the resident also had pemphigoid blisters.</p> <p>LN #1 also provided Patient Progress Notes which documented:</p> <p>* 2/28/13 - "Cast removed. Leg dressings placed per MD, PA and RN. New orders received for daily dressing change-immobilizer in place.. LLE has a small open area to back of left heel-photographs obtained-will have skin nurse assess."</p> <p>Note: This was the first documentation of the Stage II pressure ulcer on Resident #1's left heel.</p> <p>* 5/2/13 - "[Physician's name] in to see resident and assess PU [pressure ulcer] on left foot, decision made to have left lower extremity xrayed today and leave off splint while in bed and place on while up for dialysis. PU is unchanged in appearance, tolerated dressing change well..."</p> <p>LN #1 also provided Skin Observation Sheets (SOS) which documented:</p> <p>* 2/28/13 - Left heel, open area, (Stage II pressure sore), 1 cm x 1 1/2 cm, etiology of</p>	F 314		

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F 314	<p>Continued From page 11</p> <p>wound- cast.</p> <p>* 3/5/13 - Left posterior heel, stage II pressure sore, 1 cm x 1 1/2 cm, s/t (secondary to) cast.</p> <p>* 3/13/13 - Left posterior heel, Stage II pressure sore, not measured, s/t cast; left medial ankle, Stage II pressure sore, not measured, s/t splint</p> <p>Note: This was the first time a second Stage II pressure ulcer was noted.</p> <p>* 4/2/13 - Left posterior heel, Stage II pressure sore, not measured, s/t cast; Left medial ankle, Stage II pressure sore, not measured, s/t splint</p> <p>* 4/9/13 - Left posterior heel, Stage II, 1/2 cm x 1/2 cm, pressure from cast; Left medial ankle, Stage II, 1/2 cm x 1/2 cm, pressure from splint</p> <p>* 4/20/13 - Left posterior heel, Stage II pressure sore, about dime size, cast; Left medial ankle, Stage II pressure sore, about dime size, splint. (NOTE: A dime is 1.7 cm in diameter, indicating a significant increase in wound size.)</p> <p>* 5/26/13 - Left posterior heel, dark eschar suspected deep tissue injury (SDTI) unstageable covered in eschar</p> <p>* 6/4/13 - Left posterior heel, unstageable SDTI, 100 percent eschar, 1.5 cm x 1 cm, pressure from cast.</p> <p>F314 Assessment and Treatment of Pressure Ulcers states in part: "With each dressing change or at least weekly (& more often when indicated by wound complications or changes in wound characteristics), an evaluation of the pressure ulcer wound should be documented. At a minimum, documentation should include the date observed &:</p> <ul style="list-style-type: none"> - Location & staging; - Size (perpendicular measurements of the greatest extent of length & width of the ulceration), depth; & the presence, location & extent of any undermining or tunneling/sinus 	F 314			

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F 314	<p>Continued From page 12 tract;</p> <ul style="list-style-type: none"> - Exudate, if present: type (such as purulent/serous), color, odor & approximate amount; - Pain, if present: nature & frequency (e.g., whether episodic or continuous); - Wound bed: Color & type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); & - Description of wound edges & surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate." <p>The facility failed to thoroughly and consistently assess Resident #1's pressure ulcers with thorough descriptions and measurements.</p> <p>On 8/1/13 at 5:45 p.m., the Administrator, DON, and MDS Nurse were informed of the pressure ulcer issue for Resident #1. No other information was provided that resolved the issue.</p>	F 314		
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure residents received the appropriate care</p>	F 323	<p>F-323</p> <ul style="list-style-type: none"> • A shower mat was placed in the in the shower for Res #6: the bath aide is responsible to assure the shower mat is in place before each use. Resident #10 is deceased. The CNA assigned to care for her was terminated. A new emphasis was placed on the importance of adherence to the Care Plan. A fall reduction plan was initiated. 	9/4/13

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F 323	<p>Continued From page 13</p> <p>and services, including adequate supervision, to prevent falls with injuries. This was true for 3 of 8 sample residents (#s 6, 9, and 10) reviewed for falls. Resident #6 was harmed when he fell in the shower and sustained a fracture to his left hip which required surgical intervention. Resident #10 was harmed when she sustained a C2 (second cervical vertebrae) fracture, a laceration to the forehead, pain, and died 4 days after a fall from the bed. And, Resident #9 had four falls in 28 days which created the potential for harm to the resident. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 12/8/8, and readmitted on 9/28/12 and 5/29/13. The resident had multiple diagnoses which included dementia and status post left and right hip surgeries. Additionally, the resident was diagnosed with CVA (cerebrovascular accident, or stroke) during an acute care stay between 9/13/12 and 9/28/13.</p> <p>Note: Review of an Incident/Accident (I/A) Report dated 9/13/12, documented Resident #6 fell on a "slippery" shower floor when a shower mat was not in place. The conclusion of the Fall Scene Investigation Report (FSI), documented, "Res[ident] [transferred] to acute care for ORIF [Open Reduction Internal Fixation] r/t [related to] [left] nondisplaced lower femoral neck fracture.</p> <p>Resident #6's annual MDS assessment, dated 7/31/12, prior to the 9/13/12 fall, included:</p> <ul style="list-style-type: none"> * Impaired cognition with a BIMS score of 10; * Extensive assistance of 1 person for bed mobility, transfers, and bathing; * Limited assistance of 1 person for dressing, toileting, and hygiene; * Scheduled and PRN (as needed) pain 	F 323	<p>Res #9 received orders for physical therapy for strengthening and has since become more ambulatory. Emphasis was being placed on the importance of adhering to the Care Plan for her. Staff members received training in fall prevention at Inservice on 08-08-13.</p> <ul style="list-style-type: none"> • A fall risk assessment will be done on admission, quarterly and with change in condition to determine whether a resident is at risk for falls and what interventions need to be implemented based on the results of the assessment. • The Morse Fall Scale will be used to assess fall risk. CNA's are provided daily 'mini care plans' to assist them in learning the CP of each individual resident. • Care Plans and fall logs will be reviewed at weekly QA meetings to determine whether interventions are appropriated or if further interventions should be considered. 	

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F 323	<p>Continued From page 14</p> <p>medications;</p> <ul style="list-style-type: none"> * Occasional pain at "8" on a scale from 0-10; and, * No falls since admission or the prior MDS assessment. <p>Resident #6's admission MDS assessment, dated 10/5/12, after the 9/13/12 fall, included:</p> <ul style="list-style-type: none"> * Severely impaired cognition with a BIMS score of 6; * Extensive assistance of 1 person for bed mobility, transfers, ambulation in room/hallways/on unit, dressing, toileting, hygiene, and bathing; * PRN pain medication; * Frequent pain at "8" on a scale from 0-10; * Pain limited day to day activity; * One fall with significant injury; * Two days of Occupational Therapy; and, * Six days of Physical Therapy. <p>An operative report documented Resident underwent a, "Left hip dynamic screw with derotation screw" for a left intertrochanteric hip fracture on 9/15/13.</p> <p>On 8/1/13 at 10:00 a.m., when asked about Resident #6's fall on 9/13/12, the DNS confirmed that a shower mat was not in place when the resident fell. The DNS stated, "A mat should have been on the floor."</p> <p>The facility failed to ensure a mat was in place on the shower room floor. This resulted in harm when Resident #6 fell and required surgical intervention for a non-displaced intertrochanteric hip fracture.</p> <p>On 8/1/13 at 6:00 p.m., the Administrator was</p>	F 323	<ul style="list-style-type: none"> a. The DNS or other appointed licensed nurse will monitor. b. Monitoring will be done weekly times 3 months then monthly thereafter. c. Audits will begin 08-27-13. <ul style="list-style-type: none"> • Date of completion: 09-04-13 	

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F 323	<p>Continued From page 15</p> <p>informed of the issue. No other information or documentation was received from the facility that resolved the issue.</p> <p>2. Resident #10 was admitted to the facility on 4/5/04, and readmitted on 6/28/04, with multiple diagnoses which included, renal insufficiency, diverticulitis with a colostomy, osteoarthritis, and recurrent UTI's (urinary tract infections). Additionally, the resident died in the facility on 5/13/13, four days after a fall on 5/9/13.</p> <p>Resident #10's last quarterly MDS, dated 4/9/13, coded in part:</p> <ul style="list-style-type: none"> * Short and Long-term memory problems; * Minimal hearing difficulty and impaired vision; * Able to understand others and make self understood; * Moderately impaired cognition - decisions poor, cues/supervision required; * Extensive assist of 2 people for bed mobility, transfers, and toileting; and * No falls. <p>The Resident's Care Plan, modified 1/25/13, included the following problems and their interventions:</p> <ul style="list-style-type: none"> * ADLS - "...Needs extensive two person assistance for bed mobility...Needs extensive, two person assistance for transfers...Needs extensive two person assistance for toileting. She is unable to maintain balance..." * Injury Risk, at risk for injury from falls - "...Needs two person assistance for transfers... Assure proper foot placement and that she is well balanced before beginning transfer...[Resident's name] does not typically attempt to stand unassisted but beware that increased confusion and delirium increase her risk for falls..." 	F 323			

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F 323	<p>Continued From page 16</p> <p>The Resident's Care Plan, reviewed and updated on 4/19/13, included the following problems and their interventions: * ADLS "Functioning/Structural", and, in handwriting, was "[Secondary] to fall [with] fx [fracture]of neck." - Handwritten interventions included, "5-9-13 bed rest only...Provide repositioning hourly throughout the day using log roll technique using caution to stabilize head/neck during movement...Provide comfort bath using 3-4 person assist for repositioning 5-9-13." Additional interventions included, "...Needs extensive 3-4 person assistance for bed mobility... She is non-ambulatory at this time...Needs extensive two-3 person assistance with dressing...Assess for pain before beginning cares. Notify nurse if noted for medication to minimize pain during cares." * Injury, fall with fx on 5/9/13 - "5-9-13 Report anxiousness to nurse if observed. Do not leave unattended if she is anxious or restless.</p> <p>Resident #10's Incident/Accident Report, dated 5/9/13 at 6:30 a.m., documented, in part: * "Fall from bed to floor, landed on head/L [Left] shoulder/L hip." * Describe exactly what happened - "I [CNA #10's name] on May 9 2013 was doing [sic] [Resident #10's name] AM cares and getting her dressed for the day. I sat her up on the bed in sitting position with her feet hanging over the edge, the same way I have done for a year straight prior to today. I had just finished changing her shirt and turned to grab her comb...when I turned back she had leaned toward the head of the bed and then fell forward. I tried to catch her as soon as I saw her falling but I couldn't stop her from falling. She landed on the floor and hit her head. I</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>immediately pushed the help button and the nurses and a few of the other aides came running in..." Below this, LN #2, documented, "She [the resident] was on floor [with] copious amount of blood pooling on floor from head injury. Calling for help. Assisted [by] 4 to W/C [wheel chair] [and] taken immediately to ER [Emergency Room]..."</p> <p>* Type of Injury, indicate on diagram location of injury - A front body diagram noted a laceration at the left forehead and "Pain" with a line drawn to the left shoulder and left hip.</p> <p>A Fall Scene Investigation Report (FSI), dated 5/9/13, documented in part:</p> <p>* CNA #10 witnessed the fall.</p> <p>* Factors at the time of the fall - "Resident lost their balance" and "Lost strength/appeared to get weak."</p> <p>* What appears to be the root cause of the fall? - "Res[ident] being assisted [with] 1 asst [assist] [at time] of fall-CP [Care Plan] requires 2 asst for bed mobility [and transfers]. Bed elevated to unsafe height. Res left unattended while CNA went to get comb. Res unable to maintain balance, fell forward striking head on floor. Resulting in C1-C2 spine Fx - ST [skin tear] to [right] hand, Laceration [left] forehead. Possible Fx of [right] hip."</p> <p>* "Conclusion: Fall d/t [due to] non-adherence to Plan of Care, resulting in physical harm to res. BFS [Bureau of Facility Standards] notified..."</p> <p>* Multiple staff interview statements were attached to the FSI. Three of the statements indicated the resident's bed was raised higher than it should have been. A statement by a CNA student documented the resident said, "I hurt, my neck, head." A statement by LN #11 documented, "Res ashen colored face - Crying in pain, Shaking, stated was going to throw up."</p>	F 323		

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F 323	Continued From page 18 Physical Assessment Patient Progress Notes (PAPNP) documentation included: * 5/9/13 at 2:13 p.m. - "Amended: 05/09/13 [at 2:22 p.m.] Note: Resident back to facility at 1100 this AM. Resident has stitches to forehead and neck brace to keep C-spine in place. Orders for bedrest and comfort measures with C-spine support with rolling, and IV [intravenous] morphine 2 mg [milligrams] [every] 1 H [hour]...administered 2 doses since returning to SNF..." * 5/9/13 at 11:43 p.m. - "Amended: 05/10/13 [6:55 a.m.] Note: MD [physician's initials] in to assess. Orders received for morphine PCA at 1 mg/hr [milligrams per hour]...now hooked up..." * 5/10/13 at 5:52 a.m. - "...C/o [complained of] pain once..." * 5/11/13 at 11:35 a.m. - "Note: 2 mg PRN IV push MSO4 giver per PCA [2 milligrams morphine sulfate given IV push per PCA pump as needed for pain]. Resident restless, pulling at neck collar, trying to set [sic] up, and screaming. Tried...repositioning, 1 on 1, offering fluids, no decrease in behavior..." * 5/11/13 at 1:45 p.m., "Note: Res awake...in pain, MD [physician] notified...increased morphine..." * 5/11/13 at 3:26 p.m. - "Sleeping, [resident's name] was getting kind of agitated so i [sic] sat...with her...tried to massage her legs...but she did not like that. I tried to swab her mouth out but she grabbed it from me." * 5/11/13 at 10:40 p.m. - "Note: Res...mostly unresponsive... When cares done, often wakes up and resists cares. She stated over and over 'Kill me.' 2 mg morphine bolus around 1725 [5:25 p.m.], which appeared to help her calm down and cares were done..." * 5/12/13 at 6:00 a.m. - "Rested majority of night.	F 323			

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F 323	<p>Continued From page 19</p> <p>Will awaken briefly...anxious X2 [times two] and called out. Easily calmed...</p> <p>* 5/12/13 at 2:49 p.m. - "Amended: 05/12/13 [3:01 p.m.] Note: Res agitated this AM, calling out, trying to remove neck brace. Crying out while repositioned, morphine bolus of 2 mg...[at 6:46 a.m.] with noted pain relief. Additional morphine bolus of 2 mg given [at 7:50 a.m. and 11:15 a.m.]. Continuous morphine infusing at 1 mg/ml... Dressing to forehead C/D/I [clean, dry, and intact]. Bruising noted to face [and] left shoulder..."</p> <p>* 5/12/13 at 8:32 p.m. - "Amended: 05/12/13 [8:38 p.m.] Note: Pt [patient] repositioned with 4 assist every hour... Pt has had episodes of agitation, pulling at bed linen, taking off gown, pushing neck brace up over chin and onto face. Facial grimace and crying out also noted with movement. Pt pulled PICC [peripherally inserted central catheter] out at approximately [6:00 p.m.]. MD notified. IV peripheral line started...X2 attempts. MD increased drip rate [IV morphine] to 1.5 mg/hour. Pt given bolus of morphine X2 thus far... This appears to help with relaxation and comfort."</p> <p>* 5/12/13 at 10:30 p.m. - "...log rolled with four staff at [10:00 p.m.]. Supported head and neck brace on. Restless... Pulled gown off... PCA morphine infusion at 1.5 mg per hour..."</p> <p>* 5/13/13 at 12:30 a.m. - ""Checked on resident. No response. No respiratory effort... Vital signs absent. Pupils fixed and dilated. Color pale. Cyanotic mucous membranes."</p> <p>A letter from the facility to the BFS, dated 5/14/13, regarding the investigation of Resident #10's fall on 5/9/13, documented in part, "The bed was measured and was determined to be elevated to [a] height of 27 [inches] from the top of the mattress to the floor. At this height the resident</p>	F 323			

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F 323	<p>Continued From page 20</p> <p>was unable to properly position her feet on the floor. [CNA #10] indicated that she had positioned the resident at the side of the bed to complete AM cares and turned to get her comb, leaving her unattended briefly."</p> <p>On 8/1/13 at 1:35 p.m., the DNS was interviewed about Resident #10's 5/9/13 fall. When asked if the resident had previous falls or orthostatic hypotension, the DNS answered "No" to both questions. The DNS stated CNA #10 did know the resident was care planned for 2 person assist with bed mobility and transfer, "But she did not do that." The DNS added, "I have let the staff know before how important it is to follow the care plans." The DNS stated that in early 2013, before the resident's fall, the facility recognized a trend in falls and implemented multiple corrective measures. She stated the corrective measures included a communication board for staff on which to share and/or reinforce information about residents' care plans; Kardex notes for CNAs; placed a White Board in the staff break room regarding changes for residents; and, a weekly interdisciplinary team (IDT), meeting about falls, which the physician attended. The DNS stated that since the resident's fall, a plan for fall reduction for 2013 was initiated. The DNS said the fall reduction plan included the aforementioned corrective measures and the following: a weekly newsletter about current issues, including falls, and staff must sign each newsletter to document they read them; the shift-to-shift report policy was updated; staff were in-serviced about care plans and rounding sheets were reinforced; and, the Nurses' Station was remodeled to improve the line of site to residents and to reduce the amount of time needed to exit the Nurses' Station.</p>	F 323			

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F 323	Continued From page 21 Resident #10 was harmed when she fell on 5/9/13 and sustained a laceration to the head, a C2 fracture, pain that required IV morphine, and died 4 days after the fall. The facility failed to ensure the resident's care planned interventions for 2 person assistance with bed mobility and transfers and proper foot placement were followed. The facility also failed to ensure staff did not leave the resident alone when she was seated on the side of the bed. On 8/1/13 at 6:00 p.m., the Administrator and the DNS were informed of the finding of harm to Resident #10 related to the 5/9/13 fall. However, no other information or documentation was received from the facility. 3. Resident #9 was admitted to the facility on 2/27/12. The Resident had multiple diagnoses including, congestive heart failure, hypertension, osteoporosis, dementia, and depression. An annual MDS assessment, dated 2/5/13, prior to Resident #9's first fall on 2/27/13, coded in part: * Severely impaired cognition with a BIMS score of 5; * Extensive assistance of 2 or more people for bed mobility, transfers, walking in room, and walking in corridor; * Extensive assistance of 1 person for locomotion on and off the unit, dressing, and toilet use; * Limited assistance of 1 person for personal hygiene; and, * No falls since admission or the prior MDS assessment. A quarterly MDS assessment, dated 4/30/13,	F 323			

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F 323	<p>Continued From page 22</p> <p>after Resident #9's falls on 2/27/13, 3/17/13, 3/18/13, and 3/26/13, coded in part:</p> <ul style="list-style-type: none"> * Impaired cognition with a BIMS score of 10; * Extensive assistance of 2 or more person for bed mobility, transfers, walking in room, and walking in corridor; * Extensive assistance of 2 or more person for locomotion on and off the unit; * Extensive assistance with 1 person for dressing and toilet use; * Extensive assistance with 1 person for personal hygiene; and, * Falls after admit/previous MDS assessment. <p>Resident #9's Long Term Care Plan, dated 2/13/13, documented interventions for limited physical mobility, in part:</p> <ul style="list-style-type: none"> * Needs 1-2 person assistance for transfers. She is able to transfer from her bed to the bedside commode (BC) with one person assisting; * Needs 2-3 person assistance for ambulation. Two person assistance for ambulation and a third person to push wheelchair behind to allow for breaks as needed; * Needs one person assistance for use of BC during the day and bed pan at night; and, * Bed alarm in bed to alert staff to attempts to stand unassisted. <p>On 5/8/13, Resident #9's care plan was revised and documented in part:</p> <ul style="list-style-type: none"> * Needs 2 person assistance for transfers. She is able to transfer from her bed to the BC with 2 person assisting; and, * Needs 1-2 person assistance for ambulation. One person assistance for ambulation and a second person to push wheelchair behind to allow for breaks as needed. 	F 323		

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F 323	<p>Continued From page 23</p> <p>Incident/Accident Reports (I/A) documented Resident #9 had four falls in a 28 day period as follows:</p> <p>* On 2/27/13 - "Res. [resident] was found laying on floor on back...Res. states, 'Trying to reach for pillow on ground [and] slid on butt.'"</p> <p>* On 3/17/13 - "She used the restroom and we were walking back out and got right to the doorway and [resident's name] started to wobble. I had my right hand on the gait belt so I grabbed hold with both hands and she fell backwards into me and I held on to her with the belt and slowly lowered her to the floor as I was helping her slide down the front of me."</p> <p>* On 3/18/13 - "Bed alarm noted to be going off. Staff in to assess. Resident found on left side of bed laying on right side...Resident stated, 'I rolled off trying to get comfortable.'"</p> <p>* On 3/26/13 - "CNA stated, 'Resident lost balance while I was cleaning her up after using BC [bedside commode].' Resident stated, 'My helper was cleaning me up when I lost balance and she helped me sit on the floor.'"</p> <p>FSI -- Fall Scene Investigation Report documented Resident #9's aforementioned falls as follows:</p> <p>* On 2/27/13 - The root cause, "Bed alarm not plugged in to box. Wearing normal sox [socks]." Intervention by facility: "Bed alarm placed [and] plugged in correctly."</p> <p>* On 3/17/13 - The root cause, "Res [resident] being amb [ambulated] [with] 1 asst [assist]- Legs became weak et [and] res lowered to floor to prevent injury. CP [care plan] states needs 2-3 asst for [transfers] et amb." Intervention by the facility: "CNA received disciplinary action for failure to adhere to care plan."</p> <p>* On 3/18/13 - The root cause, "Resident trying to</p>	F 323			

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F 323	Continued From page 24 get comfortable." Intervention by facility: "Considered [changing] to high-low bed to prevent injuries if res falls. Family desires to maintain current bed." * On 3/26/13 - The root cause, "Resident lost balance." Intervention by facility: "Use 2 person assist AAT [at all times]." Note: Resident #9's first and second falls were due to the facility's failure to adhere to the care plan related to the use of the bed alarm and 2-3 person assist for ambulation, respectively. On 8/1/13 at 1:40 p.m., the DON acknowledged that Resident #9 had 4 falls in less than a month, and indicated the resident's care plan had been updated. No other information was received from the facility that resolved the issue.	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 observation, record review, and staff interview, it was determined the facility failed to	F 328	F-328 <ul style="list-style-type: none">The O2 order for Resident (Res) #1 was verified and correction made to her Care Plan (CP) O2 @ 2L/min. on 08-2-13. Staff members received education in adhering to MD order for prescribed amount of oxygen on 08-08-13.All residents who require supplemental oxygen have the potential to be affected by the deficient practice.Staff members will be required to check flow rate at the end of each shift and document findings on rounding sheets.	9/4/13	

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F 328	<p>Continued From page 25</p> <p>ensure oxygen was administered per physician orders. This was true for 1 of 10 sample residents (#1). This failure created the potential for increase in respiratory problems if residents' respiratory needs were not met. Findings included:</p> <p>Resident #1 was admitted to the facility on 10/16/10 with multiple diagnoses including morbid obesity.</p> <p>Resident #1's most recent quarterly MDS assessment, dated 6/25/13 coded, in part, oxygen (O2) use.</p> <p>The resident's care plan identified the focus area, "Impaired gas exchange r/t[related to] inability to transport oxygen aeb [as evidenced by] episodes of hypoxia." One intervention was, "Needs O2 per nasal cannula [NC] continuously at 3L/min [3 liters per minute]."</p> <p>A recapitulation (recap) of the resident's Nursing Orders for July 2013 included an order for oxygen at 2 liters per minute (LPM) via nasal cannula continuously to keep O2 saturations greater than 90 percent for hypoxia.</p> <p>Note: On 7/31/13 at 10:30 a.m., an interview with the DON confirmed that the Nursing Orders are a direct reflection of the Physician's orders.</p> <p>Resident #1 was observed with a NC in place and the O2 liter flow rate as follows: * 7/30/13 at 10:00 a.m., 1.5 LPM per O2 concentrator; * 7/30/13 at 2:30 p.m., 1.5 LPM per O2 concentrator; and, * 7/30/13 at 5:30 p.m., 1.5 LPM per O2</p>	F 328	<ul style="list-style-type: none"> • Random checks will be made at different times and on different shifts to assure O2 liter flow meters are adjusted to the prescribed rate. <ul style="list-style-type: none"> a. The DNS or other appointed licensed nurse will monitor. b. Monitoring will be done daily times two weeks, the weekly times 3 months and monthly thereafter. c. Audits will begin 08-26-13. • Completion Date: 09-04-13. 		

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F 328	Continued From page 26 concentrator. On 7/31/13 at 12:40 p.m., Resident #1's O2 concentrator was observed to be set at the ordered 2 LPM. On 8/1/13 at about 9:25 a.m., the DON was informed of the observations and concerns about Resident #1's O2. However, no other information or documentation was received from the facility.	F 328		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to maintain a medication error rate of less than 5 percent. This was true for 5 of 26 medications (19%) which affected 4 of 12 residents (#1, #2, #11, and #13) reviewed for medication administration practices. The failure created the potential for harm if residents received less than optimum benefit from prescribed medications. Findings include: 1. Resident #11's Physician's Medications Report for August 2013 included orders for Vancomycin 125 mg/100 ml NS over 30 minutes every 12 hours, Prevacid SoluTab 30 mg once daily per PEG [percutaneous endoscopic gastrostomy] tube, and 1 can of Jevity 1.0 via PEG tube every 2 hours during the day from 7:00 a.m. to 7:00	F 332	F-332 <ul style="list-style-type: none">The administration time for Prevacid SoluTab for Resident (Res) #11 was changed to be given @ 16:30, 30 minutes prior his scheduled tube feeding @ 17:00. The administration time Vancomycin for Res # 11 was verified with pharmacy and determined that the low dose was safe to be administered over 30 minutes. Nursing staff educated and/or reminded to verify prescribed rate @ Inservice training on 08-28-13 Licensed Nurse (LN) #3 was questioned why only 1 gtt was administered to Res #13 when 2 gtt was ordered. She stated she was aware that 2 gtt were ordered, but was nervous when being observed by surveyors.	9/4/13

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F 332	<p>Continued From page 27 p.m.</p> <p>a. On 7/30/13 at 4:45 p.m., LN #3 was observed giving 2 medications (meds) through a feeding tube to Resident #11. The meds included tamsulosin and Prevacid SoluTab, both of which were crushed and placed in separate medicine cups.</p> <p>At about 4:55 p.m., Resident #11's wife was observed administering the 5:00 p.m. tube feeding per bolus.</p> <p>The Nursing 2013 Drug Handbook on page 794, regarding the oral administration of Prevacid SoluTab, states in part, "Give 30 to 60 minutes before a meal."</p> <p>Note: The Prevacid SoluTab medication was administered only 10 minutes prior to the bolus tube feeding, rather than 30 to 60 minutes as indicated.</p> <p>b. On 7/31/13 at 8:07 a.m., LN #1 was observed administering Vancomycin intravenous (IV) 125 milligrams (mls) to Resident #11. After the IV infusion had been set up, the LN stated, "We run it over an hour." LN #1 was then asked if the order had stated to run it over 30 minutes, at which she replied, "Oh! Yes it does." LN #1 adjusted the IV flow rate to 100 ml/30 minutes.</p> <p>On 8/1/13 at about 5:15 p.m., the Administrator, DON, and MDS nurse were informed of the medication errors. No other information or documentation as received from the facility which resolved the medication error issues.</p> <p>2. On 7/30/13 at 5:05 p.m., LN #3 was observed</p>	F 332	<p>The LN was observed by the DNS administering eye gtts to the resident on 08-19 @ 17:00, 08-21 @ 11:30 and 08-22 @ 17:30. She demonstrated appropriate technique and administered the prescribed 2 gtts each time she was observed. Additional education provided to all LN's on 08-28-13 of the risk for decreased effectiveness of administering the prescribed dose.</p> <p>LN #4 was questioned why she failed to roll the insulin for Res #1. She stated she was nervous when being observed by the surveyors. The policy for insulin administration was reviewed with her. She was observed by the DNS preparing insulin on 08-20 @ 07:45, 08:00, and 11:40. She demonstrated appropriate technique and understanding of the need to mix the insulin prior to administration.</p>		

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F 332	<p>Continued From page 28</p> <p>giving 2 medications (meds) to Resident #13 which included GenTeal eye drops. The LN was observed administering only one drop of GenTeal eye drops to each eye of the resident.</p> <p>The next morning upon reconciliation, Resident # 13's Physician's Medications Report for July 2013, revealed the order was for GenTeal eye drops, 2 drops to each eye four times daily.</p> <p>Note: The resident received only 1 drop when 2 drops should have been administered.</p> <p>On 8/1/13 at about 5:15 p.m., the Administrator, DON, and MDS nurse were informed of the medication error. No other information or documentation as received from the facility which resolved the medication error issues.</p> <p>3. On 7/30/13 at 5:25 p.m., LN #4 was observed preparing a Humalog insulin injection for Resident #1. The LN did not mix, or roll/swirl, the insulin in any way. When asked if the Humalog vial had been agitated, or rolled, prior to drawing up the insulin in the syringe, the LN stated, "I did not."</p> <p>Resident #1's Physician's Medications Report for August 2013 included orders for Humalog insulin, give per sliding scale.</p> <p>The Nursing 2013 Drug Handbook on page 733, regarding subcutaneous administration of Humalog insulin, states in part, "To mix insulin suspension, swirl vial gently or rotate between palms or between palm and thigh. Don't shake vigorously, to avoid bubbling and air in syringe."</p> <p>On 8/1/13 at about 5:15 p.m., the Administrator, DON, and MDS nurse were informed of the</p>	F 332	<p>LN#3 was questioned about the amount of fluid mixed with the MiraLax and stated she filled the 5 oz. cup to "almost" 4 oz. She stated she was not aware that the medication should be mixed in 4-8 oz. of fluid. Additional training was provided @ LN Inservice on 08-28-13. "Give with 4-8 oz of fluid" was added to the MAR of Res #2.</p> <ul style="list-style-type: none"> • All residents receiving medications have the potential to be affected if medications are prepared and/or given incorrectly. • Random medication administration observations will be conducted at different times and on different shifts to assure medications are prepared and/or given correctly. A refresher course on safe medication administration will be provided to licensed nurses annually. • Results of medication administration observations will be reviewed @ weekly QA meetings with education or additional training given as needed based on findings during observations. 	

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F 332	Continued From page 29 medication error. No other information or documentation as received from the facility which resolved the medication error issues. 4. On 8/1/13 at 10:35 a.m., LN #3 was observed giving 3 oral medications to Resident #2 which included polyethylene glycol 17 grams (gm). Resident #2's Physician's Medications Report for August 2013 included orders for polyethylene glycol powder, 17 gm once daily. The medication label on the polyethylene glycol bottle directed to mix the powder in 4-8 ounces of liquid. The LN mixed the medication in approx. 100 milliliters (less than 4 ounces) of water and administered it to Resident #2. When asked how much liquid the water cup used to mix the polyethylene glycol could hold, LN #3 stated, "4-5 ounces." When asked how much water had been used to mix the polyethylene glycol powder, LN #3 stated, "I'd give it at least 3.8 ounces." On 8/1/13 at about 5:15 p.m., the Administrator, DON, and MDS nurse were informed of the medication error. No other information or documentation as received from the facility which resolved the medication error issues.	F 332	a. Monitoring will be done by the DNS, ADNS or RDH (pharmacist). b. Monitoring will be done daily times 4 weeks, the weekly times three months and monthly thereafter. c. Monitoring will begin 08-26-13 • Completion Date: 09-04-13		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 367	F-367 • The recommendation for Res #6 from the Speech Therapist (ST) was clarified on 07-31-13. The MD was notified and order received for thickened liquids and specifies when res allowed having thin liquids. An order clarification was posted in the SNF kitchen, the Kardex and CNA shift report CP.	9/4/13	

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F 367	<p>Continued From page 30</p> <p>interview, it was determined the facility failed to ensure a resident received thickened liquids as recommended by speech therapy. This was true for 1 of 6 sample residents (#6) reviewed for dietary services. Failure to provide thickened liquids as recommended, placed Resident #6 at risk for choking and aspiration. Findings included:</p> <p>Resident #6 was admitted to the facility on 12/8/08, and readmitted on 9/28/12 and 5/29/13, with multiple diagnoses which included CVA (cerebrovascular accident).</p> <p>Resident #6's significant change MDS assessment, dated 6/11/13, coded, in part: * Severe cognitive impairment, with a BIMS score of 3; and * Holds food in mouth/cheeks or residual food in mouth after meals.</p> <p>The resident's Nutritional Status CAA, dated 6/11/13, documentation included: * Swallowing problem; * Very slow eating; * Short attention span; and * SLP (speech-language pathologist) for swallowing problems.</p> <p>Resident #6's Speech and Language/Dysphagia Evaluation, dated 6/12/13, documentation included, "...The patient also demonstrated reduced oral-laryngeal transit time of bolus and pocketing in the buccal pockets. Oral mastication seemed within normal limits..." The conclusions and recommendations included, "The patient is safe for a mechanical soft diet with thickened liquids. Water may be had between meals after aggressive oral cares (e.g. teeth brushing, mouth</p>	F 367	<ul style="list-style-type: none"> • Any resident with choking and/or swallowing difficulties has the potential to be affected by the deficient practice if ST recommendations are not followed. • Speech therapy notes will be reviewed by the medical records nurse who will forward the information to the Res physician for review. The DNS will be notified of all new orders so interventions can be care planned to meet the needs of each individual resident. A staff member will do random observations during different meals to assure the resident's liquids are thickened appropriately. • New orders and CP's will be reviewed @ weekly QA meetings to assure orders are appropriately addressed on the resident's CP. Observations will be reviewed for compliance. <ol style="list-style-type: none"> a. Monitoring will be done by the medical records nurse or DNS. 	

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F 367	<p>Continued From page 31 swabs)..."</p> <p>Subsequent twice a week ST visit notes, dated 6/14/13 through 7/22/13, documented, "The patient continues to present with moderate dysphagia...and mild to moderate memory deficits."</p> <p>The resident's nutrition care plan, dated 6/14/13, interventions included, "Adhere to mechanical soft, thickened liquid diet. May have thin liquids between meals but requires meticulous oral care every morning, after meals and before bed to minimize the risk of aspiration pneumonia...Able to feed himself but requires extensive cueing and encouragement to complete the task..."</p> <p>On 7/30/13 at 8:15 a.m., during a breakfast meal, CNA #12 was observed to mix 3 heaping scoops of thickener into a clear liquid in a small red glass and serve it to Resident #6. The CNA left the container of thickener on the table near the resident. A small box of orange juice (OJ) was also on the table in front of the resident. The juice box had a straw in it through a tiny opening near the top of the box. The juice box was otherwise unopened. The resident took 1 sip of the thickened liquid in the red glass and drank the juice through the straw.</p> <p>At about 8:30 a.m., CNA #12 was asked about Resident #6's liquids during breakfast. The CNA stated, "His water needs to be thickened during meals." When asked if the OJ was thickened, the CNA stated, "It is not."</p> <p>On 7/30/13 at about 12:30 p.m., during a lunch meal, Resident #6 was observed in a regular chair at a table in the dining room. The resident's</p>	F 367	<p>b. Monitoring will be done daily times two weeks, weekly times two months and monthly thereafter.</p> <p>c. Monitoring will begin 08-27-13.</p> <ul style="list-style-type: none"> Date of Completion: 09-04-13. 		

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F 367	<p>Continued From page 32</p> <p>wife was seated next to the resident. The resident drank several times from a small red glass that contained a thin clear liquid. Another small red glass full of an off white colored thickened liquid the consistency of pudding was also on the table near the resident's plate. And, a pitcher of water was on the table within the resident's reach. When asked about the 2 red glasses of fluids, the resident's spouse pointed to the glass with the thin liquid and said it was water and that the other glass contained lemonade. The spouse said the water did not need to be thickened but the lemonade did.</p> <p>On 7/30/13 at 12:45 p.m., LN #1, who was in the dining room, was asked if Resident #6's water was to be thickened. The LN stated, "No. Just thickened juice and other liquids."</p> <p>On 7/30/13 at 4:05 p.m., Resident #6 was observed seated at the same table in the dining room and wearing head phones. The resident was observed to drink from a small red glass several times. A thin clear liquid was observed in the red glass.</p> <p>On 7/31/13 at 7:55 a.m., during a breakfast meal, Resident #6 was observed seated at the same table in the dining room. Two small red glasses were on the table in front of the resident and a water pitcher was on the table within the resident's reach. One of the red glasses contained a thin clear liquid. The other red glass contained a almost clear pudding consistency thickened liquid. The Activity Director (AD) was in the room at the time.</p> <p>At 8:00 a.m., when asked about Resident #6's liquids, the AD, who said she was also a CNA,</p>	F 367			

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

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F 367	Continued From page 33 stated the thin clear liquid was water and the thickened liquid was juice. The AD stated, "He needs nectar thick liquids, except for water." On 7/31/13 at about 10:00 a.m., when asked what the consistency of Resident #6's oral liquids should be, the DON reviewed the resident's clinical record then stated, "He has an order for mechanical soft with thickened liquids including water." When informed of the multiple observations of non-thickened water and/or juice provided to the resident, and a water pitcher in front of the resident, the DON stated, "I think the confusion came because of the speech therapy order for thin water after oral care."	F 367			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure food was	F 371	F-371 <ul style="list-style-type: none">Both mixers were cleaned by dietary manager on 08-01-13. An Inservice was presented on 08-07-13 to the dietary staff instructing them in the importance of making sure equipment is maintained in clean and sanitary condition. The popcorn machine was cleaned by the restorative nurse's aide on 07-31-13. An Inservice was provided to SNF staff on 08-08-13 instructing them in the importance of assuring equipment is maintained in clean and sanitary condition.	9/4/13	

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F 371	<p>Continued From page 34</p> <p>prepared in sanitary conditions. This was true for sample Resident #s 1-9, 12, and 13, as well as any resident eating food prepared with the mixers in the kitchen or popcorn from the facility popcorn machine. Findings included:</p> <p>1. On 7/29/13 at 3:00 PM, during the initial tour of the facility's kitchen, two stand mixers were observed by the surveyor. The stand and frame of Mixer #1 was covered with a clear plastic bag, with the area for the bowl exposed. Mixer #1 was identified by the CDM as being clean, just needing the bowl replaced. Mixer #2 was covered with a dark-colored plastic bag, and identified by the CDM as being clean and ready to use. Mixer #1 was noted with a dried white caked substance adhering to the frame of the mixer where the bowl should be attached. Mixer #2 was noted with a similar substance adhered to the frame directly over the bowl. The CDM stated, "They should have been cleaned. We have been short-handed lately."</p> <p>On 8/1/13 at 12:00 PM, Mixer #1 and Mixer #2 were observed in the kitchen with plastic bags covering them, indicating they were clean and ready for use. The CDM was asked if they had been cleaned since the surveyor's initial observation on 7/29/13. The CDM stated, "I don't know." Mixer #1 was observed by the surveyor and the CDM to have the same white caked substance adhered to it. Mixer #2 was clean.</p> <p>2. On 7/30/13 at 8:15 AM, and again at 11:40 AM, the surveyor observed a popcorn machine sitting in the corner of the dining room. The popcorn machine had a hopper approximately three feet tall by two feet wide by two feet deep. It had a metal framed base and glass doors. It was sitting</p>	F 371	<ul style="list-style-type: none"> • Any resident eating food prepared with the mixers in the kitchen or popcorn from the popcorn machine has the potential to be affected by the deficient practice. • Cleaning schedules have been implemented in the dietary and activity departments to assure equipment is kept clean and sanitary. • Dietary manager to monitor cleaning schedules and inspect equipment for cleanliness in dietary department. Activity staff to monitor cleaning schedules and inspect popcorn machine for cleanliness in SNF. <ul style="list-style-type: none"> a. Dietary manager to monitor cleaning schedules in dietary kitchen. Activity Director or other activity staff to monitor cleaning schedule in SNF b. Monitoring will be done daily times one week, then weekly times one month and monthly thereafter. c. Monitoring will begin 08-26-13 • Date of Completion: 09-04-13 		

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F 371	<p>Continued From page 35</p> <p>on the top shelf of wheeled cart. There was a black weaved mat directly under the machine, covered with popcorn hulls and partially popped kernels. There was a metal tray in the front of the hopper, also full of hulls and partially popped kernels. The black knob for the tray was coated in a greasy dust-type substance. The hopper itself had approximately 4 inches of shriveled popcorn inside. The glass doors on the hopper were coated in a thick substance consisting of grease, dust, and popcorn hulls, both on the inside and the outside. On the inside of the hopper, at the top of the metal frame base, two popped kernels of shriveled popcorn were suspended in the substance.</p> <p>On 7/30/13 at 2:35 PM, the DNS observed the popcorn machine with the surveyor. The DNS stated she did not know when the popcorn machine had last been used, but to the best of her knowledge it had not been used recently. The DNS agreed the popcorn machine was not clean.</p> <p>On 7/30/13 at 5:10 PM, the surveyor noted the popcorn machine to still be in the dining room. The shriveled popcorn had been removed from the hopper, but the machine had not been cleaned. The tray at the base of the machine had been emptied, but there were a number of popcorn hulls adhered to the bottom of the tray in a grimy/oily substance. The surveyor asked the DNS again about the popcorn machine, and it was immediately removed from the dining room.</p> <p>On 7/31/13 at 10:35 AM, the surveyor observed the popcorn machine in the DNS's office. The machine and the cart had been cleaned.</p> <p>On 8/1/13 at 5:45 PM, the Administrator, DNS,</p>	F 371	

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F 371	Continued From page 36 and MDS nurse were informed of the surveyor's findings. The facility offered no further information.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and 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.	F 431	F-431 <ul style="list-style-type: none">A Fentanyl patch change was scheduled for Res #3 on 8-6. The patch was removed, destroyed and witnessed by a 2nd LN. A Fentanyl Patch was scheduled to be changed for Res #12 on 8-2. The patch was removed, destroyed and witnessed by a 2nd LN. Subsequent Fentanyl patch changes have been observed to be done appropriately.All residents who require Fentanyl Patches have the potential to be affected by the deficient practice.A policy for the removal and disposal of Fentanyl patches was reviewed with LN staff on 08-28-13. The controlled substance record was revised to reflect used patch removal /destruction as well as application.	9/4/13

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F 431	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, it was determined the facility failed to ensure the disposal of used fentanyl (a controlled medication) patches was witnessed by 2 licensed nurses (LNs) and documented. This was true for 1 random resident (#12) and 1 sample resident (#3) during medication pass observations. The failed practice created the potential for harm from the diversion of the residents used fentanyl patches. Findings included: Note: Informational Letter, Reference: S&C: 13-02 NH, stated, in part, "Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for abuse, misuse and diversion, and the substantial amount of fentanyl remaining in the patch after use. The facility's policies must address safe and secure storage, limited access and reconciliation of controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and disposition of the medications. One benefit of the patch is the continuous delivery of fentanyl over 72 hours. This slow-release of fentanyl from the transdermal reservoir allows for more consistent pain control in patients with chronic pain. This unique delivery system, however, is not impervious to diversion, even after the fentanyl patch has been used, removed and/or disposed. One study determined that even after three days of use, 28 to 84.4% of the original fentanyl dose was still present in the	F 431	<ul style="list-style-type: none"> • CSR will be monitored to assure compliance with patch changes, removal and destruction. <ul style="list-style-type: none"> a. The DNS, ADNS or medical records nurse will do the monitoring. b. Monitoring will be done daily times 2 weeks, then weekly times two months and monthly thereafter. c. Audits will begin 08-29-13. • Date of Completion: 09-04-13. 		

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F 431	<p>Continued From page 38</p> <p>patch. The study noted that the dose remaining in the patch was within the limits of a lethal fentanyl dose.</p> <p>The remaining fentanyl in a used patch is a potential vehicle of abuse and accidental overdose and warrants implementation of adequate disposal policies. Fentanyl products contain several boxed warnings related to potential abuse, misuse, and diversion, and specifically, the contraindication of fentanyl transdermal patch use in individuals who are not opioid tolerant.</p> <p>Staff should dispose of fentanyl patches in the same manner as wasting of any other controlled substances, particularly because the active ingredient is still accessible. Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized. ..."</p> <p>1. On 7/30/13 at 11:05 a.m., LN #2 was observed as she prepared 3 medications, which included a Fentanyl patch, for Resident #12. The LN removed the resident's old Fentanyl patch and disposed of it in the sharps container located in the resident's room. LN #2 then stated, "I don't know where else to put it."</p> <p>Note: A second nurse did not witness or document the disposal of the used fentanyl patch.</p> <p>2. On 7/31/13 at 9:15 a.m., LN #2 was observed as she removed a fentanyl patch from Resident #3's back. The LN held onto the old fentanyl patch in her gloved hand and placed a new patch onto the resident's back. LN #2 then walked to the nurses station and disposed of the used fentanyl patch in the sharps container located on the medication cart.</p> <p>Note: A second nurse did not witness or document the disposal of the used fentanyl patch.</p>	F 431		

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(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 431	Continued From page 39 On 8/1/13 at 5:30 p.m., the DON was informed of the 2 observations where only one LN disposed of a used fentanyl patch. The DON was asked if she was familiar with the informational letter regarding the disposal of used fentanyl patches. She stated she was, "Vaguely familiar" with the letter. When asked if the facility had a policy regarding the disposal of used fentanyl patches, the DON stated, "We should. I know we had discussed it with [the pharmacist]." On 8/1/13 at 5:45 p.m., the Administrator, DON, and MDS Nurse were informed of the fentanyl patch issue. The facility did not provide further information or documentation that resolved the issue.	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	F 441	F-441 <ul style="list-style-type: none">A plastic receptacle has been secured to the rail on the side of Res #11 bed. He has been educated in the need to place the urinal in the receptacle between uses. CNA #2 was re-educated in proper hand-washing and the need to wear gloves when touching resident 14's food. All staff members received education in infection control in Inservice on 08-08-13.Residents who use a urinal @ bedside have the potential to be affected. All residents have the potential to be affected if a staff member touches their food with bare hands.	9/4/13	

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254	
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F 441	<p>Continued From page 40</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 2 random residents (#s 11 and 14). Failure to follow standard infection control measures placed the residents at risk for infections. Findings included:</p> <p>1. On 7/30/13 at 4:55 p.m., during a medication (med) pass by LN #3, a urinal, 2 uncovered glasses with straws with various amounts of in them, a water mug with a lid and a straw, and a box of tissues were observed on an over bed table at the left side of Resident #11's bed. The LN did remove the urinal, nor did the LN not ask or instruct the resident to remove the urinal from the over bed table.</p>	F 441	<ul style="list-style-type: none"> • Any resident who uses a urinal will be provided a receptacle for placing the urinal in between uses. All staff members will receive training in infection control at least quarterly. • Random observation will be made at different times and on different shifts to assure urinals are not place in inappropriate areas that may cause cross-contamination and dining room will be monitored to assure proper infection control measures are taken to protect staff and residents during meals. <ul style="list-style-type: none"> a. The DNS and other appointed staff members will monitor. b. Monitoring will be done daily times two weeks then weekly times 2 months and monthly thereafter. c. Audits will begin 08-29-13 • Completion date: 09-04-13 	

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 441	<p>Continued From page 41</p> <p>On 7/31/13 at 8:00 a.m., during another med pass observation LN #1, a urinal, 2 uncovered paper cups with a small amount of liquid in each, a small glass with a straw and a small amount of clear liquid in it, a water mug, and a box of tissues was observed on the resident's over bed table. The LN did remove the urinal, nor did the LN not ask or instruct the resident to remove the urinal from the over bed table.</p> <p>On 8/1/13 at about 10:00 a.m., the resident's over bed was observed without a urinal on it.</p> <p>On 8/1/13 at 3:30 p.m., when informed of the observations regarding a urinal on Resident's 11's over bed table, the DNS nodded "yes" and stated, "Yeah."</p> <p>On 8/1/13 at about 4:00 p.m., the Administrator was also informed of the infection control issue. No other information or documentation was received from the facility.</p> <p>2. On 7/30/13 at 12:20 p.m., during the lunch meal observation in the dining room, CNA #1 was observed placing her bare hand on top of Resident #14's hamburger bun to pat it down, and again to hold the hamburger in place to cut it in half.</p> <p>At 1:25 p.m., when asked about the bare handed contact with Resident #14's hamburger bun, CNA #1 nodded her head, "Yes." When asked if this was a usual practice, the CNA stated, "No. Usually they don't have a whole hamburger that way. It's usually cut up meat or something."</p> <p>On 7/30/13 at 6:30 p.m., the DNS and MDS Nurse were informed of the infection control</p>	F 441			

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

PRINTED: 12/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2013
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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F 441	Continued From page 42 issue. However, no other information was received from the facility.	F 441		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/02/2013
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F/	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH 5TH STREET MONTPELIER, ID 83254
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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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 were: Nina Sanderson LSW BSW Linda Kelly RN Lauren Hoard RN BSN	C 000	<p style="text-align: center;">RECEIVED SEP - 4 2013 FACILITY STANDARDS</p> <p style="text-align: center;">See POC for F 241</p> <p>C 168.100.02.c</p> <ul style="list-style-type: none"> • Skin tear to resident #4 (not 5) healed. The dressing was discontinued 08-03-13. The facility's Accident and Investigation Policy was revised on 08-06-13 to instruct licensed nurses to investigate the cause of all marks, discolorations, skin breaks and injuries to residents of the SNF. (Previous policy instructed to investigate if cause of injury was unknown) 	
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 see F 241 as it pertains to resident privacy.	C 125		
C 168	02.100,12,c Record of all Incidents/Accidents c. An incident-accident record shall be kept of all incidents or accidents sustained by employees, patients/residents, or visitors in the facility and shall include the following information: This Rule is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility did not keep records for all resident accidents and injuries. This was true for 1 of 9 residents (Resident #5) sampled for incident records.	C 168		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Admin</i>	(X6) DATE 9-4-13
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/02/2013
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH 5TH STREET MONTPELIER, ID 83254
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C 168	Continued From page 1 Findings included: On 7/24/13 at 6:46 AM, Resident #5's Patient Progress Notes documented, "Skin tear on right forearm...done when resident was scratching arm in Sacrament meeting..." On 7/30/13 at 10:24 AM, Resident #5's Nursing Orders documented, "...skin tear right forearm...change dressing every 3 to 5 days and PRN [as needed]..." On 7/29/13 at 3:00 PM, during the initial tour of the facility, Resident #5 was noted with a small circular bandage on her right forearm. On 7/31/13 at 10:15 AM, the DNS was asked about the facility's investigation into the cause of the skin tear to Resident #5's right forearm. The DNS stated as a rule, the facility did not generate an incident record, beyond the Patient Progress Notes, for a non-fall injury when it was known how the injury occurred. The DNS was asked if this was consistent with the state requirement for incident records on all resident injuries. The DNS stated, "I hadn't thought of that. It's probably a good idea, for tracking purposes." On 8/1/13 at 5:45 PM, the Administrator, DNS, and MDS nurse were informed of these findings. The facility offered no further information.	C 168	<ul style="list-style-type: none"> Any resident who has a bruise, skin tear or other injury has the potential to be affected by the deficient practice. The facility's Accident and Incident Investigation policy will be reviewed with LN staff at Inservice on 08-28-13. All incidents will be reported to the DNS and administrator (or acting administrator) within 24 hours and recorded on the Incident report Log. All incident and accident reports, witness and resident statements will be reviewed within 5 working days and weekly QA meetings to determine whether current interventions for prevention are appropriate or if further interventions are needed, and also, to determine whether abuse may have occurred. <ol style="list-style-type: none"> The DNS or ADNS will monitor. Monitoring will be done daily times 2 weeks, then weekly times 3 months and monthly thereafter. Audits will begin 08-29-13. 	
C 293	02.107.04,b Therapeutic Diets per Physician Orders b. Therapeutic diets shall be planned in accordance with the physician's order. To the extent that it is medically possible, it shall be	C 293	<ul style="list-style-type: none"> Date of Completion: 09-04-13. <p>See POC for F-367</p>	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F,	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH 5TH STREET MONTPELIER, ID 83254
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C 293	Continued From page 2 planned from the regular menu and shall meet the patient's/resident's daily need for nutrients. This Rule is not met as evidenced by: Refer to F367 as it related to thickened liquids.	C 293		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F 371 as it pertains to food preparation and storage.	C 325	See POC for F 371	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it related to infection control in the facility.	C 669	See POC for F441	
C 671	02.150,03,b Handling Dressings, Linens, Food b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Refer to F441 as it related to infection control regarding food.	C 671	See POC F-441	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

BEAR LAKE MEMORIAL SKILLED NURSING F, **164 SOUTH 5TH STREET**
MONTPELIER, ID 83254

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C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it related to care plan revision.	C 782	See POC F 280	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it related to the use of oxygen.	C 788	See POC F 328	
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 pressure ulcers.	C 789	See POC F 314	
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it related to adequate supervision to prevent falls.	C 790	See POC F 323	

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C 811	Continued From page 4	C 811		
C 811	02.200,04,g,vii Medication Errors Reported to Physician vii. Medication errors (which shall be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Refer to F332 as it related to medication errors greater than 5 percent.	C 811	See POC F332	
C 853	02.201,03,g Documentation of Loss/Wastage g. If there is a loss or wastage of unused portions of a prescribed schedule II drug, a notation to that effect shall be made in the nursing notes and signed by the person responsible and attested to by the Director of Nursing Services. This Rule is not met as evidenced by: Refer to F431 as it related to disposal/wasting of narcotic medication.	C 853	See POC F431	