



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 2366

August 14, 2013

Robin J. Leary, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Leary:

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

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 27, 2013**. Failure to submit an acceptable PoC by **August 27, 2013**, may result in the imposition of civil monetary penalties by **September 16, 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.

Robin J. Leary, 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)

Robin J. Leary, Administrator
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **August 27, 2013**. If your request for informal dispute resolution is received after **August 27, 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

This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.

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

PRINTED: 08/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification, state licensure, and complaint investigation survey of your facility. The surveyors conducting the survey were: Michael Case, LSW, QMRP, Team Coordinator Sheri Case, LSW, QMRP Karla Gerleve, RN Amy Jensen, RN Becky Thomas, RN Survey Definitions: BID - twice daily CNA - Certified Nursing Assistant COPD - Chronic Obstructive Pulmonary Disease DON - Director of Nursing DNS - Director of Nursing Services LN - Licensed Nurse MDS - Minimum Data Assessment POST - End of Life Advance Directive PRN - As needed QID - four times a day QOD - every other day RCM - Resident Care Manager	F 000			
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	F 280	F-280 SPECIFIC RESIDENT Resident # 6 and #14 care plans have been up-dated to accurately reflect interventions related to dialysis services including monitoring dialysis access site, managing potential emergencies and complications, and pre/post dialysis form completed.		

RECEIVED
AUG 23 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Robert Deary TITLE Executive Director (X6) DATE 8/21/13

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

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F 280	<p>Continued From page 1</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, it was determined the facility failed to ensure care plans included pertinent information related to dialysis for 2 of 2 sampled residents (#6 and #14). This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #14 was admitted 3/5/13 and readmitted on 7/11/13 with diagnoses which included non-healing surgical wound, chronic kidney disease, diabetes mellitus and hypertension.</p> <p>Review of Resident #14 most recent Quarterly MDS assessment, dated 7/19/13, documented the resident was cognitively intact.</p> <p>The resident's 7/11/13 Dialysis Flow Sheet documented the resident was to go to dialysis on Tuesday, Thursday and Saturday.</p> <p>During an observation on 7/31/13 at 3:50 PM, a</p>	F 280	<p>OTHER RESIDENTS</p> <p>Residents who require dialysis have the potential to be affected by this practice and their dialysis care plans have been up-dated with the necessary information including completion of the pre/ post dialysis form.</p> <p>SYSTEMIC CHANGES</p> <p>License nurses were in-serviced on ensuring that dialysis care plans accurately reflect resident status and managing potential emergencies and complications and completion of pre/ post dialysis form.</p> <p>MONITOR</p> <p>Nurse Mangers and or designee will perform audits of the care plans for dialysis residents and pre/ post dialysis form 3 times a week for 4 weeks, then 2 times a week for 4 weeks and then weekly for 3 months.</p>		

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F 280	<p>Continued From page 2</p> <p>sign above Resident's #14 bed was observed which stated "No blood pressure in right arm." The resident stated she went to dialysis on Tuesday, Thursday and Saturday. The port site was observed to be in the right upper chest.</p> <p>Resident #14's Care Plan dated 3/5/13 for dialysis identified to check port (left upper chest) site for s/sx (signs and symptoms) of infection, pain or bleeding daily and PRN. However, the port site was observed in the upper right chest during observation on 7/31/13 at 3:50 PM. The Care Plan did not include information on how to manage emergencies and complications due to bleeding/hemorrhaging and infection/bacteremia/septic shock. The Care Plan did not include the resident's blood pressures should not be taken on the right arm.</p> <p>When interviewed on 8/1/13 at 1:20 PM, the RCM stated the Care Plan did not include information on how to manage emergencies and complications such as bleeding.</p> <p>2. Resident #6 was admitted to the facility on 6/1/09 and readmitted on 11/16/12 with diagnoses which included end stage renal disease and above the knee amputation.</p> <p>Review of Resident #6's most recent Quarterly MDS assessment, dated 5/26/13, documented the resident was cognitively intact and was on dialysis.</p> <p>The resident's 7/27/12 Care Plan documented the resident was to go to dialysis on Monday and Friday.</p>	F 280	<p>The audits were initiated on 8-13-13. The trends of the audits will be brought to QA/PI monthly by the Director of Nursing for 3 months to identify the need for further education and/ or system revision.</p> <p>The Director of Nursing is responsible for ongoing compliance.</p> <p>DATE OF COMPLIANCE</p> <p>August 29, 2013</p>		

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F 280	Continued From page 3 During an observation on 8/1/13 at 2:20 p.m. Resident #6 stated he went to dialysis 2 times each week. When asked if he ever took an information sheet to the dialysis center he said, "Not very often." Resident #6's Care Plan dated, 7/27/12 for dialysis included to monitor the shunt site, to protect the shunt site from injury and to not take his blood pressure on his right arm. The Care Plan did not include information on how to manage emergencies and complications due to bleeding/hemorrhaging and infection/bacteremia/septic shock or to ensure communication between the facility or the dialysis center. On 8/1/13 at 1:20 PM, the RCM stated the Care Plan did not include information on how to manage emergencies and complications such as bleeding.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure an outdated oral antibiotic was removed from the medication refrigerator and was not available for resident use. This failure created the potential for decreased efficacy if oral Vancomycin was administered after the expiration date. This was true for one of three (100 hall) refrigerators and	F 281	F-281 SPECIFIC RESIDENT Resident # 4 is administered medications that are not outdated. OTHER RESIDENTS Residents receiving medication have the potential to be affected by this practice and will receive medications that are not outdated.		

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F 281	<p>Continued From page 4 had the potential to affect one sampled resident (#4). Findings include:</p> <p>Pharmacology and the Nursing Process, Fifth Edition, 2007, "Nurses may reduce the likelihood of medication errors by taking the following precautions... carefully reading all labels for accuracy and expiration dates..."</p> <p>Resident #4 was admitted to the facility on 10/3/11 and readmitted on 6/24/13 with multiple diagnoses including, Pneumonitis, Stage III Kidney disease, and Clostridium Difficile.</p> <p>The residents 6/24/13 Physicians Orders documented the following: -Vancomycin 250 mg QID (four times a day) for 2 weeks, then -Vancomycin 150 mg QID for one week, then -Vancomycin 150 mg BID (twice a day) for one week, then -Vancomycin 150 mg daily for one week, then -Vancomycin 150 mg qod (every other day) for two weeks.</p> <p>On 7/31/13 at 10:45 a.m., the 100 Hall medication refrigerator was examined for outdated medications. One bottle of Vancomycin 250 mg/5 ml, dated 7/5/13 with an expiration date of 7/19/13 was found in the fridge.</p> <p>On 7/31/13 at 11:15 a.m. LN #4 was interviewed about the expired bottle of Vancomycin in the fridge. The LN was asked which bottle she was using to administer Resident #4 his Vancomycin and the LN told the surveyor she was using the open bottle in the fridge. The surveyor asked the LN if she had checked the expiration date and the LN said she had not.</p>	F 281	<p>SYSTEMIC CHANGES Licensed Nurses were in-serviced on ensuring they check medications for date of expiration prior to administration.</p> <p>Evergreen Pharmacy Nurse Consultant will visit the facility monthly for 3 months, to inspect medication carts, med room, medication refrigerators and also observe medication pass.</p> <p>MONITOR DON , RCM's and/or designee will perform medication cart, med room and medication refrigerator audits 3 times a week for 4 weeks, then 2 times a week for 4 weeks then weekly for 3 months.</p> <p>Audits were initiated on 8/14/13.</p> <p>The trends of the audits will be brought to QA/PI monthly by the Director of Nursing for 3 months to identify the need for further education and/ or system revision.</p> <p>The Director of Nursing is responsible for ongoing compliance.</p> <p>DATE OF COMPLIANCE August 29, 2013</p>		

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F 281	Continued From page 5 On 7/31/13 at 11:30 a.m. RCM #2 was notified about the expired Vancomycin. RCM #2 looked at the medication label on the bottle and confirmed the expiration date of 7/19/13. She asked LN #4 what bottle of Vancomycin was being used and LN #4 said, "The open bottle in the fridge." Note: The RCM immediately disposed of the medication and ordered a new bottle from the Pharmacy.	F 281			
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 observation, record review, review of the dialysis contract, resident and staff interview, it was determined the facility failed to ensure continuity of care for residents receiving dialysis services. This was true for 2 of 2 sampled residents (#6 and #14) reviewed for dialysis. This created the potential for harm if residents did not receive the care and/or services based on their current needs. Findings included: 1. Resident #14 was admitted 3/5/13 and readmitted on 7/11/13 with diagnoses which included non-healing surgical wound, chronic	F 309	F-309 SPECIFIC RESIDENT Resident # 6 and #14 care plans have been up-dated to accurately reflect interventions related to dialysis services including monitoring dialysis access site, managing potential emergencies and complications and medications to be held prior to dialysis. The pre/post dialysis form will be completed on dialysis days. OTHER RESIDENTS Residents who require dialysis have the potential to be affected by this practice and will have the pre/post dialysis form completed and have had their care plan reviewed and updated to include monitoring dialysis access site, managing potential emergencies and complications and medications to be held prior to dialysis.		

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F 309	<p>Continued From page 6 kidney disease, diabetes mellitus and hypertension.</p> <p>Review of Resident #14 most recent Quarterly MDS assessment, dated 7/19/13, documented the resident was cognitively intact.</p> <p>The resident's 7/1/13 Dialysis Flow Sheet documented the resident was to go to dialysis on Tuesday, Thursday and Saturday.</p> <p>During an observation on 7/31/13 at 3:50 PM, a sign above Resident's #14 bed was observed which stated "No blood pressure in right arm." The resident stated she went to dialysis on Tuesday, Thursday and Saturday. When asked if a communication sheet was between the facility and dialysis center, the resident stated "no."</p> <p>On 8/1/13 at 2:15 PM the DON provided a copy of The Agreement for Dialysis Services and on page 2 in Section h, entitled Interchange of Information and Development and Implementation of Facility Resident's Care Plan it stated, "Provider and Facility shall cooperate and work together in exchanging necessary information, including information regarding the condition of Facility residents, which is necessary to develop and implement a care plan enabling the Facility residents to receive quality care in accordance with all federal, state, and local regulations. Such exchange of information shall include, but not be limited to, the Provider providing training and information to Facility personnel on the care of shunts/fistulas, infection control..."</p> <p>Resident #14's Care Plan dated 3/5/13 for dialysis included to check the port site for s/sx (signs and symptoms) of infection, pain or</p>	F 309	<p>SYSTEMIC CHANGES</p> <p>Licensed nurses were in-serviced on ensuring that medications to be held on dialysis days were identified on the care plans and physician orders, completion of pre-post dialysis form, and care planning to include managing potential emergencies and complications and monitoring dialysis access site.</p> <p>The facility met with the pharmacy to ensure dialysis information would be transcribed to the re-caps.</p> <p>A dialysis specific MAR is now being utilized to ensure information is readily available to the nurses. The contracted dialysis units have been contacted to ensure adequate communication between facility and the dialysis units and the expectation to complete the pre/post dialysis form.</p> <p>A new dialysis communication form is being use to aide in communication following dialysis.</p> <p>MONITOR</p> <p>Medical Records and or designee will perform audits of MAR, care plans and pre / post dialysis forms for the dialysis residents 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then weekly for 3 months.</p> <p>Audits were implemented on 8/14/13.</p>		

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F 309	<p>Continued From page 7</p> <p>bleeding daily and PRN. The Care Plan also documented the facility was to communicate with the dialysis center regarding medications, diet and lab results.</p> <p>*NOTE: The Care Plan did not include information on how to manage emergencies and complications due to bleeding/hemorrhaging and infection/bacteremia/septic shock. Additionally, the Care Plan did not include that blood pressures should not be taken on the right arm. The Care Plan identified to check Port (L Upper Chest). However, the port site was observed to be in the right upper chest. Refer to F-280.</p> <p>On 8/1/13 at 1:20 PM, RCM #1 reported to the surveyor that, in the past, the facility had sent a "Pre/Post Dialysis Checklist" to dialysis with Resident #14. However, it was never returned so the checklist form was not consistent. RCM #1 stated the form should have been sent each time Resident #14 went to dialysis. Additionally, the RCM stated the Care Plan did not include information on how to manage emergencies and complications such as bleeding.</p> <p>Later that day the DON provided a copy of the checklists for 7/2/13, 7/25/13 and 8/1/13. The dialysis center did not complete the post dialysis section on 7/25/13. They did, however, complete the post dialysis sections for 7/2/13 and 8/1/13. The DON stated these were the only checklists she could find for this resident.</p> <p>Resident #14's medical record did not document the physician had reviewed the resident's medication orders to indicate if medications were to be administered before or after dialysis to maximize their effectiveness and avoid adverse</p>	F 309	<p>The trends of the audits will be brought to QA/PI monthly by the Director of Nursing for 3 months to identify the need for further education and/ or system revision.</p> <p>The Director of Nursing is responsible for ongoing compliance.</p> <p>DATE OF COMPLIANCE</p> <p>August 29, 2013</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854	
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F 309	<p>Continued From page 8 effects. The resident's MAR dated 7/11/13 and Recapitulation Orders dated 7/11/13 did not indicate if medications were to be administered before or after dialysis.</p> <p>During the interview on 8/1/13 at 12:35 PM when asked for documentation the physician had reviewed the resident's medication to determine when the medication should be administered, the RCM #1 stated she would check. No further information was provided.</p> <p>On 8/1/13 at 4:15 PM the Executive Director and DON were notified of the above concerns. No further information was provided by the facility.</p> <p>2. Resident #6 was admitted to the facility on 6/1/09 and readmitted on 11/16/12 with diagnoses which included end stage renal disease and above the knee amputation.</p> <p>Review of Resident #6's most recent Quarterly MDS assessment, dated 5/26/13, documented the resident was cognitively intact and was on dialysis.</p> <p>The resident's 7/27/12 Care Plan documented the resident was to go to dialysis on Monday and Friday.</p> <p>During an observation on 8/1/13 at 2:20 p.m. Resident #6 stated he went to dialysis 2 times each week. When asked if he ever took an information sheet to the dialysis center he said, "Not very often."</p> <p>Resident #6's Care Plan dated, 7/27/12 for dialysis included to monitor the shunt site, to protect the shunt site from injury and to not take</p>	F 309		

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F 309	<p>Continued From page 9 his blood pressure on his right arm.</p> <p>*NOTE: The Care Plan did not include information on how to manage emergencies and complications due to bleeding/hemorrhaging and infection/bacteremia/septic shock.</p> <p>On 8/1/13 at 1:20 PM, RCM #1 reviewed the resident's medical chart and stated it did not document communication between the facility and the dialysis center. RCM #1 stated the form should have been sent each time Resident #6 went to dialysis. Additionally, the RCM stated the Care Plan did not include information on how to manage emergencies and complications such as bleeding.</p> <p>Later that day the DON provided an undated checklist for Resident #6. The facility had not completed the Pre-Dialysis section; however, the dialysis center had completed the Post Dialysis section. The DON stated these were the only checklists she could find for this resident.</p> <p>Resident #6's 7/1/13 Medication Administration Record (MAR) documented he was to receive his Furosemide (diuretic) 80 mg every morning on non-dialysis days. The MAR did not include any other medications that stated if he was to receive the medication prior to or after dialysis.</p> <p>During an interview on 8/1/13 at 12:35 PM, when asked for documentation the physician had reviewed the resident's medication to determine when the medication should be administered, the RCM #1 stated she would check. No further information was provided.</p> <p>On 8/1/13 at 4:15 PM the Executive Director and</p>	F 309		

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F 309	Continued From page 10	F 309			
F 314 SS=G	<p>DON were notified of the above concerns. No further information was provided by the facility.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure that a resident who entered the facility without a pressure sore did not develop a pressure sore. This was true for 1 of 5 (#3) sampled residents reviewed for pressure sores. The facility failed to assess and monitor a stage II pressure sore on Resident #3's coccyx from 6/18/13 to 7/23/13. During that time, the stage II pressure sore developed into a stage III pressure sore, causing Resident #3 harm, and put the resident at further risk for pain and infection. Findings included:</p> <p>Resident #3 was admitted to the facility on 8/2/12 with diagnoses of left sided stroke with hemiplegia and type II diabetes mellitus.</p> <p>Resident #3's 3/26/13 significant change MDS assessment, coded in part:</p>	F 314	<p>F- 314</p> <p>SPECIFIC RESIDENT</p> <p>Resident # 3 receives the necessary care and services to promote healing, prevent infection and prevent new pressure ulcers including head to toe skin assessment weekly and weekly wound assessment and documentation.</p> <p>OTHER RESIDENTS</p> <p>Resident who have pressure ulcers have a potential to be affected by this practice and will have timely treatment orders, weekly skin assessment completed including wound assessment with measurements documented.</p> <p>SYSTEMIC CHANGES</p> <p>Licensed Staff were in-serviced on pressure ulcer prevention, treatment, monitoring, documentation, assessment, and identification and communication of new pressure ulcers.</p>		

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F 314	<p>Continued From page 11</p> <ul style="list-style-type: none"> -Long and short term memory ok -Independent for daily decision making -Usually understood -Understands others -Dependent of two persons for bed mobility and transfer -Locomotion on and off the unit did not occur -Extensive assistance of 1 person for eating and personal hygiene -Extensive assistance of 2 persons for dressing, toilet use, and bathing -Upper and lower extremity impairment on one side -Always incontinent of urinary and bowel -Wheelchair use -At risk for developing pressure ulcers -No healed or unhealed pressure ulcers -Moisture associated skin damage (MASD) <p>Resident #3's 6/26/13 most recent quarterly MDS assessment differed from the significant change assessment as follows:</p> <ul style="list-style-type: none"> -Sometimes understood -Dependent of two persons for dressing, and toilet use -Extensive assistance of one person, for locomotion on and off the unit -Extensive assistance of two person for personal hygiene -Had an unhealed pressure ulcer -Had one stage 2 pressure ulcer -Date of oldest stage 2 pressure ulcer, 6/18/13 <p>Resident #3's 1/11/13 "Braden Scale For Predicting Pressure Sore Risk" assessment documented Resident #3 scored a 15, "At risk" for developing pressure sores.</p> <p>Resident #3's care plan identified the problem:</p>	F 314	<p>Residents with pressure ulcers will have weekly assessment of wound and documentation completed. The residents will be discussed at the weekly resident at risk meetings to ensure that interventions and treatments are effective or if changes need to be made to their plan of care.</p> <p>MONITOR DON, RCM's and or designee will audit weekly skin assessments and wound documentation 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then weekly for 3 months.</p> <p>Audits were implemented on 8/14/13.</p> <p>The trends of the audits will be brought to QA/PI monthly by the Director of Nursing for 3 months to identify the need for further education and/ or system revision.</p> <p>The Director of Nursing is responsible for ongoing compliance.</p> <p>DATE OF COMPLIANCE August 29, 2013</p>		

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F 314	Continued From page 12 "8/2/12: Resident is at risk for developing a pressure ulcer related to immobility, disease process/condition post stroke" Approaches included in part: -Assist PRN to reposition/shift weight to relieve pressure, -avoid prolonged periods of skin to skin contact, -complete Braden scale risk assessment quarterly PRN, -complete weekly skin assessment, -notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing or daily care, -position with pillows to maintain proper body alignment PRN, provide incontinence care after incontinence episodes. Apply barrier cream PRN, -provide pressure relieving or reduction device: pressure reduction mattress, chair cushion -report changes in skin status to physician -2/12/13 turning and repositioning program frequently -use lifting device, draw sheet to reduce friction Additional care plan identified problems for Resident #3 included in part: "Wound type/location - 6/18/13 Stage II open area coccyx, this area heals and re-opens, moisture related excoriation" Approaches included in part: -Complete Braden Scale Risk Assessment quarterly and PRN, -Complete Weekly Skin Assessment, -Educate resident responsible party about skin condition, treatment, -Inspect skin during bathing, especially over bony prominences, -Observe for pain and medicate PRN per physicians's orders, -Observe for s/s [sign and symptoms] infection or	F 314		

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F 314	<p>Continued From page 13</p> <p>delayed healing and report to physician PRN, redness/erythema, drainage-purulent or bloody, -Report changes in skin status to physician, -Wound care as ordered (see current physician's orders/MAR) observe effectiveness or response to treatment as ordered.</p> <p>"3/21/2013 Resident is diagnosed with terminal condition and is at risk for loss of dignity during the dying process. Breast cancer with mets [metastasis] to the brain [sic] Resident is at risk for unavoidable significant declines initiation [sic] of Palliative cares" Approaches included in part: -Allow resident to discuss feeling if able and -Notify physician for change in condition.</p> <p>The 7/1/13 "Physician's Orders" documented in part: -8/7/12-Span America Air Mattress, -8/31/12-Side to side positioning every 2 hours, -12/01/12-Weekly skin assessment every Saturday Evening shift, -3/01/13-LN to monitor function of air mattress daily.</p> <p>F314 regulations state: "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 &: o Location & staging; o Size (perpendicular measurements of the greatest extent of length & width of the ulceration), depth; & the presence, location & extent of any undermining or tunneling/sinus</p>	F 314		

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F 314	<p>Continued From page 14 tract;</p> <ul style="list-style-type: none"> o Exudate, if present: type (such as purulent/serous), color, odor & approximate amount; o Pain, if present: nature & frequency (e.g., whether episodic or continuous); o Wound bed: Color & type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); & o Description of wound edges & surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate." <p>Resident #3's "Weekly Skin Integrity Data Collection" tool read, "If Open Area, proceed to appropriate skin condition record" and documented in part:</p> <ul style="list-style-type: none"> -3/1/13-Skin Intact, -3/16/13-Skin Condition: Old, on R buttock excoriation, -4/6/13 & 4/13/13-Skin intact, dry, redness coccyx, -4/20/13 & 4/24/13-Skin intact, dry, -5/4/13, 5/12/13, 5/18/13, & 5/19/13-Skin intact, dry, redness coccyx, -5/26/13-Skin intact, dry, redness, excoriated area on coccyx, open area, -(Not dated)-Skin intact, dry, excoriated area on coccyx healing, open area, Old, -6/8/13-Skin intact, dry, excoriated area on coccyx healing, -6/15/13-Skin intact, dry, excoriated area on coccyx, -6/22/13-Skin intact, dry, -6/29/13-Skin intact, dry, -7/23/13-Open area, Old, -7/27/13-Dry, Open area, Old. <p>Note: The Care Plan quoted above identified that</p> 	F 314		

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F 314	<p>Continued From page 15</p> <p>a stage II pressure ulcer was discovered on Resident #3's coccyx on 6/18/13. There was no description of the Stage II pressure ulcer from 6/29/13 to 7/23/13 on the "Weekly Skin Integrity Data Collection" tool.</p> <p>Resident #3's 6/1/13 TAR documented in part: "12/01/12 Weekly Skin assessment Every Saturday Evening Shift" "6/27/13-Cleanse open area on coccyx c [with] NS [normal saline] then apply Allevyn Gentle Q 3 days."</p> <p>Note: A physicians order for treatment to the wound was ordered on 6/27/13. This was 9 days after the care plan had identified the wound.</p> <p>Resident #2's 7/1/13 TAR documented in part: "12/01/12 Weekly Skin Assessment Every Saturday Evening Shift" The TAR was initialed as completed on July 6 and 13. July 20 and July 27 were blank, and indicated no assessment was provided. Note: Although the "Weekly Skin Assessment" was initialed as completed on July 6 & 13, there was no documentation of the Stage II Pressure Ulcer, and there were no entries on the "Weekly Skin Integrity Data Collection" tool from June 29 to July 23, 2013. This did not meet the minimum requirement as directed by F314 regulation as mentioned above when evaluating and documenting pressure ulcers.</p> <p>The order to "Cleanse open area on coccyx [with] NS then apply Allevyn Gentle Q 3 days" was discontinued on 7/24/13.</p> <p>A new treatment was initiated on 7/24/13 that read: "Cleanse area on coccyx [with] NS apply</p>	F 314		

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F 314	<p>Continued From page 16</p> <p>iodosorb to wound bed. Cover [with] Allewyn Gentle [change] Q M-W-F [Monday-Wednesday-Friday] [and] PRN until resolved."</p> <p>Note: There was no evidence the Stage II Pressure Ulcer on Resident #3's coccyx was assessed, measured, or monitored from 6/18/13 to 7/23/13. There was no documentation the treatment the resident was receiving was effective or should have been changed. Then, on 7/23/13, the Stage II pressure ulcer had become a stage III pressure ulcer.</p> <p>Resident #3's 7/25/13 Progress Notes documented: "Late entry for 7/23/12. Skin team in to assess coccyx wound. Area measures 1x1.0.1cm. 100% superficial slough noted to wound bed. Periwound skin with blanchable erythema. No drainage or s/sx of infection noted. Continues with air mattress, Q 2 hr [every 2 hours] side to side turns. Remains on palliative care and comfort meds. Resident continues to refuse to eat. Takes liquids and health shakes only. Discussed with resident and spouse consequences of continued refusal to eat and likely outcome of continued or worsened skin breakdown. Resident and spouse continues to request no aggressive interventions and remain on palliative care. Spouse at facility daily and very involved in resident cares."</p> <p>On 7/31/13 at 10:00 am, RCM #2 was interviewed regarding Resident #3's coccyx pressure ulcer. RCM #2 said Resident #3 had excoriation to the coccyx that would come and go, but developed a Stage II pressure ulcer to the coccyx on 6/18/13. The Stage II pressure ulcer developed into a Stage III pressure ulcer which</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>was covered in slough. The surveyor informed RCM #2 of the blanks in the documentation of Resident #3's July TAR, and the lack of documentation for June 29, 2013 to July 23, 2013 in the "Weekly Skin Integrity Data Collection" tool. The surveyor requested documentation of the monitoring of Resident #2's coccyx pressure ulcer.</p> <p>On 7/31/13 at 1:40 pm, the surveyor observed the wound treatment to Resident #3's coccyx. LPN #5 said, "I don't remember the area around the wound being that red" and measured the wound to be 2.2x3.0 cm. The wound was covered in what appeared to be white colored, soft, and moist slough.</p> <p>On 7/31/13 at 3:00 am, RCM #2 provided the "Pressure Ulcer Status Record" and explained the difference in the "Weekly Skin Assessment" versus the "Pressure Ulcer Status Record". RCM #2 said the nurse working the floor completes an overall body check of the resident's skin for the weekly skin assessment. If open areas are found, the wound team is notified and the findings are recorded on the "Pressure Ulcer Status Record". The wound team makes rounds for the residents with pressure wounds one time a week. The wound round team measures, stages, and assesses the wounds during these rounds and documents the findings on the "Pressure Ulcer Status Record". She said the nurse that initially discovered the Stage II pressure ulcer on Resident #3's coccyx on 6/18/13, did not notify the wound team of the pressure ulcer, and the wound team failed to monitor or assess the wound until 7/23/13.</p> <p>Resident #3's "Pressure Ulcer Status Record"</p>	F 314		

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F 314	<p>Continued From page 18 documented: Risk Factors related to Healing: "Incontinence" Date First Observed: "6/18/13" Stage: "II" Location: "Coccyx" Surface area: "2x2 cm" Depth: "1 cm"</p> <p>Date: 6/18/13, Stage: II, Surface Area in cm: 2cmx2cm, Depth: 1cm, Drainage: none, Odor: 0, color: red, Tunneling: 0, Appearance of wound: (blank), Response to Treatment: No change, Is resident experiencing pain: Yes, Non-Verbal Signs: Moaning/Crying, Location of Pain: Coccyx Date: 7/23/13, Stage: III, Surface Area in cm: 1x1, Depth: 0.1cm, Drainage: None, Odor: 0, Color: Yellow, Tunneling: 0, Appearance of wound: Slough 100%, Response to Treatment: Deteriorated, Is resident experiencing pain: No, Non-Verbal Signs: (blank), Location of Pain: (blank) Date: 7/30/13, Stage: 3, Surface Area in cm: 0.8x1.5, Depth: 0.2, Drainage: None, Odor: 0, Color: yellow, Tunneling: (blank), Appearance of wound: Slough 100%, Response to Treatment: Deteriorated, Is resident experiencing pain: No, Non-Verbal Signs: (blank), Location of Pain: (blank)</p> <p>Note: There was no evidence or documentation the Stage II Pressure Ulcer on Resident #3's coccyx was assessed, measured, or monitored from 6/18/13 to 7/23/13. There was no evidence or documentation the treatment the resident was receiving was effective or that the treatment should have been changed. On 7/23/13, the Stage II pressure ulcer was documented as a stage III pressure ulcer.</p>	F 314		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 19 On 8/1/13 at 12:30 pm, during an interview with the DON, the DON agreed that the nurse who documented the Stage II pressure ulcer did not follow through the facility's protocol. The nurse failed to notify the wound team so that the wound team was aware to assess and monitor the wound. The DON said the staging of pressure ulcers was performed by two nurses and Resident #3 had developed a Stage III pressure ulcer on her coccyx. On 8/1/13 at 1:30 pm, the Administrator was informed of the concern of the Stage III pressure ulcer on Resident #2's coccyx. No information or documentation was provided that resolved the issue.	F 314			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	F- 329 SPECIFIC RESIDENT Resident # 14 has a diagnoses identified for ordered medications. OTHER RESIDENTS Residents who require medications have the potential to be affected by this practice and will have diagnosis with the medication. SYSTEMIC CHANGES License Nurses were in-serviced on ensuring that medications have diagnosis on the MAR and the recaps.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 20 contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure each resident's drug regimen had adequate indications for medication use. This was true for 1 of 16 (#14) residents sampled for medications. This created the potential for harm when Resident #14 received multiple medications without clinical indication. Findings included:</p> <p>Resident #14 was admitted to the facility on 9/16/11 with diagnoses that included Schizophrenia, COPD, Heart Failure, Chronic Pain, Hypertension, and Adult Failure to Thrive.</p> <p>Review of Resident #14's Recapitulation Orders dated 8/1/13 included medication orders for the following medications: Warfarin Sodium, Lantus, Aspirin, Atorvastatin, DOK, Furosemide, Gabapentin, Levothyroxine, Sensipar, Zyvox. However, there was no diagnoses listed for any of these medications.</p> <p>On 8/1/13 at 12:35 PM the DON was interviewed regarding the recapitulation orders not including diagnoses for the above medications. She stated the diagnoses had not been "carried over" from the admission orders. On 8/1/13 at 1:55 PM the DON provided the Physician Admission Orders which did not include diagnoses for 8 of 10 of the medications listed above.</p>	F 329	<p>The facility met with Evergreen pharmacy medical records person and clarified our expectations on ensuring medication diagnoses print out on the MAR's and re-caps.</p> <p>The facility has identified diagnosis for the current medications for residents.</p> <p>MONITOR</p> <p>DON, RCM's and or designee will audit medication orders for diagnosis 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then weekly for 3 months.</p> <p>Audits were implemented on 8/14/13.</p> <p>The trends of the audits will be brought to QA/PI monthly by the Director of Nursing for 3 months to identify the need for further education and/ or system revision.</p> <p>The Director of Nursing is responsible for ongoing compliance.</p> <p>DATE OF COMPLIANCE</p> <p>August 29, 2013</p>		

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F 329	Continued From page 21	F 329			
F 441 SS=D	<p>On 8/1/13 at 4:15 PM the Executive Director and DON were notified of the above concern. No further information was provided by the facility.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>	F 441	<p>F-441</p> <p>SPECIFIC RESIDENT</p> <p>Resident # 11 is provided incontinent care in a manner that prevents the development and transmission of disease and infections.</p> <p>OTHER RESIDENTS</p> <p>Residents who require assistance with incontinent care have the potential to be affected by this practice and will receive peri-care following acceptable standards of practice.</p>		

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F 441	<p>Continued From page 22</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 record review, observation and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 11 sampled residents (#11). Failure to follow hand hygiene procedures placed residents at risk for infections. Findings included:</p> <p>Resident #11 was admitted to the facility on 6/20/13 with diagnoses that included prostate cancer and bone cancer.</p> <p>Resident #11's most recent Admission MDS assessment, dated 6/27/13, documented he required extensive assistance of two staff for bed mobility, toilet use and personal hygiene.</p> <p>During an observation, on 7/30/13 at 7:20 a.m., CNA #6 and CNA #7 were providing peri-care for Resident #11. The CNA #6 had gloves on and used a disposable wipe to clean the resident's peri-area. The resident was documented to say "I am a mess." CNA #6 removed the disposable incontinence briefs (Attends) and CNA #7 placed it in a garbage bag. Both CNA's then began to assist the resident with getting dressed. The CNA's were asked if they had washed their hands after disposing of the Attends. CNA #6 and CNA #7 stated they had not washed their hands but should have.</p>	F 441	<p>SYSTEMIC CHANGES</p> <p>Nursing assistants were in-serviced on providing incontinent care that ensures the prevention and transmission of disease and infection including hand washing practices.</p> <p>The SDC will audit hand washing practices on the floor and following incontinent care during her infection control floor rounds.</p> <p>Infection control practice continues to be a part of the facility's orientation program.</p> <p>MONITOR</p> <p>Nurse managers and or designee will perform hand washing and incontinent care observations 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then weekly for 3 months.</p> <p>Audits were implemented on 8/21/13.</p> <p>The trends of the audits will be brought to QA/PI monthly by the Director of Nursing for 3 months to identify the need for further education and/ or system revision.</p> <p>The Director of Nursing is responsible for ongoing compliance.</p>		

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F 441	Continued From page 23	F 441	DATE OF COMPLIANCE		
F 514 SS=D	<p>On 8/1/13 at 4:15 p.m. the Executive Director and the DON were informed of the above concern. The facility provided no further information.</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to accurately document information in residents' medical records. This was true for 2 of 11 residents sampled (#10 and #11) for clinical records. This created the potential for medical decisions to be on based on inaccurate information. Findings included:</p> <p>1. Resident #11 was admitted to the facility on 6/20/13 with diagnoses that included prostate cancer and bone cancer.</p> <p>Resident #11's medical record included a</p>	F 514	<p>F-514</p> <p>SPECIFIC RESIDENT</p> <p>Resident #'s 6 and 10 medical record is maintained in accordance with accepted professional standard of practice. This includes, accurate birth date on documents, and wound/skin documentation.</p> <p>OTHER RESIDENTS</p> <p>Other residents have the potential to be affected by this practice and the medical record will accurately reflect the resident information.</p> <p>SYSTEMIC CHANGES</p> <p>Licensed Nurses were in-serviced on ensuring complete and accurate documentation in the medical record.</p> <p>The facility has audited for the accurate birth date on the POST forms and found no other discrepancies.</p>		

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F 514	<p>Continued From page 24</p> <p>Non-Pressure Skin Condition Record (NPSC) documenting an area to the right buttocks, on 6/28/13, of .5 cm by .5 cm. The diagram on the NPSC documented the area was open.</p> <p>A Weekly Skin Integrity Data Collection form, dated 6/28/13, documented the same area was red from a radiation burn. A second NPSC documented on 6/28/13 the bilateral buttocks were red.</p> <p>On 8/1/13, at 1:20 PM, RCM #1 stated the area on the buttocks had never been open and that the NPSC documentation it was open was inaccurate.</p> <p>The Executive Director and the DON were informed of the above information on 8/1/13 at 4:15 PM. The facility provided no further information.</p> <p>2. Resident #10 was admitted to the facility on 9/16/11.</p> <p>Record review of Resident #10's POST (Physician Orders For Scope of Treatment) had an incorrect date of birth (2/18/54). The resident's face sheet documented the correct date of birth. The POST was signed by the POA (Power of Attorney) on 6/6/11 and by the Physician on 6/7/11.</p> <p>On 7/30/13 at 3:40 PM, RCM #1 stated, "the date of birth for the resident listed on the POST was incorrect." The RCM stated she would get a new POST signed by the POA.</p>	F 514	<p>MONITOR</p> <p>Nurse managers or designee will perform chart audits of weekly skin assessments, wound documentation and accurate birth date on POST form 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then weekly for 3 months.</p> <p>Audits were implemented on 8/14/13.</p> <p>The trends of the audits will be brought to QA/PI monthly by the Director of Nursing for 3 months to identify the need for further education and/ or system revision.</p> <p>The Director of Nursing is responsible for ongoing compliance.</p> <p>DATE OF COMPLIANCE</p> <p>August 29, 2013</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/02/2013
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual recertification, state licensure, and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Michael Case, LSW, QMRP, Team Coordinator Sherri Case, LSW, QMRP Karla Gerleve, RN Amy Jensen, RN Becky Thomas, RN</p> <p>Survey Definitions: cm - centimeters MAR - Medication Administration Record Q - Every RN - Registered Nurse TAR - Treatment Administration Record</p>	C 000		
C 644	<p>02.150,01,a,i Handwashing Techniques</p> <p>a. Methods of maintaining sanitary conditions in the facility such as:</p> <p>i. Handwashing techniques. This Rule is not met as evidenced by: Please refer to F441 as it relates to infection control and handwashing.</p>	C 644		
C 745	<p>02.200,01,c Develop/Maintain Goals/Objectives</p> <p>c. Developing and/or maintaining goals and objectives of nursing</p>	C 745		

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FACILITY STANDARDS

Please see plan of correction for F 441

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robin Leary</i>	TITLE <i>Executive Director</i>	(X6) DATE 8/21/13
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Bureau of Facility Standards

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C 745	Continued From page 1 service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F 281 as it relates to profession standards of practice.	C 745	Please see plan of correction for F 281	
C 763	02.200,02,c,iii When Average Census 90 or More iii. In SNFs with an average occupancy rate of ninety (90) or more patients/residents a registered professional nurse shall be on duty at all times. This Rule is not met as evidenced by: Based on review of a three week nursing schedule and staff interview, it was determined the facility did not ensure a Registered Nurse (RN) was on duty at all times for 10 night shifts when the facility census was 90 or more residents. Findings include: Nursing Schedules from 6/30/13 through 7/26/13 were reviewed. They did not include RN coverage on the night shift when the census was 90 or above. RN coverage was not provided on the following dates/shifts: * On 7/2/13 through 7/4/13 for night shift, * On 7/10/13 and 7/11/13 for night shift, * On 7/17/13 through 7/19/13 for night shift, * On 7/25/13 and 7/26/13 for night shift. On 8/1/13 at 8:25 a.m., the Staffing Coordinator was interviewed related to the lack of RN coverage during the above the night shifts. The Staffing Coordinator said, "I was told when I transferred here that we only have to have RN coverage for 16 hours during the day, on the day	C 763	200.02.c.iii SPECIFIC RESIDENT No residents specified OTHER RESIDENTS Residents have the potential to be affected by this practice and will be provided 24 hour RN coverage. SYSTEMIC CHANGES Facility will have RN coverage on all 3 shifts. Staffing Coordinator was in-serviced on ensuring RN coverage on all shifts 7 days a week. The facility has hired additional RN's and has changed the license nurses to 12 shifts. MONITOR DON or designee will continue to review the schedule 5 days a week during the daily stand-down meeting to ensure RN coverage.	

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C 763	Continued From page 2 and evening shift." On 8/1/13 at 8:35 a.m., the DNS was informed about the missing RN coverage and said would look at the daily staffing sheets to see if the facility had coverage on those night shifts. On 8/1/13 at 9:15 a.m., after the DNS reviewed and provided the surveyor with copies of the daily staffing sheets, it was confirmed the facility did not have Registered Nurse coverage on the night shift for the above dates.	C 763	Manager on duty will ensure 24 hour RN coverage on the weekends. Review of staffing was implemented on <u>8/14/13</u> . Staffing trends will be brought to QA/PI monthly by the Director of Nursing for 3 months to ensure ongoing compliance or need for system revision. The Director of Nursing is responsible for ongoing compliance.	
C 780	02.200,03,a,ii Coordinated with Other Care Services ii. Developed in coordination with other patient/resident care services provided to the patient/ resident; This Rule is not met as evidenced by: Please refer to F309 as it related to coordination of care services between the facility and dialysis.	C 780	DATE OF COMPLIANCE August 29, 2013 <i>Please see plan of correction for F-309</i>	
C 781	02.200,03,a,iii Written Plan, Goals, and Actions iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Please refer to F280 as it relates to the written plan of care.	C 781	<i>Please see plan of correction for F280</i>	
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited	C 789		

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C 789	Continued From page 3 to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F314 for development of a Stage III pressure sore.	C 789	Please see plan of correction for F-314		